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The MicroInsurance Centre, LLC

## **The Landscape of Microinsurance in the World's 100 Poorest Countries**

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## Executive summary

The benefits of financial services for the poor are now universally acknowledged, and the practice of microcredit is becoming common in developing countries. In comparison, microinsurance – insurance for the poor – which has the potential to significantly aid millions of poor people, has received limited attention.

This report provides:

- A description of how microinsurance works
- A landscape study (detailed quantitative overview) of microinsurance in the world's 100 poorest countries

### Why microinsurance?

Because their resources are so limited, poor people can experience great financial disruption when unexpected events befall them. If a breadwinner is injured or falls ill, there is not only the loss of income and labor, but the prospect that without cash in advance there will be no treatment at all. If a breadwinner dies, not only must funeral expenses be paid, but continued cash for basic needs and education of the family is required. A poor person's property may be limited to a few animals or crops and a modest shelter, but the destruction of any of these may be a great blow to the family's economy. Even small sums insured can ensure some protection and peace of mind (and dignity) for a poor person.

From the point of view of insurers, however, small sums insured mean small premiums and low profit margins. Thus microinsurance has to be well-administered, cost-efficient, and delivered on a large scale if it is to benefit the poor, and those who provide the microinsurance.

### The microinsurance supply chain

The microinsurance supply chain is made up of five components:

- Reinsurer – provides insurance to insurers for catastrophic risks
- Insurer – carries the insurance risk
- Delivery channel – sells the insurance policy and provides basic servicing
- Policy holder – buys the product (can be individuals or groups)
- Covered lives – those who benefit from the cover (normally family members, or group members for group policies)

Reinsurance does not yet play a big role in microinsurance. Microinsurance tasks are essentially shared between the insurer and the delivery channel. It is crucial to understand the distinction between insurer and delivery channel. The *insurer* is the one who carries the risk, finalizes the premium and product design, and ultimately pays claims. The *delivery channel* sells the product and provides after-sales service. Insurers can range from multinational or domestic commercial insurers, to member-owned mutuals, non-governmental organizations (NGOs) or community-based organizations (CBOs), or even informal groups. Delivery channels are the ones who are in contact with the policy holder. They work best when they are organizations close to poor people – such as churches, trade unions, microfinance institutions, retailers, non-governmental organizations (NGOs) or community-based organizations (CBOs). It is possible for one entity, whether an insurance company, NGO or CBO, to be both the insurer and the delivery channel,

but the distinction between these two functions still remains. In practice CBOs tend to be good delivery channels but poor insurers, because they do not have professional insurance staff.

### **The landscape survey**

The information for this report was gathered from primary and secondary research by a team of 11 microinsurance experts, attempting to cover all microinsurance offered in the 100 poorest countries. The team attempted to identify as many microinsurers and products as possible. Products, insurers, delivery channels, regulations, social security schemes, and donor interventions were all identified and assessed.

The researchers identified:

- 579 sources of relevant information across a wide range of sources, from peer reviewed documents to unpublished reports to interviews with insurance company executives
- 357 microinsurance products (separate from social security schemes)
- 116 social security schemes
- 246 microinsurers (separate from government providers of social security)
- 78 million people in the 100 poorest countries were found to have microinsurance cover

Several tendencies stand out in the landscape data. These include:

- A significant presence of health microinsurance, especially in West and Central Africa. Though high in number of programs, the membership of these programs is generally small and their growth potential limited.
- The dramatic effect of insurance regulation introduced in India over the past few years, which has pushed microinsurance out into the rural areas and towards the poor. Over 30 million low-income people are covered by over 130 products. However, as one might expect from regulation-enforced targeting, not all these products actually benefit the poor.
- A noticeable lack of microinsurance in North Africa and the Middle East. In no other region is the absence of microinsurance as evident.
- Weak delivery channels hinder the advancement of microinsurance. Though retail models are beginning to be implemented, only 1.8 million (2%) of the people covered by microinsurance are covered by products delivered through retail intermediaries. Broker activity in microinsurance is almost non-existent.
- Considering that microinsurance products and services were found to cover 78 million lives, donor activity has been miniscule. The gross value of donor investment per covered life works out to be about USD 0.12 for the few who are covered.
- Most microinsurance programs identified were found to be very small measured by numbers of policyholders

Some good news that emerges from the landscape survey is that microinsurance for the world's poor is growing fast, with most of its recent growth coming from the private sector. The microinsurers surveyed were positive about the future, predicting at least 10% growth over the following year and 100% growth over five years. It could be argued that this is relatively easy, given the low volume base of microinsurance currently, but it does also mean that microinsurers are realistically optimistic about the prospects of growth in a huge unserved market.

### **Microinsurance products – opportunities and barriers**

The landscape survey found that the highest demand from poor people was for health products and life products, followed by property insurance and accidental death and disability (AD&D) cover. The research team found that covered lives for these products were 6.8million for health, 35.3m for life, 12.6m for AD&D and 7.8m for property.<sup>1</sup> The potential market is much larger, up to 30 times larger for all products.

Before microinsurance can be made available on such a vast scale, a number of barriers have to be overcome. Some barriers are external constraints and delivery barriers, some are shortcomings of existing products, some are related to people's perceptions about insurance in general, and finally others are related to insurance regulations or their absence. For example:

- *Health microinsurance*: the poor physical and administrative condition of many health care facilities in the world's poorest countries makes the quality of health care and the management of health insurance schemes very difficult.
- *Life microinsurance*: most existing products are of poor quality, most are linked to credit schemes (credit life insurance) and are designed to protect the lender should the borrower die. Better quality products are needed which truly assist the family with continuing cover after the death of the breadwinner.
- *Property microinsurance*: it is difficult, especially given the tight margins, to control policyholder fraud and moral hazard (the tendency to be less careful with insured property)
- *Delivery channels*: these are probably the biggest single constraint on microinsurance delivery. Existing delivery channels often do not see the opportunities in microinsurance or recognize the secondary benefits (for example, that microinsurance would make their clients more stable financially). They tend rather to focus only on how insurance benefits them (for example, through commissions and portfolio protection).
- *Market barriers*: Poor people's lack of access to insurance is something of a vicious circle, as it leads to limited understanding or negative attitudes. More effort needs to be made to improve the image of insurance in general, and commercial insurers need to overcome their stereotypes of the low-income market and, as has been done with microcredit, recognize that the market is both profitable and reliable.
- *Regulatory barriers*: Insurance regulators can be a constraint to microinsurance because they do not address specific microinsurance needs – for example simplicity in language of policies and documents. However microinsurance needs regulation, because it is dangerous for consumers to be insured with unregulated insurers who hold insurance risk without reserves or reinsurance. Too frequently this has led to poor people not only losing their premiums but experiencing the full consequences of catastrophe – for health insurance, being refused treatment and possibly dying; for property insurance, losing their homes; and for life insurance, the family being left destitute.

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<sup>1</sup> These values exclude 28.3 million lives covered by the All China Federation of Trade Unions. These people have limited cover under all four general insurance types. They are excluded here because of the distortionary impact from this one program. Additionally, several organizations offer composite products that include a combination of the four microinsurance products identified here. Therefore the product use totals are greater than the basic number of covered lives.

## Types of microinsurers

The landscape survey identified four main types of microinsurers:

- *Commercial insurers* (38.0m covered lives found). These are specialist insurers already operating in the larger insurance market. They are professionally managed and registered under insurance regulations. Being regulated, they maintain reserves and have access to reinsurance, and their consumers are better protected. Commercial insurers are showing a rapidly growing interest in microinsurance, seeing it as more profitable than formerly realized. Commercial insurers prefer to partner with outside delivery channels in the low-income market but are hampered by a lack of potential partners.
- *NGOs* (9.8m covered lives found). Non-governmental organizations include development organizations, trade unions, federations of groups, and microfinance institutions. They are close to poor people and therefore close to the market for microinsurance. They are unregulated and less professionally skilled than commercial insurers. They are often very effective delivery channels.
- *Mutuals* (2.5m covered lives found). Mutuals are professionally-managed, regulated member-owned insurers, often owned by credit unions or cooperatives. They have the advantage of operating close to poor people, and are experienced in financial activities, disbursements, and confirmation of events.
- *CBOs* (0,7m covered lives found). Community-based organizations are member-owned and member-managed, and very close to poor people, who may often be their members. Their closeness to the market makes them good delivery channels. Their great disadvantage is that they are unregulated and lack the professional insurance management experience to be stable and effective insurers.

## Insurance regulation

Insurance regulators in all countries play a vital role in their supervision of the industry, as their ultimate objective is consumer protection. Regulators ensure that each insurance company complies with the country's insurance laws and policies, and that each insurer maintains adequate reserves and reinsurance to satisfy any claim. The presence of effective regulators and supervisors can boost consumer confidence. Regulation and regulators are not, however, geared to microinsurance in a number of ways:

- *Agents*. Regulations usually require all those who sell insurance to be licensed in their individual capacities. This means classes, examinations, and fees. Once licensed, an agent has an incentive to focus on the upper, more profitable, end of the market. Institutions such as NGOs acting as agents would not be allowed under current regulations because they are not individuals, yet it is difficult to expect such institutions to license each of their field staff as insurance agents to sell simple microinsurance products.
- *Supervisor capacity*. In developing countries, insurance supervisors are often underfunded and under-skilled. Converting currently unregulated CBOs and NGOs to regulated bodies will be difficult for supervisory authorities to manage, even if special microinsurance regulations are introduced with lower supervision and reporting requirements.
- *Policy documents and language*. Policy documents are often required to contain "fine print" that low-income people do not understand. Simpler policies would help improve policyholder confidence, and improve efficiency.
- *Minimum capital requirements*. Regulators typically require insurance companies to hold

a minimum capital of over USD1 million. This level of initial capital would be onerous for CBOs and NGOs wishing to convert to regulated insurers, or for other insurers focusing specifically on microinsurance.

The research team did find that some initiatives were attempting to address regulation issues. The International Association of Insurance Supervisors is working with the CGAP Working Group on Microinsurance to address microinsurance issues within their Insurance Core Principles. The World Bank's FIRST initiative is working in several poor countries to build insurance supervisory capacity.

## Acronyms and Abbreviations

ACFTU	All China Federation of Trade Unions
AD&D	Accidental Death & Disability
ADB	Asian Development Bank
AIG	American International Group
CBO	Community Based Organization
CIDR	Centre International de Développement et de Recherche
CGAP	Consultative Group to Assist the Poor
DFID	Department for International Development (UK)
GDP	Gross Domestic Product
GTZ	German Technical Cooperation
HDI	Human Development Index
HMO	Health Maintenance Organization
ILO	International Labor Organization
IAIS	International Association of Insurance Supervisors
KfW	Kreditanstalt für Wiederaufbau (German Financial Cooperation)
MFI	Microfinance Institution
NA	Not available
No.	Number
NGO	Non-governmental Organization
NSS	Non Social Security
UNDP	United Nations Development Program
USD	United States Dollar
WFP	World Food Program
WGMI	CGAP Working Group on Microinsurance

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The data base would be woefully smaller were it not for the openness of many insurers, delivery channels, donors, and others who spoke openly about their microinsurance programs. This dramatically assisted the team in generating new information, filling in gaps within published documents, and clarifying facts.



## Table of Contents

<b>EXECUTIVE SUMMARY .....</b>	<b>I</b>
<b>ACRONYMS AND ABBREVIATIONS.....</b>	<b>VI</b>
<b>ACKNOWLEDGEMENTS .....</b>	<b>VII</b>
<b>TABLE OF CONTENTS .....</b>	<b>VIII</b>
<b>WHAT IS MICROINSURANCE? .....</b>	<b>1</b>
THE STRUCTURE AND ENVIRONMENT OF MICROINSURANCE .....	3
<i>The micro-level .....</i>	3
<i>The meso-level .....</i>	3
<i>The macro-level .....</i>	3
<i>Intervening at all levels.....</i>	4
THE MICROINSURANCE SUPPLY CHAIN.....	4
THE DEMAND FOR MICROINSURANCE .....	6
INSURANCE REGULATION .....	10
<i>Insurance regulation versus microcredit regulation.....</i>	10
<i>Regulating the microinsurance delivery channel.....</i>	12
<b>THE LANDSCAPE STUDY.....</b>	<b>13</b>
METHODOLOGY OF THE LANDSCAPE RESEARCH .....	13
<i>Country selection .....</i>	13
<i>Data components .....</i>	13
<i>Data collection.....</i>	13
THE DISTRIBUTION OF MICROINSURANCE .....	15
<i>Microinsurance in the Americas.....</i>	16
<i>Microinsurance in Africa.....</i>	17
<i>Microinsurance in Asia.....</i>	18
TYPES OF MICROINSURERS .....	19
<i>Commercial insurers.....</i>	20
<i>NGO insurers.....</i>	22
<i>Mutual insurers.....</i>	22
<i>Community-based organizations and other informal insurers.....</i>	23
<i>Parastatal insurers.....</i>	24
<i>Takaful insurers .....</i>	24
MICROINSURANCE PRODUCTS .....	25
<i>Health insurance.....</i>	25
<i>Life products .....</i>	29
<i>Accidental death and disability insurance .....</i>	33
<i>Property insurance.....</i>	34
DELIVERY CHANNELS .....	37
REGULATION .....	40
DONORS .....	42
SOCIAL SECURITY SCHEMES .....	44
MICROINSURERS' VIEWS ON THE FUTURE OF THEIR INDUSTRY .....	45
COUNTRY PROFILE: UGANDA .....	49
COUNTRY PROFILE: INDIA .....	51
COUNTRY PROFILE: SRI LANKA .....	53
<b>BIBLIOGRAPHY.....</b>	<b>55</b>
<b>APPENDIX 1: 100 LOWEST INCOME COUNTRIES (BY PPP GDP).....</b>	<b>56</b>
<b>APPENDIX 2: MICROINSURANCE QUESTIONNAIRE.....</b>	<b>57</b>

<b>APPENDIX 3: REGULATIONS QUESTIONNAIRE .....</b>	<b>62</b>
<b>APPENDIX 4: COUNTRIES WITHOUT IDENTIFIED MICROINSURANCE .....</b>	<b>63</b>
<b>APPENDIX 5: RESPONDENTS TO THE REGULATION QUESTIONNAIRE.....</b>	<b>65</b>
<b>APPENDIX 6: PRODUCT ANALYSIS .....</b>	<b>66</b>
LIFE INSURANCE.....	66
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE .....	69
HEALTH INSURANCE.....	70
<i>Health Savings Vehicles.....</i>	<i>75</i>
<i>Defined benefit health (major medical, hospital cash, critical illness).....</i>	<i>77</i>
AGRICULTURAL (PROPERTY) INSURANCE.....	80
<b>APPENDIX 7: DELIVERY CHANNEL ANALYSIS AND OPTIONS.....</b>	<b>84</b>
CRITERIA FOR THE EVALUATION OF DELIVERY OPTIONS .....	84
<i>Financial systems.....</i>	<i>85</i>
<i>Benefit payments.....</i>	<i>85</i>
<i>Collection of premiums.....</i>	<i>85</i>
<i>Financial discipline .....</i>	<i>85</i>
DELIVERY CHANNELS .....	85
<i>MFIs.....</i>	<i>85</i>
<i>Religious institutions.....</i>	<i>86</i>
<i>Cell phones .....</i>	<i>86</i>
<i>Retailers.....</i>	<i>87</i>
<i>Undertakers .....</i>	<i>88</i>
<i>Lotteries.....</i>	<i>89</i>
<i>Remittance services.....</i>	<i>89</i>
<i>Employers and trade unions .....</i>	<i>89</i>
<b>MICROINSURANCE GLOSSARY .....</b>	<b>91</b>

## **What is microinsurance?**

Microinsurance is the provision of insurance services to low-income people. For the purposes of this study an insurance product is deemed to be a “microinsurance product” if the providers either targeted or sold the product to low-income people<sup>2</sup>.

The formal definition of insurance applied in this report is “a risk management system under which individuals, businesses, and other organizations or entities, in exchange for payment of a sum of money (a premium), share the risk of possible financial loss through guaranteed compensation for losses resulting from certain perils under specified conditions.” In terms of this definition, most social security schemes are not considered insurance, since social security schemes are usually funded from taxes rather than premiums from policyholders.

For low-income households, the impact of adverse events significantly affects household income and consumption levels. Of all groups in a society, poor people are the most exposed to risks and yet the least protected against the consequences. In developing countries this means extreme vulnerability of large segments of the population. This is exacerbated by the reality that risks are frequently interlinked, the occurrence of one risk commonly increasing the likelihood of others.

When exposed to financial shocks, poor households may be forced to make harsh choices, such as reducing food consumption, withdrawing children from school, or depleting productive assets to cover the expenses related to the risk event. These strategies jeopardize economic and human development prospects, and leave those who have to make such choices stuck in a poverty trap. Moreover, the threat of destitution renders the poor very risk-averse. With no protection against adverse events, they try to avoid risky situations or actions. Reluctant to engage in higher return activities because of the higher risk involved, they often forego potentially valuable new technologies and profitable production choices. As a consequence, poverty is likely to be perpetuated for them and their children.

Extending the reach of insurance to low-income groups can play a large role in ensuring that when a family faces a financial crisis, the household does not find itself further impoverished. Yet in developing countries, especially the poorest 100 countries surveyed in this report, very little insurance is available for poor people. This is especially unfortunate, as the poor are the most severely impacted by the loss of crops, property, or indeed by the loss of a member of a household.

Although microinsurance has received nothing like the attention given to microcredit, donors, governments and financial institutions have slowly come to realize that the poor,

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<sup>2</sup> There are other definitions in use, such as defining an insurance product as ‘micro’ when the premiums are below a certain specified percentage of GDP per capita. Such definitions are not very workable in practice, as they vary for each country and indeed for each type of product. Moreover, as shall be shown, information on microinsurance products is somewhat limited and the researchers were not always able to obtain premium values on what were by all other accounts clearly microinsurance products.

like everyone else, need a range of financial services of which insurance services are crucial parts. Microinsurance helps poor people to retain the financial gains they make.

As a distinct field of development practice, microinsurance is a relatively new phenomenon, although one can trace its history back almost a century. Industrial insurance, sold at the factory gates on paydays in the early 1900s, for example, made the Metropolitan Life Insurance Company not just the largest insurance company, but the largest company of any kind in the world at that time. Industrial insurance played an important role in developing an insurance culture and subsequently contributing to sustained economic development.

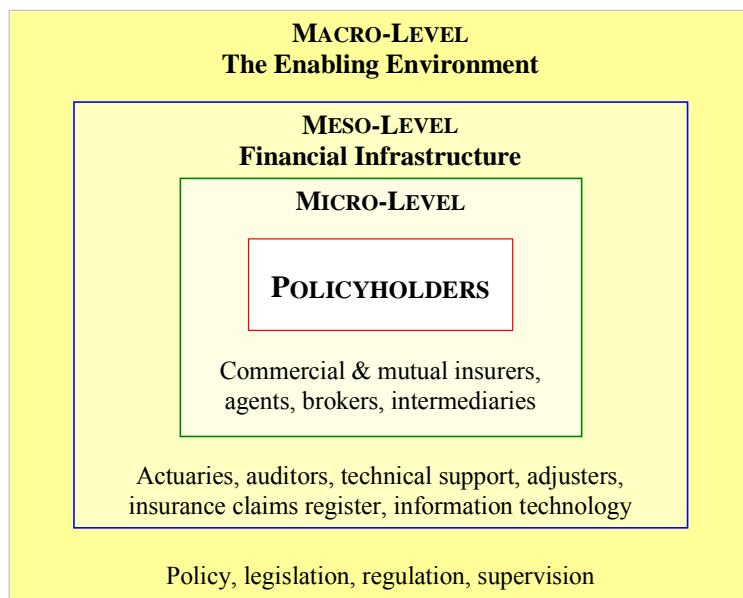
Industrial insurance was the forerunner of the partnership model that is a feature of today's commercial microinsurance. The transition from collecting premiums at the factory gates to group policies significantly enhanced the cost-effectiveness of the coverage. To reach the target market of industrial workers, employers became key partners in bundling premium payments for the insurer, and ultimately providing the coverage as an employee benefit. Today's low-income target market includes the workers in the informal economy, many of whom are self-employed. To reach them, group policies have had to find new delivery channels.

Such options emerged in the 1990s and more so in the early 2000s, when microfinance institutions began to identify insurable needs among their large numbers of low-income clients. Some MFIs turned to commercial insurers, offering to act as intermediary agents, and thus allowing their clients efficient access to insurance products. Finding this a low-risk, cost-effective way to enter a new market, some insurers began to see an opportunity, at least for basic products. The partner-agent model now becoming standard practice is thus a logical extension of a business model that has been used by insurers for more than a century.

## The structure and environment of microinsurance

The development of microinsurance involves more than the development of new products and new institutions to deliver them. Microinsurance entails the actions of many different institutions at different levels. This is illustrated in Figure 1, which shows how institutions are involved at micro-, meso- and macro-levels<sup>3</sup>. Effective interventions must take place at each level.

**Figure 1: The structure and environment of microinsurance**



### The micro-level

At the very center of the microinsurance system are the policyholders and the microinsurers. The insurer can be a single institution that carries the risk, markets or distributes the product, and administers the policy. Sometimes these tasks are carried out by separate organizations, so that the risk might be carried by the insurer and the product distributed by a microfinance institution, while a

specialized third party might undertake the claims administration.

### The meso-level

The meso-level consists of the financial infrastructure needed to facilitate the functioning of micro-level activities. For example, actuaries are necessary to assist the insurer in understanding the risks in relation to a product and in setting premiums appropriate to the risk they have accepted. Meso-level infrastructure also includes such things as training facilities for microinsurance managers and staff, the availability of efficient software, and the servicing to keep it working. A critical (though too often absent) component of the meso-level is quality market information. Such information is a key to professional product development as well as to the setting of policy, and helps to effectively drive both the macro- and micro-levels.

### The macro-level

At the macro-level, the state needs to establish the rules under which insurers can operate, and once these rules are set, to supervise insurers to make sure that they comply. Apart

<sup>3</sup> The authors are grateful to the Consultative Group to Assist the Poor (CGAP) for this useful conceptualisation.

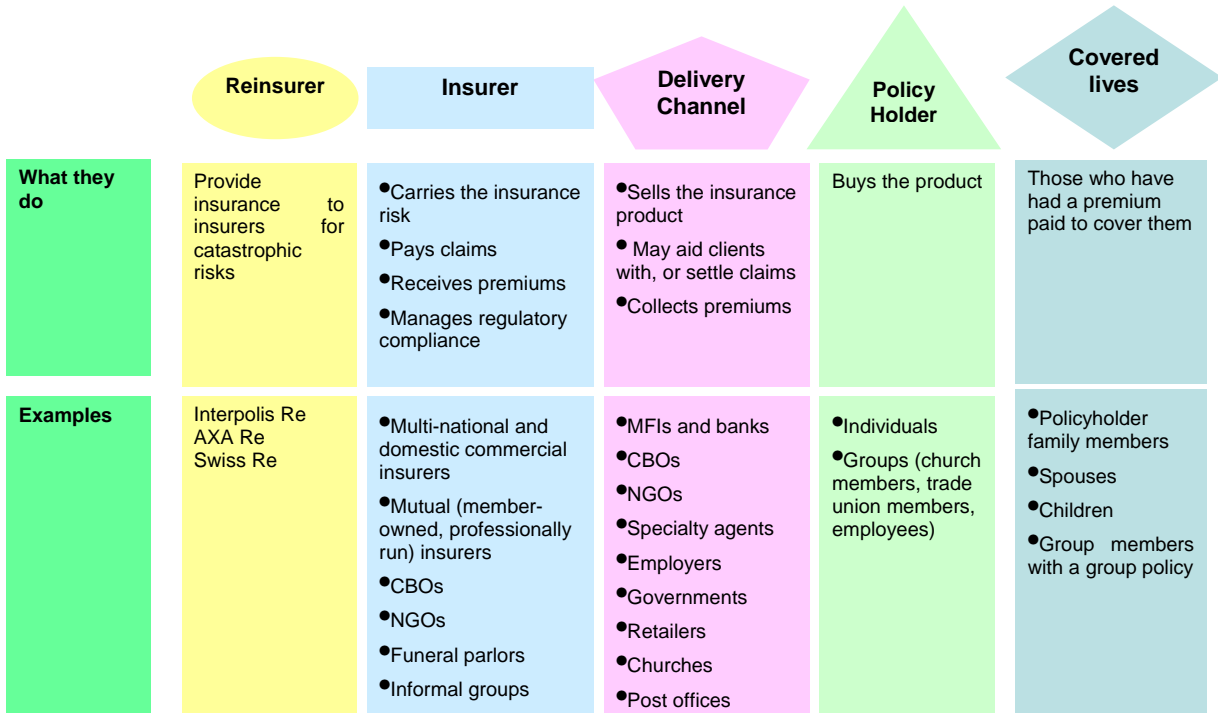
from regulating and supervising insurers, governments may need to regulate meso-level actors like actuaries or claims adjusters. They may also play a role in enhancing consumer protection through the funding of an ombudsman.

### Intervening at all levels

Traditionally, much of the donor focus in microfinance has been on the micro-level, in particular the establishment of microcredit retailers. Often these endeavors have been limited by weaknesses at the meso- and macro-levels. Microinsurance donors should not have to relearn the lessons that microcredit donors have already moved beyond. Understanding and responding to the needs at all three levels described here will make microinsurance interventions much more effective from the start.

### The microinsurance supply chain

The diagram below illustrates the key players in the microinsurance supply chain.



### The Reinsurer

Insurers hold reserves that allow them to pay for normal claims but would be insufficient to pay for claims if all their policy holders claimed simultaneously. Reinsurers are specialist types of insurers who ‘insure the insurers’ against excessive losses. Reinsurance generally does not play a very large role in microinsurance because the size of claims is small. For insurers with a mixed microinsurance and normal insurance portfolio, even if a catastrophe caused all of their microinsurance policy holders to suffer a loss simultaneously they may have sufficient reserves to cover the microinsurance claims. This of course is the current situation where there is relatively sparse delivery of

microinsurance among the world's poor. As the extent of microinsurance grows, reinsurers are likely to play a larger role.

### **The Insurer**

The most fundamental task of the insurer is to carry the risk and pay the claims. As a consequence of carrying the risk insurers have a final say in managing the risk – which means they have the final say in setting the price and ensuring that the product, and the way in which it is administered, can control some of the risk.

Insurers can be regulated or unregulated. Unregulated microinsurance schemes are often small and informal, for example the many small community-based (CBO) funeral insurance schemes in Africa. Sometimes NGOs run unregulated microinsurance schemes. In India a very large microinsurance finance organisation called SPANDANA carried the risk on life insurance that it sold to its borrowers (credit life).

Regulated insurers can either be mutual or commercial insurers. The main differences between mutual and commercial insurers are that mutual insurers are often regulated under alternative laws and do not make a profit but distribute any surplus they make to their members. There are many different definitions, but for the purposes of this report a mutual insurer is defined as a non-profit legally registered insurer run by professional insurance staff.

Commercial insurers are regulated under insurance law and are run by professional staff, but they distribute the profits they make to their shareholders. They can be local or multinational. AIG and Allianz are two well-known multinational insurers extensively involved in microinsurance.

### **The Delivery Channel**

The delivery channel is the individual or organisation that sells and services the insurance policy. Individuals, groups, or institutions can act as delivery channels. The most common individual delivery channel is the insurance agent, but insurance agents are not that common in microinsurance. Part of the reason is that agents typically are remunerated through the commission they earn on the policies they sell. In microinsurance, with its small premiums, this is often not seen as worth their while.

Delivery channels for microinsurance tend rather to be institutions rather than individuals, because institutions are generally able to reach large numbers of poor people quickly and cheaply. Common institutional microinsurance delivery channels include employers (for example tea plantations in Sri Lanka), retailers (clothing chains in South Africa), churches and post offices. MFIs, CBOs, and NGOs all can be good delivery channels.

### **Insurers or Delivery Channels?**

MFIs, CBOs and NGOs can be both delivery channels and insurers or they can just be delivery channels. The Indian MFI SPANDADA both carries the risk and delivers the insurance, and is therefore an example of an institution being both an insurer and a delivery channel. On the other hand the MFI ASA, in India, is just a delivery channel for an insurance policy of the Life Insurance Corporation of India. MFIs, CBOs and NGOs can make excellent delivery channels but are typically very poor insurers. They tend to be poor insurers because they are usually unregulated and run by non-professional staff.

In microcredit the lender is invariably the delivery agent as well as the risk carrier. In insurance this is not the case, and is one of the reasons why insurance has the potential to spread much faster than microcredit.

### **Policy Holders**

The policy holder pays the premiums and makes the claims (except in the case of life insurance where claims are made by beneficiaries). A policy holder can be an individual or a group. In microinsurance individual policy holders are less common than groups. The reason for this is that it is much cheaper to sell small value policies to all the members of a group than to sell to individuals. Trade unions are common examples of groups that buy insurance 'in bulk' for the benefit of their members.

### **Covered lives (Covered property)**

Covered lives are the people whose lives are insured (or in the case of property insurance, covered property is the property insured). An individual policy holder can, for example, take out a life insurance policy on all the members of his or her household. This is different from beneficiaries who are simply named as recipients of the claim settlement in case of loss. A beneficiary need not be covered within a policy.

### **The demand for microinsurance**

Poor people know very well the risks that they would like to mitigate, so why are they not knocking on insurance companies' doors? One reason given is the absence of active sales agents in their midst. Another is the lack of products on offer by insurers. But probably the biggest obstacles to demand are ignorance of what insurance can and cannot do, coupled with mistrust. This ignorance is not addressed by providing insurance products to groups. For example, in South Africa, many employer-based group life benefits go unclaimed because the beneficiaries of deceased employees are unaware of the existence of cover, not to mention the claim procedures.

When thinking about demand, one should remember that insurance is not the only way of dealing with financial risk. There are two broad categories of risk management strategies – *ex-ante* and *ex-post*. *Ex-ante* risk mitigation strategies involve taking actions that reduce the probability of the risk occurring. An example would be buying a lock to prevent one's valuables from being stolen, or boiling water to avoid illnesses associated with contaminated drinking water. *Ex-post* risk coping strategies are concerned with reducing the impact of the risk after it has occurred. An emergency loan to pay for the unexpected funeral of a family member would be an instance of an *ex-post* risk coping strategy. Any



assessment of demand should take into account how these strategies function in the context.

It is very difficult to estimate the demand for the microinsurance. The main reason is that the field is very new. Globally not many people have microinsurance, and most of those who have it have not had it for long. Demand studies draw inferences from historical trends. If, for example, one wanted to introduce a new model of television and wanted to know how well it would sell, the starting point would be to obtain the historical trends of television sales. With microinsurance being a new field, this is not possible. To make matters more difficult, many of the potential buyers of microinsurance have never even come across the concept of insurance. Not only is the product hypothetical for them but, unlike a television that can be turned on and demonstrated, its benefits are not immediately visible. The benefits of insurance only become visible when a policy holder claims and the insurer pays the claim.

Microinsurance demand surveys typically ask potential buyers about the risks they worry about the most, how they address those risks, and where there are gaps in their risk management strategies. These gaps help to identify potential insurance products. The results of these surveys can not be generalised across countries because in each country people are likely to worry to different degrees about different risks, and have access to different coping strategies. A further important caveat when reading demand surveys is there is likely to be a discrepancy between what people say they might buy and what they actually do buy when faced with parting with their cash. Thus the need for pilot testing new products.

Many microinsurance demand surveys have been qualitative in nature and have not been conducted with representative samples of the low-income population. In many cases the qualitative studies are based on samples of less than 100 people. Exceptions to this are market research done for KfW in several countries, and work done by the FinMark Trust in South Africa based on a very comprehensive FinScope™ database of financial services available to the poor in South Africa. Surveys of this kind tend to be very expensive as they involve in-depth interviews with large numbers of people over large areas. FinScope™ conducted 3885 face-to-face surveys in all parts of South Africa, the KfW studies involved representative samples of over 1000 people throughout each country.

The landscape research for this report showed that by far the greatest single hindrance to microinsurance in the majority of countries was consumer ignorance about insurance as a whole. In markets where penetration is a fraction of 1%, there can be little doubt of the need for this type of awareness building. While the education of clients (and dependants) is helpful, something much broader is necessary to create the awareness in people's minds of the possibility of insurance, which prepares them for the time when microinsurance arrives.

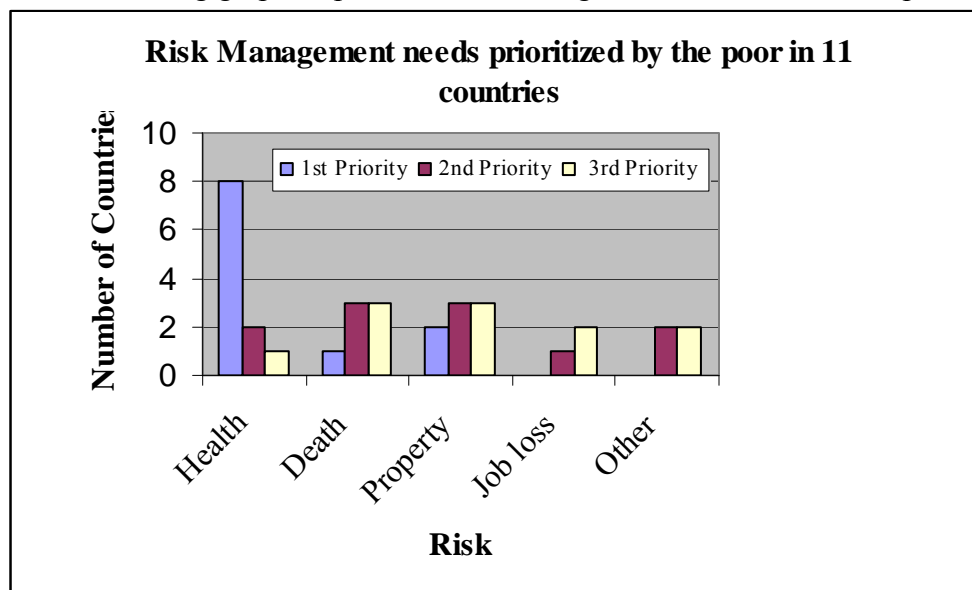
The following table provides a flavour of some of the key studies on the demand for microinsurance and what they show.

<b>Country</b>	<b>Key Insurable Risks (in order of importance)</b>	<b>Percentage or number willing to purchase microinsurance</b>	<b>Comments</b>	<b>Title of Study / Author/s and Date of Publication</b>
Albania	Property, health, life	No estimate	Much of the property risk could be mitigated through better electricity provision. The health risk is the related to not having money to pay the necessary bribe to state hospitals to obtain treatment. There is very limited knowledge or experience of private insurance in Albania. The experience of car insurance has created negative attitudes towards private insurance.	Understanding Demand for Microinsurance in Albania - Results of Exploratory Qualitative Study / Dorota Szubert / March 2004 for KfW and the MicroInsurance Centre.
Georgia	Health, unemployment, theft of property, life	No estimate 55-60% of individuals interviewed expressed an interest in buying a specified group health insurance product.	Insurance little understood among urban and rural poor, often confused with saving. Focus group indicated a high receptivity towards the idea of insurance and willingness to pay for it.	Understanding Demand for Micro-Insurance in Georgia / Michal Matul / February 2004 for KfW and the MicroInsurance Centre.
Indonesia	Health, property (crops), life	No estimate	Strong demand for products to cover non-insurable risks like education and old age. These can be covered through long term contractual savings products such as endowment policies often sold by insurance companies.	Indonesia: Understanding the Demand for Microinsurance / Liz McGuinness / June 2005 for the MicroInsurance Centre for Allianz, UNDP, and GTZ
Kenya	health, life, property (theft)	No estimate	Macroeconomic instability was presented as a key concern. In theory such a risk could be covered by innovative index insurance.	Demand Side of Micro Insurance Study-Kenya / K Rep Advisory Service / June 2002
Laos	Health, property (livestock), life	No Estimate	Schoolteachers, policemen and soldiers as well as office workers are covered by life and medical insurance. The unmet demand in Laos is principally among informal sector workers. A big risk faced is the cost of educating children, which could be met by long term contractual savings products sold by insurers.	Laos: Understanding the Demand for Microinsurance / Liz McGuinness / May 2006

Country	Key Insurable Risks (in order of importance)	Percentage or number willing to purchase microinsurance	Comments	Title of Study / Author/s and Date of Publication
Pakistan	Health, life (accidental)	7m	The biggest risk concern was macro-economic inflation, followed by unemployment and only then health, life and disability. Other risks include education and marriage expenses which could be catered for by a long term contractual savings policy sold by insurers. 60% of target market was aware of what insurance was, although only 12% had actually bought insurance.	Inaugural Steering Committee Meeting – Presentation / Aga Kahn Agency for Microfinance / September 2006
Romania	Life (accidental), health, property (weather)	9.4m life 10m health and 5.4m disability	Trust in insurers not a major problem in this market. The key issue seems to revolve around education about financial services – in particular, clients’ belief that insurance is only for the rich.	Market for Microinsurance in Romania / Michal Matul / April 2006 for KfW and the MicroInsurance Centre.

Demand surveys, as the table demonstrates, tend to be good on the risks people face and the kind of insurance they are likely to buy, but weak on estimating the potential market size.

A summary of 11 of the microinsurance demand studies done so far in poor countries is presented in the following graph. It plots the risk management needs in order of priority.



As can be seen, in 8 out of the 11 countries health is listed as the risk that causes the greatest concern, followed by death and property.

## Insurance regulation

### Insurance regulation versus microcredit regulation

In microcredit if the borrower does not pay, the lender suffers. At worst, the lender collapses, leaving many low-income people without access to a source of credit. In insurance, the company holds the policy holder's premiums, and the policy holder has to trust that the insurer will pay claims. Thus the trust relationship in insurance is the opposite to that of credit.

There is potential for immense suffering if insurers do not pay legitimate claims. Failed insurance companies can leave devastated communities in their wake. The hardship experienced by the policy holder whose insurer does not pay a claim can include in extreme cases, death (when health insurance schemes do not pay), poverty in retirement (when insurers do not pay long-term life policies), homelessness (when insurers do not pay claims on destroyed houses) and bankruptcy (when insurers do not pay claims on destroyed businesses). Health care infrastructure can collapse with the collapse of an insurance company.

The regulation of insurance is primarily concerned with consumer protection. Without effective regulation, poor people can be defrauded in ways that result in immense suffering.

Microcredit has advanced fairly well with limited or sometimes no regulation, even if sometimes borrowers get overcharged for their loans or experience abusive collection practices. Indeed

there is an ongoing debate in microcredit about the advantages for the microcredit industry if it were allowed to mature without regulation and its attendant costs. The same cannot be said for microinsurance – the risks for people when insurers act fraudulently or fail to pay can be catastrophic. Regulators are necessary to stave off such catastrophes. While regulators may on occasion overdo regulations and hinder new entrants into the microinsurance market, no practitioner would ever suggest that microinsurance should occur unregulated.

The entity charged with regulating insurance is known as an insurance supervisor. Supervisors monitor the activities of insurance companies and ensure that they comply with relevant insurance laws, regulations, and policies. An insurance supervisor also makes sure that all insurers maintain adequate reserves and reinsurance to satisfy any claim. More generally, supervisors need to ensure that insurers operate in a transparent manner with both its clients and the public.

No comprehensive survey has been done of the skills levels of supervisors in the 100 poorest countries, but the experience of research team members suggests that with a few notable exceptions, the microinsurance supervisory bodies in these countries are under-resourced and under-skilled. These supervisors have enough difficulty dealing with traditional insurance markets, and they would certainly struggle if the market were expanded. In particular, if the market were expanded to include large numbers of CBO and NGO insurers, supervisors would be severely overloaded.

In many of the poorest countries, regulatory frameworks are modeled on frameworks of the former colonial dispensations. These frameworks, most of them now outdated, were borrowed from insurance markets in middle and high-income countries, and designed for commercial insurers offering non-life cover or employee benefits to companies. Such regulations can be obstructive and limiting for the micro market. Onerous capital requirements, excessive reporting and inappropriate regulation of delivery can all stifle the low-income market. Microinsurers therefore tend to operate beneath the regulatory radar, or with the regulator's blind eye turned – an undesirable situation, because policy holders then forgo the protection that a good regulator affords.

Sustainable insurance relies fundamentally on protecting the solvency of the insurer. Microinsurers literally take poor people's money and hold it in trust against future events. As insurance markets develop, the problems of unscrupulous 'insurers' taking premiums and then vanishing tend to multiply. It is important for individual policy holders and indeed for the whole insurance system that insurance consumers are *reasonably* protected from such fraud.

One of the jobs of supervisors is to make sure that information on insurance policies is accurately disclosed to potential buyers. It is vital that buyers do not believe themselves to be covered for certain events when in fact those events are excluded from their policies. One way of ensuring this is to make sure that policy documents are easy enough to follow. In almost all cases policy documents for microinsurance policies, often sold to buyers with low levels of formal education are far too complicated, with unnecessary and obfuscatory information. Ensuring understandable microinsurance policy documents is a key task for regulators if they are to think about regulating the microinsurance industry.

Another issue is the minimum capital requirement. In order to start and register an insurance company, the regulator requires that the insurer holds certain minimum capital amount to help ensure that the organization is stable. Minimum capital requirements are typically over USD1 million – a sum that may be more than is appropriate for organizations like NGOs and CBOs when they are in the role of insurers. Some countries already have such regulations. Many former British colonies have a version of a Friendly Societies Act to govern small not-for-profit microinsurers. In other countries, such regulations need to be developed.

Finally, for the microinsurance industry to work, there must be ways for aggrieved policy holders to seek redress. They can and do go through the courts, but the costs of this make it inappropriate for low-income clients. A more appropriate solution would be a strong and independent insurance ombudsman's office, but these rarely exist in the 100 poorest countries.

Too much regulation is as bad as not enough. Getting the balance right is crucial.

### **Regulating the microinsurance delivery channel**

Regulators need to ensure that delivery channels operate honestly and fairly. They need to ensure, for example, that whoever is selling the insurance does so in an honest and fair manner, and is able to give good advice on insurance to potential policy holders. One way the regulator ensures this is by setting examinations for individuals that sell insurance, so that only if they pass the examinations will they get a license to sell insurance. This process can be quite arduous and expensive. Once people obtain a license their incentive is to sell insurance to high income clients where they will make the highest commissions. Once they have obtained their agent's license and started selling high premium and high commission insurance, it is very unlikely that they would choose to sell low premium low commission microinsurance. A possible solution is to create a different structure for microinsurance agents, as has been done in India.

Another difficulty of delivery channels is that in most cases microinsurance is not sold by individuals but by institutions. For example a church may wish to sell insurance on behalf of a commercial insurer. Typically it would not be able to obtain a license as an institution to do this. It may have to select some of its employees and send them to obtain individual agent's licenses. If institutions could obtain licenses it would certainly make the delivery of microinsurance easier.

## The landscape study

The information for this report was gathered from primary and secondary research by a team of eleven microinsurance experts, covering microinsurance offered in the 100 poorest countries. The team was tasked with identifying as many microinsurers and products as possible. Products, insurers, delivery channels, regulations, social security schemes, and donor interventions were all identified and assessed.

## Methodology of the landscape research

### Country selection

The list of 100 countries used was taken from the 2004 United Nations Human Development Report, and is provided in Appendix 1. For a variety of reasons, mainly to do with a lack of reliable data available to the UN, some countries that should be likely candidates for inclusion are not shown (Somalia is one example<sup>4</sup>).

### Data components

The survey aimed to obtain the following in each of the 100 countries<sup>5</sup>:

- 1) Information on insurers offering microinsurance products
- 2) Information on the microinsurance products they offer
- 3) The perceptions of microinsurers about the products they offer
- 4) Information on social security products available to the poor in these countries
- 5) Information on the regulation of microinsurance
- 6) Information on donors involved in microinsurance (the information obtained was not limited to their involvement in the 100 poorest countries)
- 7) Macroeconomic data for each of the 100 poorest countries including, where possible, data on the extent of insurance penetration and density

### Data collection

In order to generate comprehensive information, the team of eleven researchers and an assistant was carefully selected to ensure that all regions and all types of insurance were covered. The researchers had specific knowledge, contacts, and resources to facilitate the review of microinsurance in their assigned region or within their area of specialization. They collected both primary and secondary data from a large number and variety of sources. Table 1 summarizes the sources of data consulted.

The initial intention was to acquire data from published sources, but these sources proved to be too limited. In several instances researchers attempted to confirm data found in documentary evidence only to find that the program (typically

**Table 1: Summary of data sources used in database**

Source of data	Number
Consultancy reports	167
Primary sources	147
Internet	122
Conferences / Networks	55
Publications	45
Government data	24
Other	19
<b>Total</b>	<b>579</b>

<sup>4</sup> For a discussion of issues surrounding the UNDP's measurement criteria, see <http://hdr.undp.org/statistics/understanding/measurement.cfm>

<sup>5</sup> See Appendices 2 and 3 for copies of the questionnaires used to generate this data.

community-based insurance programs) had either collapsed or was hardly functional. Faced with this situation, the researchers spent considerable time in proactive data collection – collecting surveys/questionnaires by insurers, conducting direct phone interviews, and generating information from professional contacts. The comprehensive questionnaires (see Appendices 2 and 3) provided a sufficiently inclusive method for information gathering, although its extensive nature and number of questions met with reluctance from some sources. Some informants either could not or did not complete the entire range of questions. Researchers followed up with informants wherever possible to obtain as much data as possible. Needless to say some gaps remain. The project team in its conclusions is mindful of these gaps.

Complete information capture from all target entities would have required intensive interaction with managers from each one of the insurers, donors, or organizations involved. Even when such direct interaction took place, such as in the case study project of the CGAP Working Group on Microinsurance (WGMI), managers were not necessarily prepared to disclose all the required information. The reasons for this lack of disclosure, included:

- Lack of availability of data. Most insurers do not disaggregate the data of their microinsurance activities from that of their traditional insurance. Indeed most commercial insurers simply considering themselves to be working in insurance, not differentiating a category called “microinsurance.”
- Reluctance to divulge information that could be useful to competitors. Several mutual insurers specifically excluded certain information for this reason.
- Fear of the effect that negative information may have on investors or donors. The quality of some microinsurance programs is questionable and managers did not want to publicize this.

Once the data was captured, a spreadsheet with all the key data was sent to members of the CGAP WGMI, with a request that they search through the list and identify any omissions. WGMI identified only two microinsurance schemes as missing, confirming the thoroughness of the project team's data capture.

This landscape research project emphasized breadth over depth, as the aim was to produce a picture of the whole landscape in the limited time available. Researchers were instructed to collect as much data as possible on as large a number of microinsurance schemes as possible. As long as information was judged to be reliable, it was captured, however incomplete.

To ensure that the data was captured correctly, all questionnaires were sent to a research assistant to review each questionnaire and ensure that all the captured data was coherent. The questionnaires were then sent to Kimetrica, the project partner responsible for the database, which entered the data and checked every entry twice. Other team members sampled the results to ensure correct input as well as reliable linkages within the programming.

The project team believes that the vast majority of relevant information that exists on microinsurance in the 100 poorest countries has been captured, and that what has been captured is reliable.





The research team divided the 100 poorest countries into major regions – the Americas, Africa, and Asia – in order to more clearly identify activity, gaps, and microinsurance uptake.

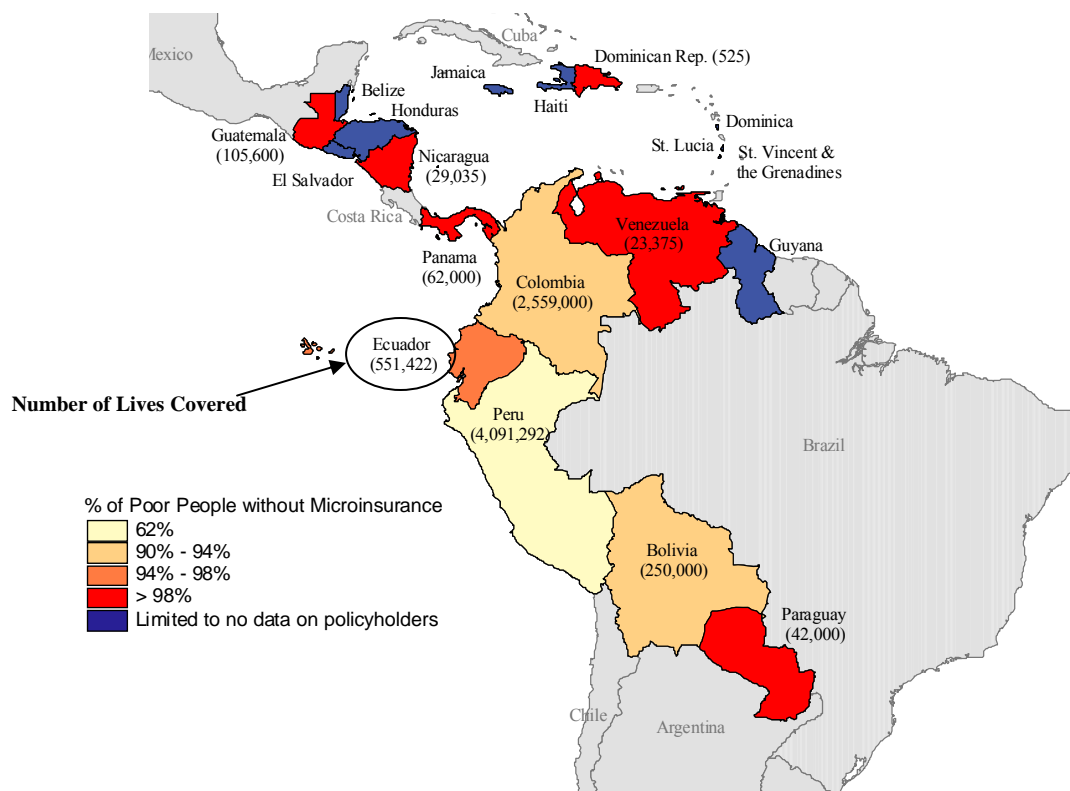
One immediate observation that cuts across all regions is the low total number of microinsured people. It is not unreasonable to consider the whole world as a “gap” for microinsurance, given the tiny global volume of microinsurance-covered lives.

Each of the three sections that follow presents a map that visually identifies countries of interest, the number of total covered lives identified in that country, and the percentage of low-income people who are *not* served by microinsurance.

### Microinsurance in the Americas

Map 2 offers details of the microinsurance activities and covered lives in Central and South America.

**Map 2: Microinsurance covered lives in the Americas**



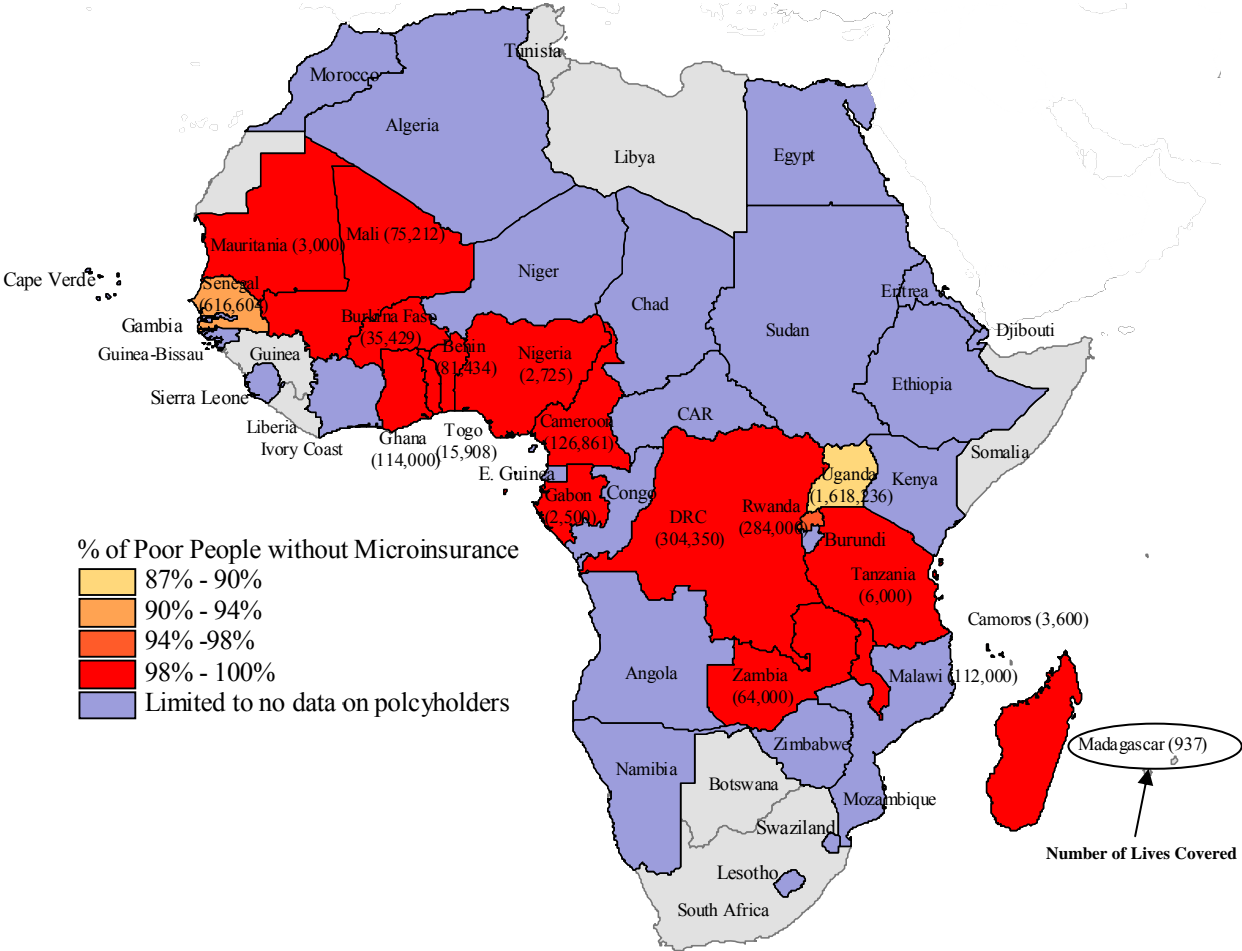
In the Americas, the team identified 7.8 million people covered by microinsurance – nearly 10% of all microinsurance-covered lives found worldwide in the countries under review. This coverage, 6.7 million, comes predominantly from two countries, Peru and Colombia. Much of Peru’s microinsurance (over 3.3 million people covered) is from one credit institution and represents credit life insurance. The majority of Colombia’s microinsurance (2.5 million people covered) is also from one entity offering funeral insurance. The research team found that a common phenomenon repeated throughout the target countries was that when there was significant microinsurance in a country, it was typically because of a single entity. Often it was

because of a mandatory microinsurance product (as in Peru) and it was usually sold to groups (as with both the Peru and Colombia products). Other programs show limited uptake from low-income consumers. On average, microinsurance availability (covered lives of poor over total population of poor) in the Americas is 7.8%, although this figure is seriously skewed by the high numbers for Peru.

**Microinsurance in Africa**

Map 3 shows a belt of microinsurance activity in Africa, running from the Northwest to the Southeast. It is clear that for the entire Africa region microinsurance cover is very limited.

**Map 3: Microinsurance covered lives in Africa**



As a region, Africa has the lowest number of identified microinsurance lives covered – only 3.5 million, or just over 4% of the total number of people covered by microinsurance in the 100

poorest countries. Furthermore, the team estimated that only about 1.6 million of these policyholders are living on less than USD 2 per day. As with the Americas, a single insurer is dominant, covering over 1.6 million total lives, close to half of all the microinsurance accessed on the continent. Notwithstanding this low volume of covered lives, Africa may be the region with the largest number of microinsurance programs (possibly excluding India). The discrepancy between low number of covered lives and the relatively high numbers of insurers and products is related to the proliferation of community-based microinsurers throughout Africa, especially in West Africa. These community-based organizations (CBOs) typically show low member per product ratios for reasons to be discussed below in the section on CBOs.

Africa is clearly much in need of microinsurance. Its density of poor lives covered to total poor lives is only about 0.3%. The reasons include fewer large delivery channels, fewer major insurance companies, and the popularity of CBOs, among other factors. A promising example of microinsurance proliferation on the continent comes from South Africa, which is not on the list of 100 poorest countries although it has a huge population of low-income people and many of the same core problems as the rest of Africa. South Africa has a thriving funeral insurance market that is particularly popular among the poor. Numerous interesting and innovative delivery channels, including funeral homes themselves, make these products available to their members, clients, and markets. National legislation is now pushing insurers (as well as the rest of the financial sector) to provide greater insurance access to the low-income segments. South Africa has become a real example for microinsurance within Africa.

A glaring gap in microinsurance availability is to be found in North Africa and the Middle East. There is a nascent life product in Jordan, some testing of weather indexing in Morocco, and minor commercial efforts in the Palestinian Territories through MFIs (for which the team could obtain no data), but as yet no significant evidence of microinsurance in this region. In general, North African and Middle Eastern countries show low penetration and density of all forms of insurance,<sup>8</sup> and even this penetration is primarily related to insuring multinational businesses and high-level national companies, rather than insurance for the individual market. Some efforts to make insurance more appropriate to the Islamic market are being made through Takaful insurance, although so far this is primarily focused on the upper income segments.

### **Microinsurance in Asia**

Microinsurance in Asia, shown in Map 4, covers over 67.2 million people, 57.9 million of whom are estimated to be living on less than USD 2 per day. Microinsurance in the region is dominated by India and China. In China, a single federation of trade unions with group policies covers over 28 million people, more than a third of all microinsurance policyholders identified. This figure will have to be separated in some of the analysis that follows because of its distorting effects. In India (which is also a special case as will be seen) over 30 million people are covered by microinsurance.

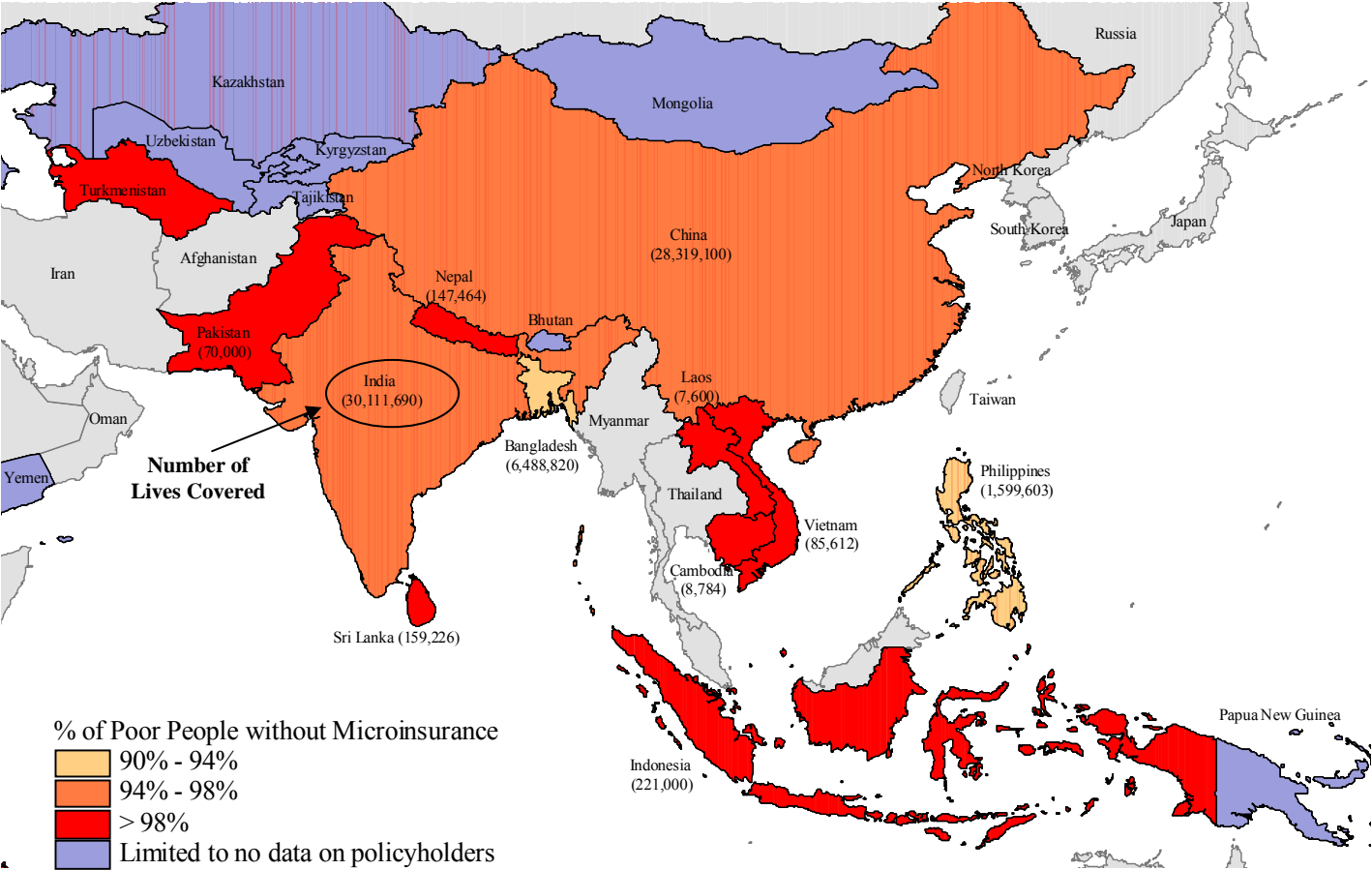
Even taking into account the volumes in India and China, more than 90% of poor people in the Asia region do not receive any microinsurance cover. The average coverage for the region is a mere 2.7% of poor people, meaning that 97.3% of low-income people in this region have no

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<sup>8</sup> Swiss Re Sigma, No 5/2006 World Insurance in 2005.

microinsurance cover at all.

**Map 4: Microinsurance covered lives in Asia**



**Types of microinsurers**

The landscape research identified seven general types of microinsurers. The lives covered by each type for each of the three regions are provided in Table 2.

**Table 2: Covered lives by microinsurer type and region**

Insurer Type	Total	Asia	Americas	Africa
Commercial	37,949,127	28,517,903	7,704,622	1,726,602
Community based	323,279	186,418	-	136,861
Informal	332,100	298,100	-	34,000
Mutual	2,474,106	1,380,369	91,035	1,002,702
NGO	37,409,196	36,827,202	4,581	577,413
Parastatal	11,177	11,177	-	-
Takaful	-	-	-	-
Other	518	-	-	518
<b>Total</b>	<b>78,499,503</b>	<b>67,221,169</b>	<b>7,800,238</b>	<b>3,478,096</b>

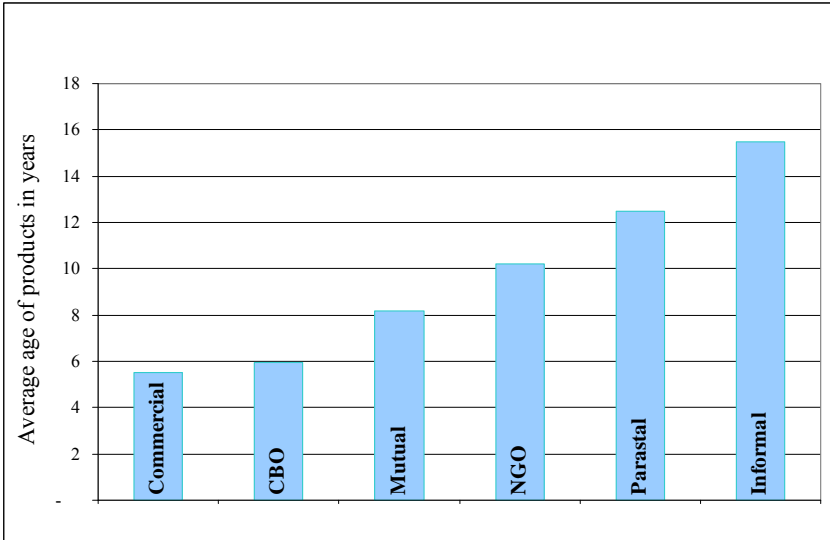
### Commercial insurers

In this report, commercial companies are defined as for-profit insurers regulated under the insurance act of their country. Although there are almost no commercial insurers that focus exclusively on microinsurance, commercial companies provide the largest number of microinsurance products – 159 different products out of a total of 357 non-social security (NSS) microinsurance products.<sup>9</sup>

Commercial companies also have the largest microinsurance outreach, covering almost 38 million lives.<sup>10</sup> However figures for outreach can conceal more than they reveal – most importantly, they conceal quality. Unlike microcredit, where there is a basic similarity between products, insurance products can vary dramatically. For example, one can easily sell millions of life policies that have small premiums, pay tiny benefits, and are very hard to claim. Such policies may have little real value to poor people compared to a cheap health insurance product that covers basic health care needs.

Commercial companies are able to provide a variety of microinsurance products with very little direct donor support. In fact, commercial insurers receive the least direct donor support of all microinsurers. AIG, the world's largest insurer, actually provides contributions to MFI networks to help them develop better delivery channels.

**Figure 2: Average age of products for various insurer types**



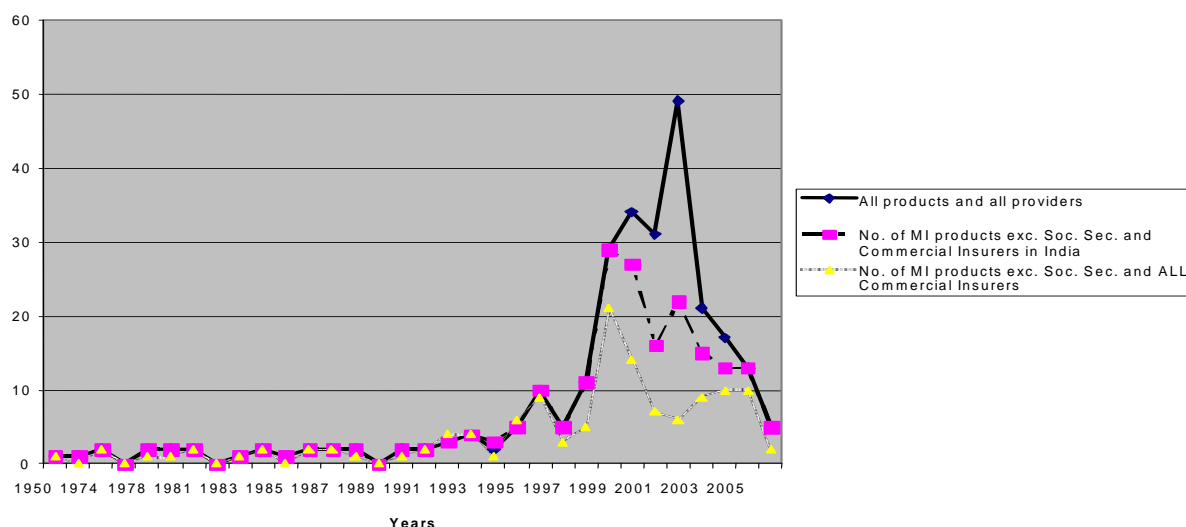
Commercial microinsurers are relative newcomers in the microinsurance industry, with the newest products (as seen in the figure above). Their growth in many ways has only just begun. They have the potential to distribute microinsurance on a very large scale, though their product quality and their response to the particular characteristics of the low-income market will have to be better managed.

<sup>9</sup> Of the 357 total products, 102 are found in India. Of the 159 commercial products, nine are found in India.

<sup>10</sup> Although the NGO insurers are close behind commercial insurers in terms of covered lives, 28 million of the 37 million covered lives for NGOs are represented by one insurer in China.

Over the last decade, commercial insurers have introduced the largest number of microinsurance products. The graph in Figure 3 plots the number of existing new products and the year in which they were introduced.

**Figure 3: Microinsurance products introduced since 1950**



In addition to the new products reflected in Figure 3, 77 new products have come from commercial insurers in India alone since the year 2000. Indian insurers are mandated by law to sell a portion of their policies to *de facto* low-income clients. However, even if Indian commercial insurers are excluded, commercial insurers remain the largest introducers of new products.

There are a number of reasons for the burgeoning interest in microinsurance by commercial insurance companies:

- Microinsurance can generate profits.
- Microinsurance is a new market compared to upper income markets that are often saturated.
- Microinsurance helps to get the company's brand name into the market. Brand name recognition is important since today's low-income client is tomorrow's middle class client. Insurance companies profit from middle class clients who purchase more insurance products at higher premiums and so brand recognition through microinsurance is especially important in countries with a rapidly growing middle class.
- Microinsurance helps develop a good relationship with the regulator and government in new markets.
- Microinsurance can be presented as an act of corporate social responsibility

Commercial insurance companies tend to focus on life insurance. Life insurance and Accidental Death and Disability cover (also a form of short term life insurance) comprise 67% of all the microinsurance products offered by commercial insurers. The most likely reason for their life

insurance focus is that, compared to health insurance or property insurance, life insurance is cheap to provide and manage, and hence potentially more profitable.

**NGO insurers**

Technically speaking, NGOs represent 47% of all microinsurance-covered lives, but 36% of the total covered lives are attributed to one body, the China Federation of Trade Unions. The true coverage for NGOs is thus about 11%.

NGOs are important to consider because they are not primarily driven by profits. This gives them a level of flexibility that allows a greater ability to experiment, for example by providing more complex types of insurance like health insurance. Significantly, NGOs tend to focus entirely on the low-income market.

**Figure 4: Covered lives by product and insurer**

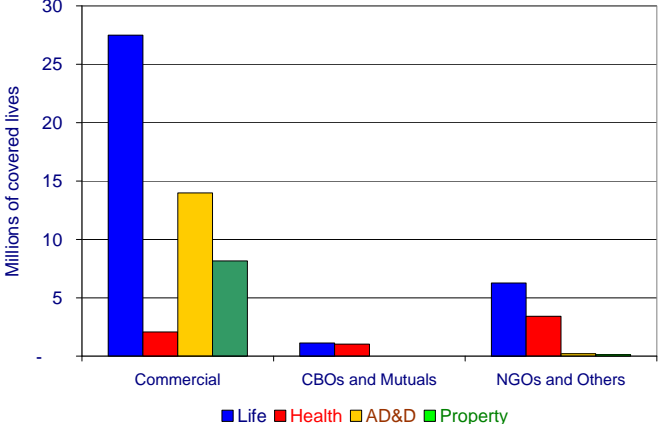


Figure 4: Covered lives by product and insurer (exclusive for the ACFTU data) shows how NGOs have been important in offering an array of products to their clients. These products are almost entirely offered to the low-income market.

There are however drawbacks to NGO microinsurance. The most significant is that most of the NGO insurers operate without the benefit of an insurance license and outside the regulations which commercial insurers must adhere to. Only seven of the NGO insurers (16%) do so within the bounds of any regulation. The state may turn a blind eye to their operations as they are seen as doing good work, or in some cases, the NGOs may be too powerful for the state to control. Because they hold the premiums of poor clients in trust, unregulated insurance operations are of concern, however well intentioned the NGOs may be.

NGOs are the largest providers of health microinsurance. One reason for this is that health insurance is a much-demanded service among their clients. Another is that the funding of health insurance is a popular area for donors, and therefore partly donor-driven. It is not clear what health microinsurers would provide if left to their own devices. More research in the form of in-depth case studies is required to discover how sustainable these insurers are, and if they are not sustainable, to try to answer the question of whether or not they are worth funding.

This landscape study was not able to uncover accurately the extent to which NGO operations are subsidized (either by donors or from other operations). But it can be surmised that the extent of subsidy is likely to be considerable, given that health microinsurance is difficult to operate profitably, and given that NGOs' lack of profit motive leads them to require significant subsidies. Donor involvement has been essential to NGOs' continued operation and will most likely continue to be essential in the future.

**Mutual insurers**



Mutual insurers can be defined as non-profit, member-based insurance organizations, distinct from CBO insurers in that they have professional management and are typically regulated under non-insurance act regulations. Many mutuals started life as CBO insurers but became professionalized when they outgrew the skills and capacities of their non-professional member staff. After commercial insurers, mutuals provide the third largest share of all covered lives with almost 2.5 million, most of them in Asia. In reality this figure is significantly less than the true volume of mutual microinsurance because several mutual insurers, concerned about competition, refrained from providing information to the research team. It is likely that the total volume of mutual insurance covered lives is two to three times the volume recorded by this survey.

**Community-based organizations and other informal insurers**

CBO insurers are member-owned and member-managed organizations. Typically, they are run by non-professional voluntary staff and restrict their operations to a small geographic community and limited products. For this study, information on 33 CBOs was collected – a rather small number which does not reflect the importance or extent of CBO microinsurance in poor countries. It should rather be seen as reflecting the fact that CBOs operate informally and their operations have barely been documented.

CBO microinsurers are very common, especially in Africa where they play a large role in financing funeral expenses. They can be considered a sub-category of informal insurers. Many of them are old and durable institutions that in some places have been the sole providers of insurance to the poor. This study found a number of informal insurers still selling products they had developed in the 1970s.

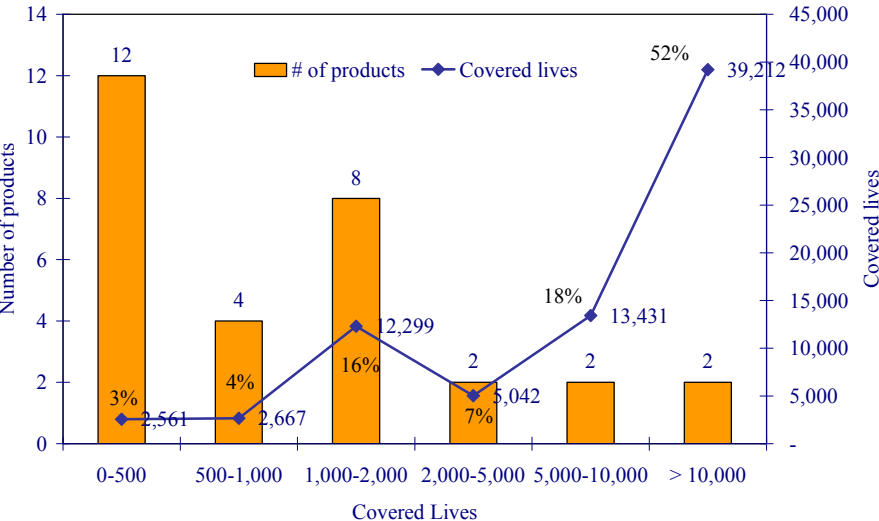
From a broad development perspective, CBOs are small in size and reach, in many cases serving no more than the inhabitants of a small village. The CBOs encountered in this study were slightly larger – in West and Central Africa, for example, 16 CBO insurers were found to have an average of 1 342 policyholders per CBO insurer.

In Mali, researchers identified thirty CBO insurers, the largest number of any country in the study.

**Figure 5: Mali: CBOs and Mutuals by product and covered lives**

Figure 5: Mali: CBOs and Mutuals by product and covered lives shows that of the thirty CBO insurers identified, all but two of them had covered lives of less than 10 000 people. Eighty percent had covered lives of less than 2 000 people.

The largest two institutions shown



cover almost 40 000 lives, although these two institutions actually are groups of CBO insurers aggregated into two federation systems. Such systems improve oversight and management and can potentially make the CBO model more effective, and may well represent an effective intervention point for improving outreach of CBO insurers, unlike the small CBO insurer model, which would require significant inputs for limited results.

Aside from their small size, CBO insurers have other limitations as insurers. As they use non-professional staff, they often require a great deal of outside input, particularly when selling complex products like health insurance. Another limitation is that they tend to operate locally only, so they are susceptible to co-variant risk (the risk that a large number of clients will befall the same misfortunes). Finally, most CBO insurers and, by definition, all informal insurers, are unregulated. Only 18% of the CBO insurers in this study were found to be running regulated insurance operations. As unlicensed insurers, CBOs are excluded from obtaining reinsurance and the financial support that many of them need.

There are numerous other kinds of informal insurers throughout the 100 poorest countries, covering tens of millions of low-income people though hundreds of thousands of tiny informal groups. These are hard to find and quantify without extensive in-country research. FinMark Trust, for example, through its work with Genesis, has identified over 8 million informal insurance members in Southern Africa.

### **Parastatal insurers**

Parastatal insurers are insurance companies that are wholly- or majority-owned by a government. Outside of India, very few of the parastatal insurers were found providing microinsurance. The management quality and innovation potential of parastatal insurers tends to be weak, and in most countries their incentive to develop new products is non-existent.

Some parastatal insurers were found to have good quality management sincerely interested in moving down-market into microinsurance, but these managers tended to be shifted elsewhere in government, leaving less qualified managers. Because they are arms of government, parastatals are often pushed towards assisting in government policies which may or may not be in the long-term interest of sustainable or profitable microinsurance provision.

### **Takaful insurers**

A takaful insurer is one that operates according to Islamic financial principles, which do not allow interest to be charged or earned. Thus, a takaful insurer can only invest in non-interest bearing assets. They operate effectively as non-profit mutuals because they must return at least a portion of their earnings to members.

This landscape survey found that worldwide there was an almost total absence of takaful microinsurers. This is of special concern given the absence of microinsurers in the North Africa and Middle East region, as some potential policyholders in these countries would probably only be prepared to purchase takaful insurance.

The research team included a takaful expert to ensure there would be an informed effort to identify takaful microinsurers. It does seem that there simply are none at this time other than one

Sri Lanka example. In Indonesia, GTZ (German Technical Cooperation) and Allianz Insurance are currently involved in a Public Private Partnership to develop takaful microinsurance in Indonesia.

### Microinsurance products

Table 3 summarizes covered lives by product category within each of the three regions of the study. It will be noted that the total exceeds the 78.5 million total mentioned earlier as the covered lives total – this is due to the existence of numerous compound products. The Indian insurer VimoSEWA, for example, sells one microinsurance product which covers life, hospitalization, property and disability. Their total number of covered lives would be reflected in all four columns, even though in an overall total each policy holder would only appear once.

**Table 3: Covered lives by product and region**

Region	Life	Health	Accident & Disability	Property & Index
Americas	7,545,057	445,876	105,000	600
Africa	2,036,141	3,053,778	1,603,000	1,600,000
Asia	54,158,332	31,697,038	39,180,508	34,557,434
<b>Total</b>	<b>63,739,530</b>	<b>35,196,692</b>	<b>40,888,508</b>	<b>36,158,034</b>

Health microinsurance, the least represented of the covered lives identified in the study, also tends to be the product that is most demanded by the poor, as was mentioned earlier in the section on demand.

It is interesting to note that a major component of the total number of life insurance lives covered is directly and only related to the potential loss of life of a borrower – credit life insurance. This shows at the bottom of the importance hierarchy. In satisfaction surveys, low-income people almost always explain credit life insurance as something that benefits the lender and not the policyholder.

### Health insurance

Health insurance emerges consistently as the most demanded microinsurance service. Aside from people's obvious desire not to suffer from pain and disease, the illness or injury of a breadwinner has serious implications for household livelihood security. When asked about the most important cause of his household's poverty, a Zambian villager responded: "Let hunger be ranked first, because if you are hungry you cannot work! No, health is number one, because if you are ill you cannot work!"<sup>11</sup>

A recent major World Bank research project entitled "Voices of the Poor" involved a qualitative

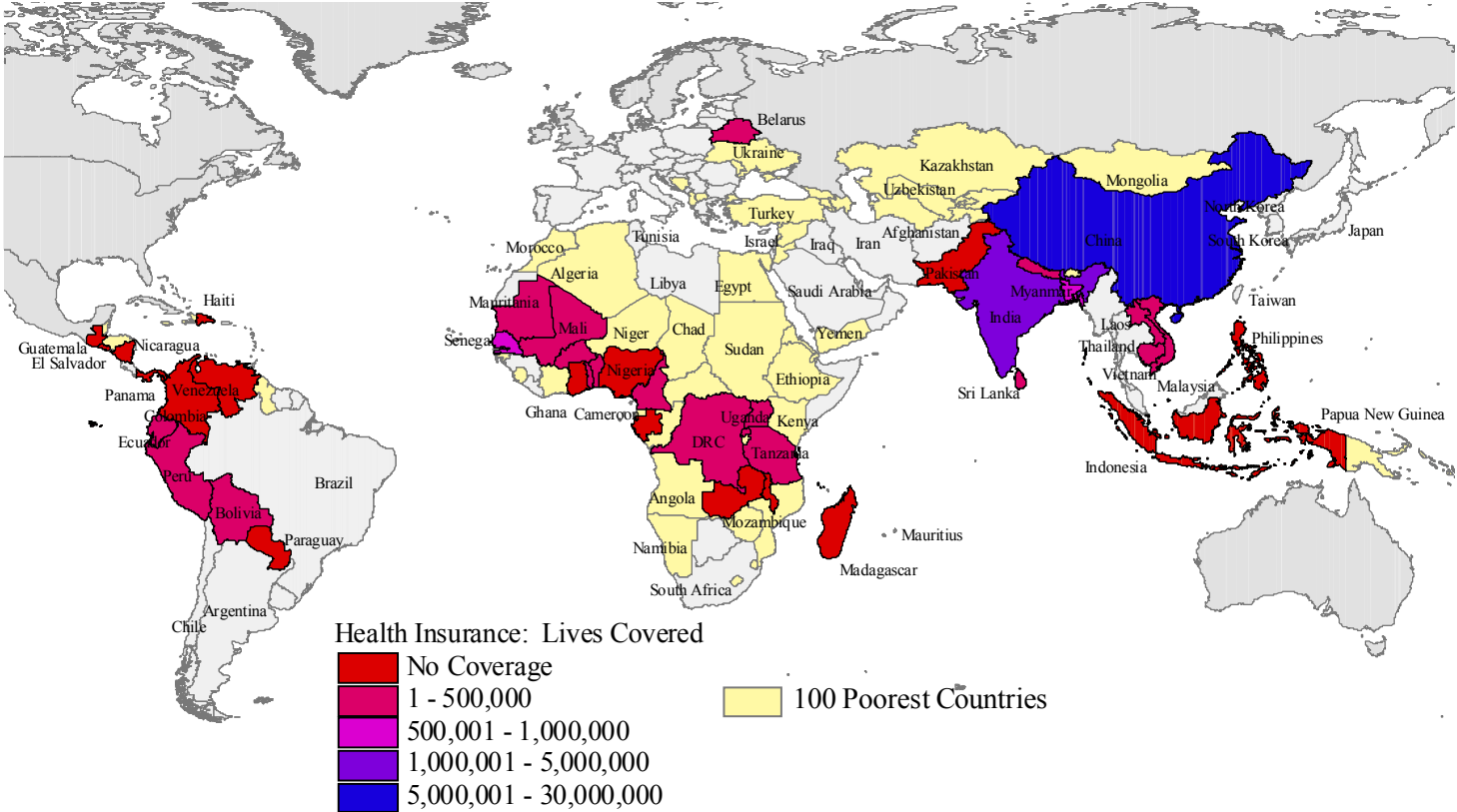
<sup>11</sup> Discussion group of women and men, Musanya Village, Zambia quoted in Dodd & Munck, Voices of the Poor, World Bank, 2001, p. 14.

analysis of interviews and small group discussions with more than 60 000 people from 60 countries (Dodd & Munck, 2001, p.4). Health risks emerged as such a crucial risk in the narratives of the poor that the World Bank commissioned a separate report on health issues, which was later published as “Dying for change: poor people's experience of health and ill-health.”

Health problems cause loss of income in two ways, first through the cost of treatment and then, more importantly, through the loss of household labor. The labor loss implications may go beyond losing the labor of the sick person, since many sick people need a full-time or part-time caregiver. Such a loss is particularly felt in poor households in developing countries. These households are mostly labor-rich and capital-poor, so when they lose labor they lose their main factor of production.

Map 5 provides a visual overview of the health microinsurance coverage around the 100 poorest countries. It is important to remember that even with substantial volumes; the actual availability of health microinsurance is well below 3% even in the best cases.

**Map 5: Health Microinsurance Products with Lives Covered**



Health microinsurance is a good example of how microinsurance benefits can be coordinated with social security systems. Most health microinsurers cover some level of primary health

care<sup>12</sup> through CBOs and NGOs in countries where the government provides secondary care. Restrictive hospitalization benefits are also relatively common as a means of helping people in situations where hospitalization is not effectively covered by the government. The cover is normally restricted to a limited range of treatments or procedures in order to retain low premiums. Table 4 details the sub-types of health microinsurance.

**Table 4: Health insurance by sub-type**

<b>Product sub-type</b>	<b>Number of Products</b>	<b>Covered Lives</b>
Comprehensive	38	786,342
Health (Other)	8	1,797,861
Hospitalization	66	3,343,752
Primary	79	31,778,723
Targeted Benefits	40	789,634
<b>Total</b>	<b>231</b>	<b>38,496,312</b>

Health activities in the 100 poorest countries are dominated by donor-driven CBO insurers in West and Central Africa. Few have reached sustainability, although some large federations of mutuals may have overcome this first hurdle. There is some evidence of defined benefit insurance like critical illness or ‘dread disease’ benefits in Haiti, and hospital cash plans in Georgia and Sri Lanka that do not provide indemnity benefits but are easily managed. The survey found no evidence of major medical expense covers.

More than any other insurance product, health insurance is intrinsically linked to a third party – the healthcare delivery system, whether public or private. A strong state healthcare system would obviate the need for health microinsurance. The reported demand for healthcare financing is directly related to the dire state of public healthcare systems in many of the poorest countries. Even where public systems exist, as in Uganda, the reality of accessing them through bribes and queues limits their effectiveness and gives rise to the demand for private health insurance. Though significant health initiatives may be possible without developing the entire infrastructure (as shown by existing Global Health programs), effective health insurance can never be readily separated from the healthcare infrastructure.

Some health microinsurance programs are health maintenance organization (HMO) based, like AAR Health Services in East Africa. Promoting its Afya Card through MFIs and other delivery channel, AAR tries to include low-income households within its network of linked clinics and hospital relationships. AAR is able to exert control over the provider in such a way as to provide quality care at a managed price. This model has potential to control costs but, as can be seen in the USA, it also has the potential to degrade into poor quality limited care.

Conventional insurance wisdom says that ‘insurable events’ are those that are rare, uncontrollable and have a high impact. Thus hospitalization for heart failure is an insurable event, whereas a high-frequency low-impact event such as visiting the doctor for a common cold

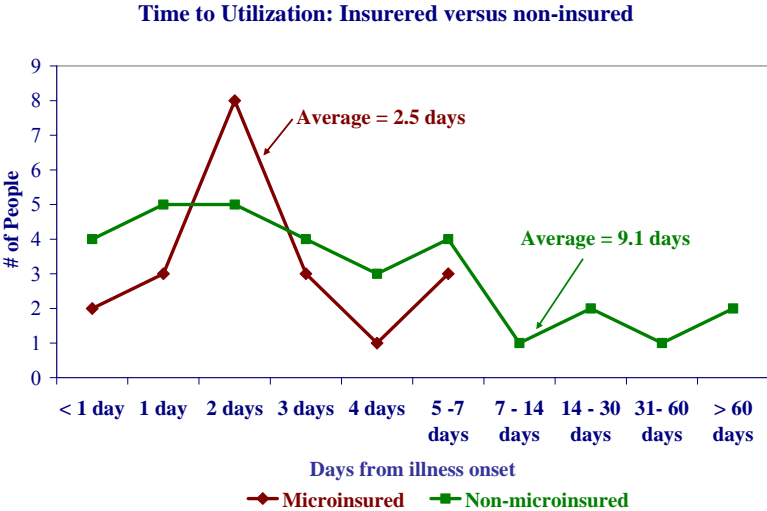
<sup>12</sup> The value for primary care includes 28.3 million covered lives for the China Federation of Trade Union. The balance is about 3.5 million covered lives.

is not. It is possible to use genuine insurance to cover the insurable events, coupled with facilitated savings or guided budgeting to cover the low-risk events. By effectively splitting the risk management strategy into insurable and uninsurable components of healthcare, appropriate tools could be devised for low-income people to better manage these risks.

The landscape survey did not probe deeply into the structure of health products, whether indemnity based, savings account based ('pre-paid') or a combination. Only very limited information is available about the healthcare delivery systems used by the low-income schemes. The experience of the researchers is that it tends to be extremely limited indemnity cover.

Low-income people themselves, when asked about their health product needs, say they want to have access to health care as soon as they become ill, without delays caused by having to find the money to pay. Studies (Blanchard-Horan 2006 and Dror 2005) have shown that insured people can access the care they need faster than the uninsured. Figure 6 shows insured people can expect a delay of 2.5 days versus 9.1 days for the uninsured.<sup>13</sup>

**Figure 6: Health seeking delay – insured vs. uninsured**



By accessing care faster, the severity of the illness is reduced and costs are typically lower. Indemnity insurance allows such immediate access. Reimbursement programs, on the other hand, minimize the benefit of the health insurance since they do not minimize the effort to seek for funds.

The great problem with health microinsurance is the problem of scale. Health insurers (particularly mutuals and CBOs) tend to have fewer than 5 000 members, although data about them is very scanty. There is a pronounced link between scheme size and product age – larger health insurance schemes having much older products. It is not clear that there is any causality to be inferred here, but one possible implication is that it takes time to reach scale with health insurance schemes. This question should be further investigated, because clearly if one wanted to

<sup>13</sup> Adapted from Blanchard-Horan, 2006.

dramatically increase non-social security health insurance schemes, one should be concerned about the time they are likely to take to stabilize. It seems that the right combination of insurer, health care provider, and delivery channel can create rapid expansion.

An interesting case of rapid growth in health care microinsurance is that of Yeshasveni Trust (Radermacher et al, November 2005). The Trust grew to 1.45 million covered lives in one year through using its networks (more details on Yeshasveni Trust can be found in the country profile of India, below). Another potential means of rapid expansion might be to include trade unions. As so often is the case in microinsurance, the key to delivery is with the delivery channel.

## Life products

Of all insurance types, life cover is, relatively speaking, the easiest to provide, because:

- It is one of the most demanded forms of cover.
- It is relatively easy to price compared to other types of insurance.
- It is mostly resistant to problems of fraud and moral hazard.
- It is not dependent, unlike many types of health insurance, on the existence and efficient functioning of other infrastructure like clinics or hospitals.
- It can easily be linked (at least with short-term life insurance) to other microfinance savings and loan products.
- The insured event is a clear-cut fact.

Considering the dramatic growth of microfinance institutions in developing countries in the last two decades, and the fact that life insurance is so easy to distribute, it is not surprising that by far the largest volume of people holding microinsurance – almost 64 million of the 78.5 million – are holding life insurance. The figure would be even larger if informal funeral and other such products were included, but data for these informal schemes was hard to obtain.

The landscape survey revealed that life insurance was by far the most widely provided of all microinsurance, with credit life the most popular variant.

**Table 5: Lives covered by life insurance sub-category**

Product sub-type	Number of Products	Covered Lives
Continuing Family benefits	2	n/a
Credit Life	103	23,187,879
Credit Life Plus	11	32,871
Endowment	16	1,229,450
Funeral	18	3,045,892
Investments	1	65,000
Pensions	14	34,685,079
Term	19	1,493,359
<b>Total</b>	<b>184</b>	<b>63,739,530</b>

### Credit life

Table 5 shows that life cover is frequently linked to credit – 36% of covered lives and 60% of life products are directly linked to credit schemes. Most of these provide credit life cover simply

in order to cover credit loss on the death of the borrower. Others, although only a few, offer a life benefit that helps the surviving family beyond the credit loss, or beyond the funeral.

Many of the credit-linked schemes require life insurance from borrowers as a condition of joining. This inflates the number of lives covered, and often reflects poor quality products from insurers or the MFIs themselves that benefit from the lack of competition. Credit life is popular with MFIs because it is cheap, simple, short term, often invisible, and entails minimal underwriting and risk management. Credit life insurance can be sold even by non-life insurers because of its short duration and its link to another short-term product. In a very real sense, it is insurance for the insurer rather than the client, against a particular type of default – the death of a borrower.

While credit life insurance mitigates some risk to the lender, its value to the dependants of the client is minimal. Mortality rates are very small compared to default rates, so from the institution's perspective, the insurance is only marginally better than provisioning. Writing off loans unpaid due to death is not likely to significantly impact on the costs of doing business. Indeed as some of the authors of this report have argued, ("Making Insurance Work for Microfinance" Churchill *et al*, 2003) provisioning is actually a better way for an MFI to approach credit life insurance in all but a few cases. The incremental value to dependants is minimal if the loan would have been written off anyway due to their inability to pay. At worst, credit life is just a public relations enabler, allowing the MFI to avoid the bad publicity of extracting money from widows and orphans.

Many MFIs actually abuse credit life insurance as a means of improving the fee income portion of their operating statements. They charge a fee as high as 3% of the loan principle as 'insurance', account for this amount directly to fee income, and simply write off losses through their Reserve for Possible Loan Losses accounts. Significant overcharging of this nature makes potential policyholders even more skeptical and damages the credibility of more appropriate insurance products.

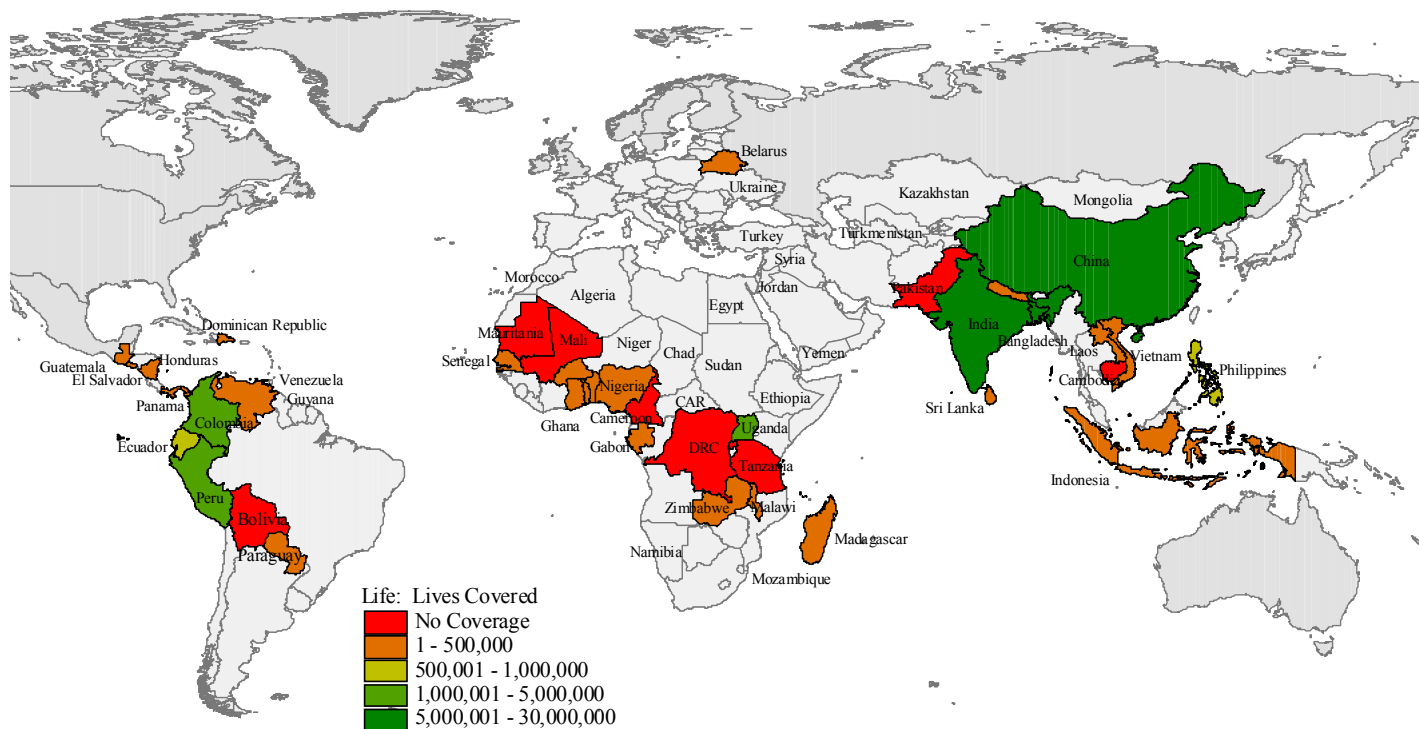
Several life schemes, like CARD MBA and Delta Life, include a savings endowment component. Such savings-based products have been limited in popularity because:

- MFIs and banks do not want to share limited savings from low-income people
- Investment requirements and macro-economic uncertainties make long-term products difficult to manage
- It is expensive and difficult to aggregate small amounts of savings

As can be seen on Map 6, Asia covers significant volumes of life products, although with little overall coverage. Individual programs in Colombia and Peru boost the numbers in the Americas.



**Map 6: Life microinsurance products**



The South Asian and West & Central African figures are largely as expected. As a result of India's regulations, which compel insurance products to be sold to the poor, they account for the surge in the life insurance provided, as well as the number of life products offered since 2002. West and Central Africa has been a focus of donor involvement over the last 10 years, although much of this has been related to health insurance.

An unexpected statistic was the average age found for life products in the Philippines – 22.3 years compared to an average product age for the 100 countries of around 7.2 years. These products were all sold by non-profit insurers who emerged a few decades ago and remain robust.

### Term life insurance

Life products like funeral covers are very common in all countries where microinsurance is offered, with the exception of health-focused West Africa. They are also the most popular products with commercial insurers. Term life cover is relatively simple to price and risk-manage (though with extended families it becomes more complex<sup>14</sup>). Key challenges for this product pertain to delivery and minimizing of expenses. It is tempting to mistake broad delivery and low-cost for broad impact. The fertilizer bag product in India reaches millions of people, at least in

<sup>14</sup> Typically a direct policyholder is reasonably well when he or she purchases insurance, especially in the case of an MFI or other type of agent. The insurance agent is often unaware of the health status of the rest of the family members and this frequently makes the other family members significantly more of an insurance risk than the policyholder. In the Philippines and in Uganda it was found that death rates of spouses (males) were significantly greater than that for the female member / policyholder. The ratios were 3.5:1 and 4:1, respectively.

theory. In reality, the number of claims that will actually be submitted is miniscule, relying on the family or associates of the deceased client to not only be aware of the cover, but also to retain the original purchase receipt, and contact a physical office of the insurer to make the claim.

**Long-term life insurance products**

Longer term and whole life products, while much more limited in number, were still found in the landscape survey, as shown in Table 6.

The landscape survey revealed that one gap in the life insurance market is long-term life insurance, which are a mixture of savings and term life insurance. An example of such a product would be an endowment policy, which involves the regular payment of a premium paid over a relatively long period, usually more than five years. If the policyholder survives the stated term, he or she receives a lump sum. Should the policyholder die before the expiry of the term, the beneficiaries receive a lump sum. Unfortunately, the long-term products that are available are often not helpful to low-income people because of devaluations, inflation, poor returns, and loss of savings due to early terminations.

**Table 6: Long-term life sub-products**

Product Sub-type	Number of Products	Covered Lives
Endowment	16	1,229,450
Investments	1	65,000
Pensions <sup>15</sup>	14	34,685,079
<b>Total</b>	<b>31</b>	<b>35,979,529</b>

Long-term life products are of great interest to insurers as they bring in regular income over a longer period. But they require greater protection of the policyholder, complex risk management (long-term investment, mortality and expense risks), a high degree of actuarial monitoring, and more capital. Longer-term products also offer greater protection to policyholders. However careful product design is necessary to ensure that continuity of cover can be

maintained in the long term, given the often uncertain income of poor households.

The complexity of long-term products presents challenges for current microinsurance delivery channels, which are mostly geared to short-term products. In fact MFI managers see funds going to long-term insurance products as competition for their own capital generation efforts to feed loan portfolios. This implies that MFIs might not be the best delivery agent for long-term policies.

Unstable macroeconomic conditions can potentially erode any long-term benefit to a low-income (or indeed any other) policyholder. Stories abound of low-income clients who struggled to maintain their policy through good times and bad, only to find that the policy value had eroded to almost nothing. One story tells of a policyholder who took a bus to a capital city to collect on his long-term policy, only to find that the benefit amount, after currency devaluations and high inflation, did not even cover the cost of the bus ticket.

**Pensions**

Pensions require special mention. Table 6 shows that pensions cover 34.7 million people, the largest category of life microinsurance and indeed the largest category of microinsurance as a whole. Although there are 14 institutions that report offering micro-pensions, all but 28 000 of

<sup>15</sup> 28.3 million of this amount is from the All China Federation of Trade Unions, and 6.3 million are from LIC India.

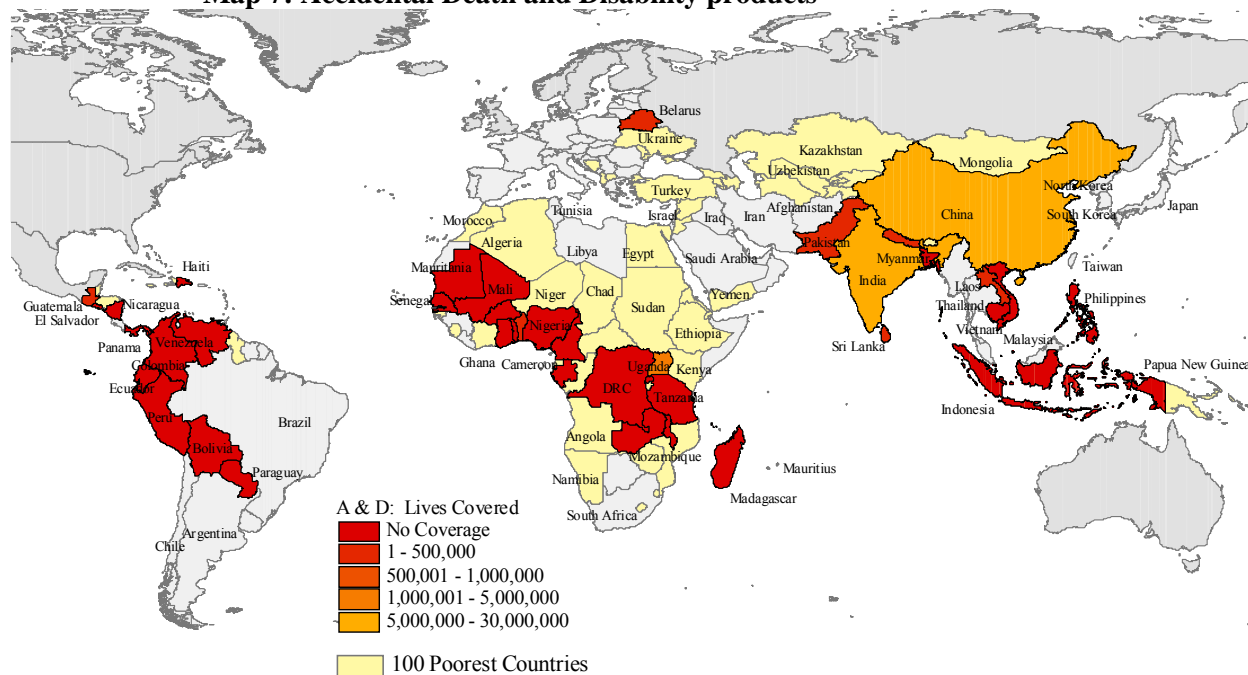
the covered lives are represented by two entities. The All China Trade Union Federation policy includes health, life, property, and accidental death and disability covers for its 28.3 million members, and the Life Insurance Corporation of India offers micro-pensions to 6.4 million people. These two institutions are not replicable and can be considered anomalous.

There is a vital need in developing countries for pension provision and financial security for old age. Poor people often have access to small amounts of money but few ways of converting this into ways of supporting themselves when they are old. Only 15 developing countries offer pensions for the poor – in some countries, like Brazil and South Africa, the coverage is extensive, while in others, like India, it is extremely patchy. Most elderly people in the 100 poorest countries, especially those without land, have no financial support other than relatives and friends. This is a crucial area that needs further attention.

### Accidental death and disability insurance

Accidental death and disablement are serious concerns for the very poor. With long-term illness, the household may have an opportunity to make plans for the death of a breadwinner, whereas accidental death and disability have a sudden impact on the livelihoods of families. Map 7 shows the lives covered by AD&D microinsurance policies.

**Map 7: Accidental Death and Disability products**



AD&D schemes are found in largest volumes in South Asia, both in the numbers of schemes and numbers of lives covered. Compared to other types of microinsurance, the number of products is far fewer, and these products are generally offered by commercial insurers. In other parts of the poor world, existing products seem to have been running for longer (7.5 to 12 years) than in South Asia, where the average duration is six years. This again probably reflects the recent legislative drivers in India.

Micro-disability products tend to focus on easily verifiable dismemberments, like loss of an arm or leg. Less easily definable occupational disability products are more costly and difficult to manage, as well as being vulnerable to fraud and other problems. These issues push the premiums of all but the simplest products out of reach of the low-income market.

There are several microinsurance products that address disability, typically limited to a once-off payment for permanent disability. Products covering temporary disability are often tied to the life products that are sold with microcredit, so that if the borrower/policyholder is disabled, the creditor suffers no loss. These products appear to be aimed at providing benefits only to the lender.

Accidental death and disability products are popular with insurers as an entree into microinsurance because the risk is limited – anecdotally in many of the 100 poorest countries, only about one in five or six deaths is by accident. Thus the policy can be very cheap for the policyholder and at the same time often very profitable to the insurer.

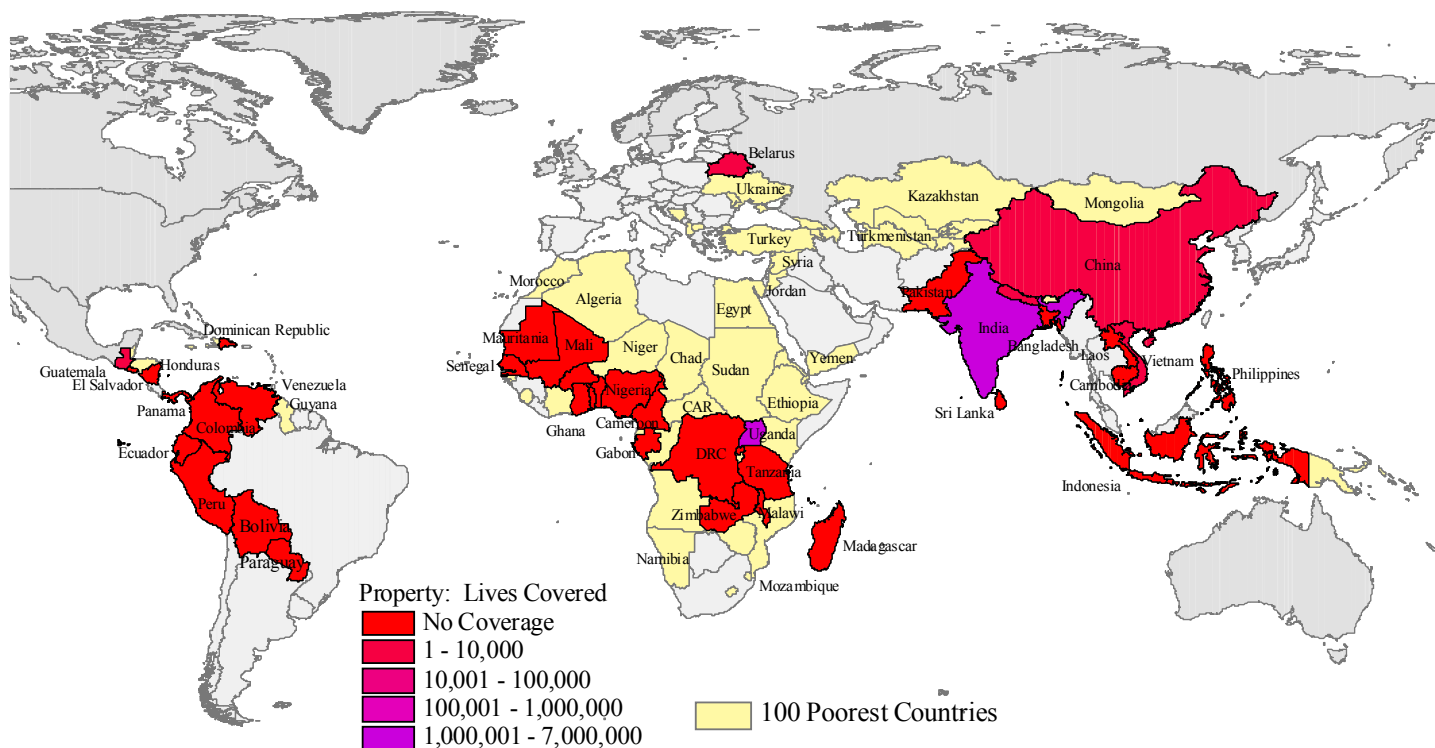
In all 100 poorest countries, only three new accidental death and disability products were launched in the last three years. This is partly because the biggest market for accidental death and disability microinsurance is India, and most Indian products were launched over three years ago to meet regulatory requirements.

### **Property insurance**

Poor people usually live in cheaply constructed housing, without title deeds, often located in flood plains or other risk-prone sites which may be exposed to fire and other hazards. The survey found that 99.3% of low-income people in the 100 poorest countries were without property insurance. This is no surprise, as demand for property cover is significantly less than demand for health and life insurance. The survey found that non-profit insurers tend to specialize in health and life and to ignore property covers. Again, this is not surprising, because, compared to the relatively easy underwriting and claims validation of life insurance, property cover can be very difficult. With small sums assured and small premiums received, the cost of the necessary controls, including loss adjustment, often renders the property insurance business unviable. Map 8 provides details of property insurance that is available.

Crop insurance is expensive to administer and claims are difficult to validate. Much the same is true of equipment insurance. Microinsurance coverage of livestock loss is very limited. These programs tend to suffer from moral hazard and fraud; in addition, the controls to manage them adequately – purchase reviews, veterinary assessment costs, and loss adjustment – cost too much for livestock cover to remain viable. Low-income people seem no different than others when it comes to trying to obtain insurance compensation where none is legitimately due.

**Map 8: Property products**



The research team found only 54 property microinsurance products in the poor world, distributed fairly evenly between crop, home, livestock and ‘other possessions’ insurance. Only one motor policy was found, which is not surprising, given the poverty focus of microinsurance.

Of the 36.2 million people covered by property microinsurance, over 28 million are from the ACFTU, leaving a ‘truer’ picture of 8 million covered by property policies.

One reason for the small volume of property microinsurance is that it tends to be sold to individuals rather than to groups – 39 of the 54 property insurance products were sold to individuals. This increases transaction costs, which in turn means increases in premiums beyond what poor people can afford.

One way around the difficult administrative and claim validation problems of property insurance is to provide a set sum for the total loss of property. This method has been attempted by a number of Indian microinsurers. Commonly these programs cover small dwellings and their contents, with the cover being a fraction of the replacement value. Having such a small sum assured reduces the need for expensive loss adjustment, but has limited value to the policyholder who receives a fraction of the replacement cost.

The survey found that 22% of property microinsurance was distributed through MFIs and 11% through retailers, typically by providing insurance on the goods or equipment being purchased.

This type of property insurance is ideal for small entrepreneurs who purchase equipment on credit. It is potentially an exciting and large new channel for the delivery of property microinsurance and should be investigated further.

Most property products (78%) are provided by for-profit commercial insurers. With an average product age of around five years, one can reasonably infer that at least some of the products are profitable or at least break even. It would be useful to do more in-depth research into the profitable products to see whether they could be replicated and scaled up.

### **Index insurance**

As mentioned above, many countries have tried some form of crop insurance, but with little to no success due to moral hazard and fraud problems. One way of getting around this is through index insurance,<sup>16</sup> especially a promising new initiative known as weather index insurance.

In developing and transitional economies, agriculture is one of the most important sources of income for low-income people, but returns from agriculture tend to be unstable, subject as they are to the vagaries of weather among other factors. Weather indexing is a way of linking benefit payments to an objective index like rainfall, making it less susceptible to manipulation and fraud than traditional crop or livestock insurance.

Weather-based risk management instruments first grew in popularity in the 1990s in the United States, when power companies were deregulated. Very hot or very cold weather placed peak demands on electricity companies, which had to buy their power at high cost. The companies began to use index insurance as a hedge against this risk.

The research team managed to get details on only one weather index scheme for low-income farmers, but it is known that the World Bank, working with a range of partners, has implemented pilot projects in several countries including Argentina, Mexico, Morocco, India, Malawi, Nicaragua, Ukraine, and Peru. Box 1 that follows provides an example of an index scheme from Ethiopia.

Index insurance products are too new for extensive financial assessment, although such assessment would be valuable to this discussion. Reinsurers such as Swiss Re are heavily involved in these products. They have noted that so far the index product within the book of one insurer in a country is extremely expensive, with limited potential for reasonable term returns.

There may well be significant potential for index based insurance products to address the catastrophic risks of large numbers of people, but it is important to first understand the effectiveness and sustainability of the programs currently in pilot test mode.

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<sup>16</sup> Technically these indices are not 'insurance' because there is no formal link between the benefit and the loss.

**Box 1: AXA Re – WFP Humanitarian Emergency Insurance program for Ethiopia**

The World Food Programme (WFP), the government of Ethiopia, and the insurance company AXA Re, have jointly developed a weather insurance product for Ethiopia. WFP pays a premium to AXA Re, and if rainfall levels in Ethiopia fall below a trigger amount, the benefit is paid to the WFP.

Although this product is not microinsurance, it is a macroinsurance product that is of relevance to poor countries. It came about because of the lengthy periods of time needed to apply for donor funds to mitigate the impact of a drought in a very poor country like Ethiopia – time that could not be spared in such emergencies. Instead donors now pay a small premium on a regular basis, and when drought occurs, the payment is swift and the effects of the drought are alleviated much faster than before.

The policy, based upon a calibrated index of rainfall data gathered from 26 weather stations across Ethiopia, takes advantage of financial and technical innovations in the weather risk market. Payment is triggered when data gathered over a period from March to October indicates that rainfall is significantly below historic averages, pointing to the likelihood of widespread crop failure.

While the experimental pilot transaction provides only a small amount of contingency funding, the model has been designed on the basis of the potential losses that 17 million poor Ethiopian farmers face, in the event of an extreme drought arising.

(Source: [http://www.axa-re.com/pdf/HumanitarianInsurance\\_pressRelease\\_en.pdf](http://www.axa-re.com/pdf/HumanitarianInsurance_pressRelease_en.pdf))

**Delivery channels**

It is clear both from the landscape survey and from the experience of the research team that delivery channels are one of the most significant constraints to the expansion of microinsurance. In some instances – Delta Life and Tata-AIG are examples – insurers have developed their own specialized microinsurance agent force, although there is evidence that such a mechanism has limitations and can be expensive.

**Table 7: Delivery channels by type and covered lives**

Delivery Channel Type	Covered Lives
Agents - microinsurance or other	7,569,773
Brokers - microinsurance or other	292,947
CBOs, NGOs and other groups	25,645,596
Employer groups	181,192
Government and Parastatals	11,815,690
Mutuals	13,800,214
Other financial services (e.g. MFIs)	17,001,644
Retailers of other service providers including funeral parlors	1,755,682
Not specified	436,766
<b>Total</b>	<b>78,499,503</b>

Insurers throughout the 100 poorest countries have been searching for new channels. From post offices to fertilizer bags, from MFIs to churches, insurers interested in this business are actively testing new channels.

Table 7: Delivery channels by type and covered lives, shows the various delivery channels used in microinsurance. CBOs, NGOs,

and mutuals provide the largest volume, with a combined 39.5 million people accessing microinsurance through them. This is expected since a necessary (though not sufficient) requirement for an effective microinsurance delivery channel includes working with large numbers of low-income people. NGOs, mutuals, and federations of CBOs work with large numbers of poor people and generally have the trust of their members. Mutuals often have the additional benefit of managing other financial transactions within the low-income market – an important facilitating input which MFIs and other financial service providers can offer.

Most microinsurance is sold in groups. Microinsurance to individuals could be made more effective if more individuals had efficient access to transaction accounts from which premiums could be paid and claims could be settled. It was assumed in the preparation of this research that there would be a clear correlation between the presence of microfinance institutions and the availability of microinsurance. This has proven not to be so. Microfinance availability seems to correlate very little with microinsurance availability. This is probably related to the relative newness of microinsurance in developing countries, coupled with the efforts of insurers to use alternative delivery channels.

In several countries, India in particular, there is a movement towards retailers and specialized microinsurance agents. Brokers traditionally are effective delivery channels. Unlike agents, who sell the products of one insurance company, brokers directly represent the policyholder. They assess client needs, identify or develop appropriate insurance products for them, and then get quotes for these products from different insurers. In many ways brokers would seem a perfect delivery channel for microinsurance, at least with large groups. In practice, however, most insurance brokers tend to have a specific niche in the more lucrative commercial or multinational markets.

The broker concept is not lost to microinsurance however. Opportunity International has developed a microinsurance brokering model that it is currently testing in Uganda. The MicroInsurance Centre has promoted microinsurance brokers at national and regional levels. This is a concept that could prove an important intervention in scaling up microinsurance in the mid- to long-term.

In a number of countries, Sri Lanka for example, several insurers are ready, interested, and actively seeking a means to get into the microinsurance market. They know they must do this through delivery channels, but potential delivery channels in Sri Lanka are weak or uninterested. This lack of an available and efficient delivery infrastructure is slowing the progress of microinsurance expansion – not because there is no demand or because there is no supply, but simply because there are no efficient means of connecting demand with supply.

Microinsurance delivery channel development and improvement will prove a critical factor in whatever is done in the future to promote microinsurance access on a large scale. Box 2, below, provides an example of an interesting delivery channel, from India.



**Box 2: The fertilizer bag policy**

Iffco Tokio is an example of a commercial company with extraordinary outreach figures for a microinsurance product. The Sankat Haran Policy, sold in India, is perhaps the world's biggest microinsurance product as measured by number of policyholders. By the end of 2005, according to *The Hindu* newspaper (Revathy, 2006), it had 25 million policyholders. The policy provides accidental death and disability cover, which is automatically obtained when a client buys a 50kg fertilizer bag of the Iffco or Indian Potash brands. The receipt for the fertilizer acts as proof of payment, and the policy document is printed on the fertilizer bag. The amount of cover is USD 90 in the event of an accidental death and USD 45 for certain categories of dismemberment and disability. The insured is whoever purchases the fertilizer bag, and a single person can hold multiple policies up to a maximum of USD 2,260 cover. Claiming on the policy appears to be somewhat arduous, as claimants must submit a variety of documents to the Iffco-Tokio Company directly. (Roth and Chamberlain, 2006)

MFIs are often mentioned as the logical delivery channels for microinsurance because they already reach many low-income people efficiently with other financial transactions. In practice, however, MFIs have been found to be limited in their delivery of microinsurance. The landscape survey found that MFIs deliver no more than 25% of the products identified. The survey revealed widespread use of CBO delivery channels and trade unions to distribute insurance provided by commercial insurers. This role of CBOs as delivery channels is quite different from CBOs as insurers.

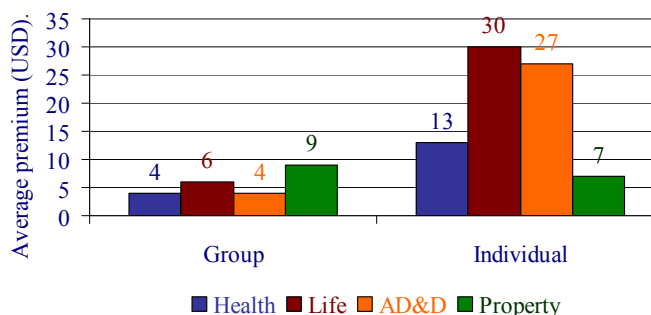
As mentioned, with the example of the Indian fertilizer-bag insurance and certain kinds of social security, it is important not to confuse numbers with genuine access or product quality. Selling large quantities of insurance that costs very little and provides little benefit has limited value, no matter how widely it is sold.

The research team identified four keys to effective delivery strategies to achieve scale:

*Leverage of groups:* Groups range from clearly defined groups like MFI clients and employee groups, to CBO delivery channels and church organizations, and even looser affinity groups like clients of a particular retailer, or subscribers to a particular mobile phone service. All of these types were found in the landscape survey.

The landscape survey clearly revealed the effectiveness of group-based delivery rather than individual products. The costs of group products across all products (except property, anomalously) were lower than individual products by factors between 3 and 6. This is shown in Figure 7. (It should be noted, however, that part of the reason for the large difference between group and individual life premiums is that individual life products in this study

**Figure 7: Average premium costs**



frequently included a payment for long-term savings.)

*Leverage of institutions and systems:* In some case group leverage can be taken one level higher to become system leverage. For example an insurer can move from targeting of employers with group products, to creating pressure through supply chains for every employee of every company supplying a particular global multinational to have group life cover.

*Leverage of transactional infrastructure:* Affinity groups centered on financial transactions are helpful for microinsurance delivery, since they already have transactional capacity and processes that can be leveraged to facilitate premiums and claim payments. Such groups include employees, retail clients, and clients of other services such as banks, remittance providers, post offices, healthcare providers, funeral providers, electricity suppliers, and communications services. Church-based groups can even be set up with financial infrastructure, as has been done through the collection books of the Zionist Christian Church in South Africa. In general, formats that support electronic gathering of information and data are preferable for risk management and validation purposes, as well as for actuarial, monitoring and reporting functions.

*Leverage of technology:* Closely related to leverage of transactional infrastructure are the opportunities being opened up by technological development. Mobile communication and transaction technologies, the internet, and bio-identification systems can all facilitate scale. High tech is not always the way to go (again consider the fertilizer-bag method) and is no substitute for smart delivery design. But used well, it can certainly enable scale.

Technology has tremendous potential to increase the efficiencies of microinsurance, bring down operating costs and ultimately reduce premiums to low-income people. Several uses of technology have already had important impacts on microinsurance delivery. ICICI Prudential sells life insurance through kiosks in rural villages in India, and there has been talk of expanding this to include hospitalization cover. In South Africa and the Philippines, microinsurance has been sold via cell phones. In numerous banks and MFIs microinsurance premiums are deducted from policyholders' accounts. In Georgia, information is transacted between MFIs and insurers in electronic form.

## **Regulation**

The landscape study showed that in poor countries there has been very limited regulation<sup>17</sup> of microinsurance. The Philippines makes special mention of microinsurance and has regulation that oversees mutual benefit associations. A number of ex-British colonies, for example Belize, have a Friendly Societies Act intended to regulate the workings of small CBO insurers.

India has attempted to regulate microinsurance specifically, by compelling insurers to sell microinsurance. As many as 38% of the microinsurance products surveyed in the 100 poorest countries were found in India, most of them emerging after new regulations were passed in 2002. The lack of regulation or at least lack of interest in microinsurance by most regulators is

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<sup>17</sup> Data for this section was compiled using direct interviews with 106 insurers and a questionnaire that was sent to all the insurance regulators in the 100 poorest countries. Regulators overseeing 73 of these countries responded. The respondent countries are identified in Appendix 5.

unsatisfactory, as regulators can play a great role in promoting microinsurance.

To address the lack of regulation, the International Association of Insurance Supervisors (IAIS) has formed a working group on microinsurance to identify and consider the relevant regulatory issues implicit in microinsurance. This group has been working with the regulatory sub-group (led by GTZ) of the CGAP Working Group on Microinsurance. Their level of interest and seriousness in relating microinsurance to insurance legislation suggests that useful recommendations and guidelines will emerge for all their members.

Box 3 outlines the regulatory requirements that have led to the rapid expansion of microinsurance in India.

**Box 3: Changing the face of microinsurance: the obligations of insurers in India**

In 2002, the Indian insurance regulator published a regulation titled ‘Obligations of Insurers to Rural Social Sectors’. This regulation was essentially a quota system that compelled insurers, as a condition of licensing, to sell a minimum percentage or premium value of their insurance policies in specified rural sectors. With the great majority of poverty in India located in rural areas, the effect of the regulation was to ensure that insurance reached poor people.

The regulation was imposed directly on new insurers who entered the Indian insurance market after the market was liberalized in 2002. The old public insurance monopolies were not given quotas, but had to ensure that the amount of business they did in the specified rural social sectors was “not less than what has been recorded by them for the accounting year ended 31st March, 2002”.

The regulation put massive pressure on insurers because it meant that unless they sold microinsurance, they would not be able to sell their more profitable products. The regulator has subsequently fined a number of insurers for failing to meet their targets.

Until 2002, the innovation in microinsurance worldwide came from donors, academics, or MFIs. Now for the first time, with an obligation to meet microinsurance sales targets, insurers themselves began developing innovative new products and delivery channels, and allocating considerable resources to this task.

A cost-benefit analysis of the Indian approach is urgently needed. Whatever its advantages and disadvantages, there is no doubt that having a regulator paying specific attention to microinsurance has had important outcomes for the wider delivery of microinsurance.

Regulations and regulators are not always forces for the good. The research team asked insurers whether regulatory barriers impeded their work. In all regions the insurers’ main concern was about reserve and capital requirements, otherwise regulation was not generally seen as a problem. This does not suggest that regulation is always appropriate or well enforced, but it does suggest that it provides some kind of functional environment.

The concern about capital and reserve requirements is significant, especially in relation to starting new insurance companies. In India, there is much to suggest that the capital required to

start an insurance company is far too high. In 2003, an insurer in India required approximately USD 21.7 million to undertake life insurance compared to USD 3.7 million in Sweden, USD 2.0 million in New York State, USA, USD 1.2 million in South Africa, USD 0.57 million in Uganda, and only USD 0.26 million in Sri Lanka.

There may be ways to change these constraints. One solution could be the use of reinsurance to reduce reserve requirements. Another could be for donors to lend the capital required to start microinsurance companies by creating venture capital funds. Another possibility would be for donors to fund research that could convince regulators to lower capital requirements where this is warranted.

Of major concern to donors is that thirty-five percent of all microinsurance products encountered were offered by unregulated insurers. In fact the true percentage is probably higher because of the number of informal microinsurance schemes, which tend to be small, hidden, and not documented in any significant way. Donors are reluctant to invest in illegal insurers. Those who have worked with unregulated schemes have encountered difficulties with local regulators. The regulators argue, often quite rightly, that the unregulated insurers undermine the regulations and undercut regulated insurers.

## **Donors**

Donors<sup>18</sup> are becoming increasingly involved in microinsurance. The survey found 159 donor-funded microinsurance projects for the period 2003 to 2006, with a total donor contribution to microinsurance activities and studies of USD 10.2 million (this is clearly a minimum value as microinsurance is sometimes a publicly indistinguishable part of a larger contribution, and some donor information was not made available). For the donor-recipient 57 countries out of the 100 poorest, this averages out to USD 180k per country. If one further assumes the funds were spread out evenly over three years, the figure comes down to USD 60k per country per year. At this level of funding, one cannot claim that donors could possibly be driving the microinsurance industry.

Donors tend to fund microinsurance in countries where they typically operate, e.g., DFID in ex-British Colonies, French donors in ex-French colonies, and the Asian Development Bank in Sri Lanka and Vietnam. The country with the largest number of donor-funded microinsurance projects was India with 19 projects, followed by Uganda, Indonesia, and the Philippines, each with eight projects. Map 9 provides details on donor activities in the 100 poorest countries. The top five donors and the value of their investments are identified in Figure 8: Top 5 microinsurance donors.<sup>19</sup>

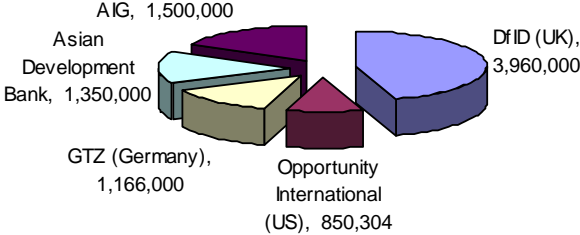
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<sup>18</sup> Data on donor involvement in microinsurance was obtained from two sources – a questionnaire sent to all donors known to be involved in microinsurance, and a question in the global questionnaire asking whether or not each specific product received donor support. Although this information was not available for every product, there were 85 responses.

<sup>19</sup> Because of difficulties distinguishing the value of contributions of the Bill & Melinda Gates Foundation and ILO STEP, both of whom are substantial contributors to microinsurance, they not shown in this diagram. Their combined contribution is likely more than USD 15 million. Also, it is possible that other donors are not included in the totals reflected here. However, the total investment of other unidentified donors is not likely to exceed USD 5 million.

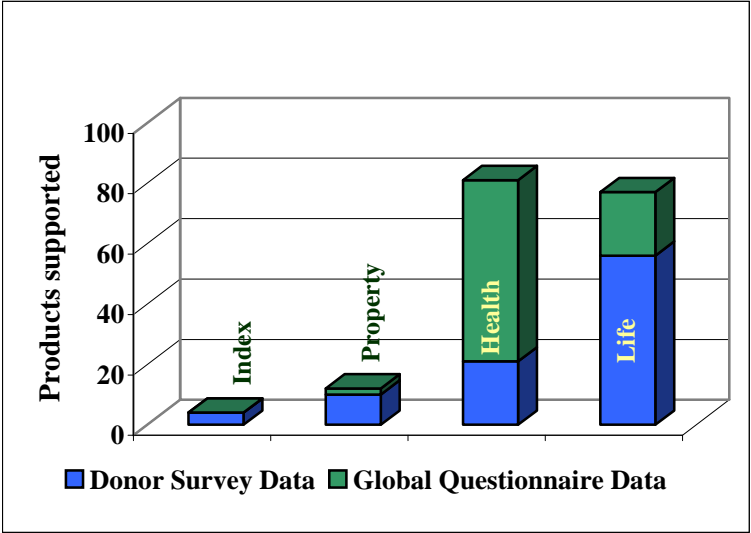
Commercial insurers, by far the largest providers of micro-insurance as measured by policyholder numbers, are not supported in any significant way directly by donors (only 8% received direct donor support). This is partly a function of the regulatory imperative in India, and partly because commercial insurers provide simple life or credit life products, from which they can make profits with relative ease.

**Figure 8: Top 5 microinsurance donors**

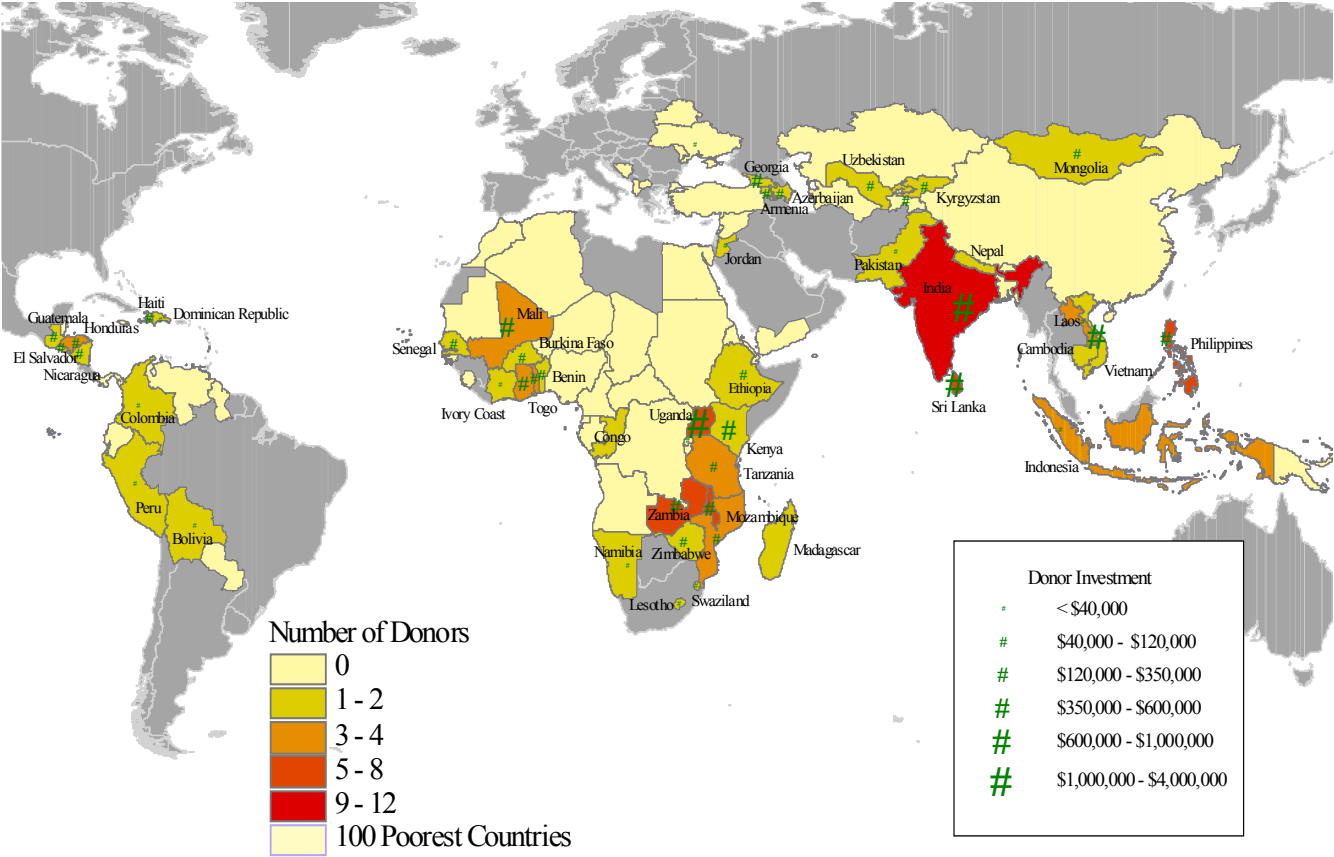


Support by donors, if analyzed by product category, is heavily focused on life and health products, as shown in Figure 9.

**Figure 9: Donor support by product**



**Map 9: Donor activities in microinsurance**



The other significant microinsurance distributors not dependent on donor support are small informal insurers. As mentioned earlier, only limited data could be captured about informal insurers because most of them are very small and hidden.

**Social security schemes**

Social security schemes are pensions and various kinds of grants provided by governments. They clearly complement and influence the need for microinsurance. Many countries provide some kind of social security benefits – even for people living on less than USD 2 per day. These benefits can be broadly divided into social assistance and statutory contributory schemes.

The research team’s primary purpose in capturing social security data was to understand where microinsurance might fill gaps in social security schemes, and conversely where strong social security schemes may render microinsurance schemes unnecessary. A specialized social security expert was contracted to collect information on all social security schemes in the world’s 100 poorest countries. In total 130 social security products were captured.

Information on social security schemes should be approached with caution. What may look like a good program on paper, backed up by good legislation, may in practice prove inaccessible. Even

when accessible, the products may be insufficient to provide relevant coverage. Too often, social security programs for the low-income sector are mostly seriously flawed and provide little benefit to low-income families – in some cases, they actually reduce overall risk-coping ability.

The survey found that by and large, social security schemes were not adequate and should be complemented by microinsurance. Some examples illustrate this:

- Packages of free medical care through government health care providers should be assessed in the context of public health care facilities, which in many countries are inadequate. 'Free' healthcare may well be more expensive for low-income people, because of the bribes that people are required to pay directly to health care providers. People have been known to die in the waiting rooms of 'free' hospitals simply because they do not have the bribe to get to the front of the queue. In most countries, access to adequate health care for low-income people cannot be guaranteed.
- Though several countries provide old age pensions, these often require between 240 and 360 months of contributions. This is impractical to expect of informal workers, especially in cases where there is no simple system of making payments. In too many countries, even employed people who have qualified for pension benefits find great difficulty in accessing their rightful benefits, and too often simply give up. Finally, when low-income workers do receive their due pensions, these may be too small to be effective. In Georgia, for example, there was a time when the old age pension was USD 6 per month while the extreme poverty line was USD 30 per month.

The strengths and weaknesses of social security efforts should be understood so that microinsurance can be complementary to effective government programs.

### **Microinsurers' views on the future of their industry**

The landscape survey set out to uncover not just the physical landscape, but also perceptions and attitudes of microinsurers. In particular, microinsurers were asked to indicate the extent to which they agreed or disagreed with the following four statements:

- Economic policies are favorable for the microinsurance business
- Financial regulations are favorable for the microinsurance business
- Domestic microinsurance business would grow more than 10% in the next year
- Domestic microinsurance business would grow more than 100% in the next five years

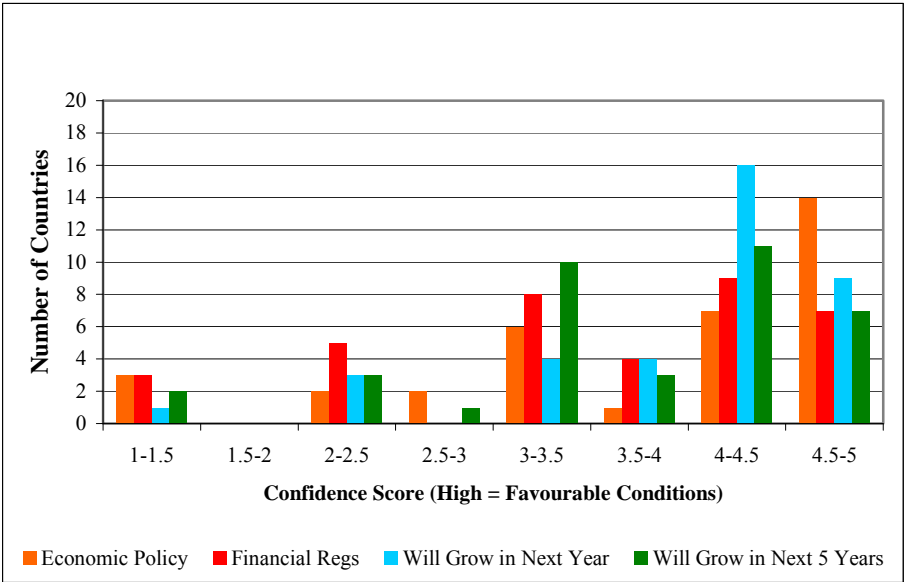
Microinsurers were also asked to assess the extent to which the following factors were hindrances to the industry:

- Ignorance of insurance amongst policyholders and potential policyholders
- Inability to write microinsurance on a profitable basis
- Poor people's inability to afford microinsurance products
- The lack of demand for microinsurance from poor people
- Lack of access to reinsurance

Figures 10 and 11 attempt to quantify the microinsurers' attitudes towards the future of

microinsurance and their difficulties with various hindrances.<sup>20</sup> It shows the delivery of the scores for the various indicators averaged across insurers within each country – a high score indicating an optimistic view and a low score a negative view. As can be seen, there is a spread of scores, but on balance, the microinsurers seemed generally very positive about their environments and prospects.

**Figure 10: Average Optimism of Microinsurance at Country Level**



Country economic policies were viewed favorably, with the highest proportion of countries showing strong agreement with the statement that “economic policies in your country are favorable to microinsurance”. The lowest scores (i.e. the least favorable economic environments) were found in Democratic Republic of Congo, Congo, Guinea, Cambodia and Madagascar. On the other hand, Venezuela, Paraguay, Panama, Mauritania, Guatemala, Gabon, Cameroon, and Azerbaijan were all viewed by respondents as having highly favorable economic environments.

In response to the question whether financial regulations seemed to be neutral, slightly favorable or unfavorable, financial regulations were reported as most problematic in Democratic Republic of Congo, Congo, the Dominican Republic, Cambodia, Honduras, and Nicaragua (scores of 2 and below). The highest levels of confidence were found in Panama, Mauritania, Guatemala, Gabon, and Madagascar.

Microinsurers seemed generally fairly positive about the growth prospects for one year ahead, with nearly 70% mainly or strongly agreeing that 10% growth was likely. Growth prospects for the year ahead were most favorably viewed in Panama, Guatemala, Burkina Faso, Paraguay and Kyrgyzstan, and least favorably viewed in Comoros, Nigeria, Tanzania and Senegal (scores of less than 3).

<sup>20</sup> Microinsurer attitudes were derived from specific questions on the general questionnaire (Appendix 2), which were answered by 141 respondents. These responses correlate reasonably with the respective overall percentages of insurer types within the survey and thus can be considered representative.

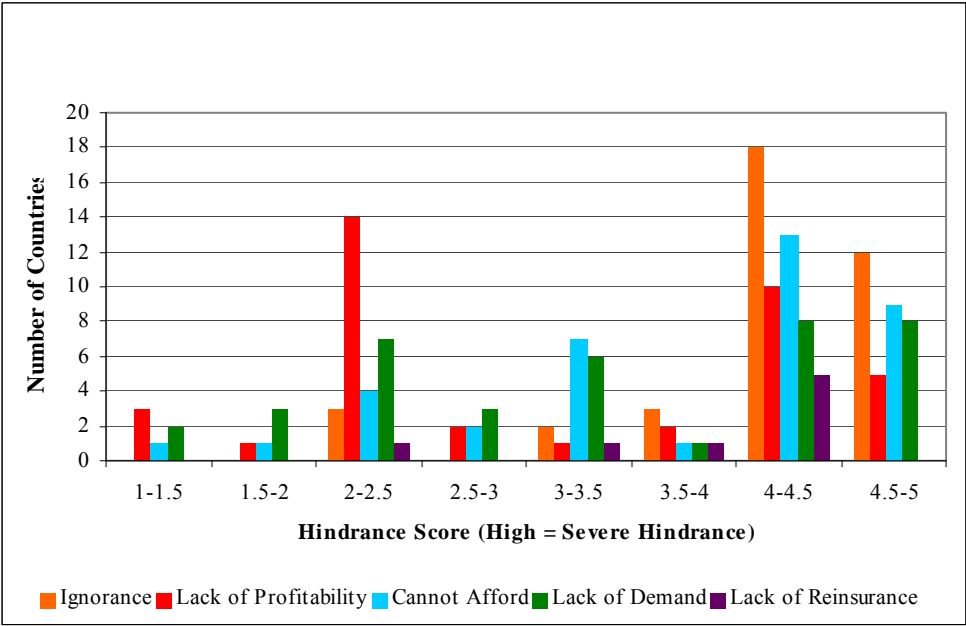


Just over 40% of microinsurers were mainly or strongly in agreement that their businesses would double over the next five years, suggesting a bullish medium-term view (or simply a very small starting position). The countries most negative about their five-year prospects were Comoros, Senegal, Nigeria, Tanzania, and Dominican Republic. The most optimistic were Panama, Guatemala, Burkina Faso, Paraguay, and Uzbekistan.

The entire analysis was also re-examined via numbers of lives covered rather than by number of insurers. This viewpoint gives a much heavier weighting to the large schemes – especially the very large schemes that dominate the data. It is interesting to note that from the ‘number of lives’ perspective, the overall gist of the perceptions swings completely: the large schemes are rather negative about growth and prospects, but feel there are no great hindrances. This is not surprising, since large schemes are already established (and hence not facing hindrances). Being very large, they have lower growth prospects. Very small schemes, on the other hand, would be more bullish about growth but more preoccupied with difficulties.

Fig 11 summarizes the hindrance factors. A high score indicates that the hindrance is a great problem.

**Figure 11: Average Hindrances to Microinsurers at Country Level**



Public ignorance about insurance is widely rated as a significant barrier, getting the highest possible score in Togo, Panama, Mauritania, Madagascar, Guatemala, Gabon, Dominican Republic, and Burkina Faso, and only marginally lower in Mali. The former Soviet Union states mostly appear in the second highest category. Countries having the least problem with ignorance (score of 2 out of 5) were Honduras, Comoros, and Philippines. Peru and Senegal were neutral on balance (3).

Very interestingly, lack of profitability of microinsurance business is perceived NOT to be a hindrance in the majority of cases, with Gabon, Guatemala, Colombia, and Benin being

noticeably unconcerned about this issue. The profitability issue was, however, perceived as a major problem in Mauritania, Dominican Republic, Paraguay, Kazakhstan, and Kyrgyzstan (the latter two have amongst the highest microinsurance premiums of all countries).

The ability of people to afford insurance is perceived as a significant issue and has an important interaction with the profitability question: if it's unaffordable, drop the premium, but then expect problems with profitability! Countries regarding affordability as a major problem were Uzbekistan, Azerbaijan, Cameroon, Nigeria, Madagascar, and the Dominican Republic.

Another closely related hindrance is the lack of demand by poor people for insurance, and shows a pattern more or less in between the affordability and profitability patterns. Most significant problems were found in what are now becoming familiar countries: Mauritania, Gabon, Kazakhstan, and Dominican Republic.

The question of the lack of access to reinsurance was very sparsely answered. The reason may be that many microinsurance schemes (particularly CBOs and other informal insurers) simply do not think about it. However, it was reported as a significant hindrance in the former Soviet republics of Kyrgyzstan, Uzbekistan, and Kazakhstan, and also in Armenia and El Salvador, and was marginally a problem in Belarus.

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### Overview of three countries – Uganda, India, Sri Lanka

# Country Profile: Uganda

Macroeconomic / Social Statistics	
HDI Rank (2003)	144
Population	27.8m
GDP Growth Rate (2004)	5.7%
Average Annual Inflation (2004)	6%
Adult Literacy Rate (2004)	66.8%
Primary School Completion Rate (2004)	63%
Under 5 Mortality Rate per 1000 (2003)	140
Total Workers Remittances (USD) 2004	0.3b



Captured Statistics on Microinsurance	
No. of health/life/property/AD&D insurance products	5 / 2 / 1 / 1
No. Commercial/Mutual/CBO/NGO providers	2 / 1 / 0 / 0
No. Regulated/Unregulated (microinsurance operations)	2 / 1
No. of donors working of microinsurance	8
No. of covered lives	1,618,236

## Insurance Industry Basics

Issues	Observations
Name of insurance regulatory body	Uganda Insurance Commission
Key responsibilities of the regulatory authority	Policy development, recommendations to Parliament, implementation, enforcement, supervision, and licensing of insurers, brokers, reinsurers, and agents.
Minimum capital requirements for insurance license	UGX 1 billion (USD 556,000) each for life and non-life licenses
Other key requirements for regulatory compliance	Regular weekly, monthly, quarterly, and annual reporting; 5% of reinsurance business must go to Africa-Re, and 10% to the preferential trade area reinsurance company.
Number of private insurers	20 Non-life; 4 Life
Annual premiums of private insurers	Non-Life – USD 27.8 million; Life – USD 2.1 million (2003)
Annual premiums of public insurers	UGX 7.8 billion (USD 4.3 million) in premiums in 2003 (The Monitor, July 7, 2004)
Other unregulated organizations, that offer insurance	Numerous community-based “insurance” schemes.

## Example of a Ugandan Microinsurance Product

AIG Uganda – Group Personal Accident insurance

Microinsurance Type	Group personal accident, permanent disability, death by accident, credit life and disability, and disasters that wipe out the entire business.
Group or individual product	Group policies written to the MFI
Term	Variable linked to loan term
Eligibility requirements	Insured must be a borrower from a participating MFI.
Voluntary or compulsory	Mostly compulsory
Renewal requirements	“Renewed” or purchased with each loan. Those not borrowing cannot be insured
Rejection rate	Approval is automatically granted if the client gets a loan.
Key exclusions	Extensive list of common exclusions including: self-inflicted injury and war.
Pricing – premiums	Small adjustments are made to the product for each MFI. The premium by which the product is sold to the MFI is between 0.5% and 1.0% of the loan disbursed.

### **Microinsurance evolution in Uganda**

Microinsurance in Uganda has followed a dual path since the mid-1990s, one direction through community-based insurers, the other through commercially-based insurers. The community-based insurers started when DFID (UK Department for International Development) began promoting local approaches to health microinsurance. DFID worked with hospitals and other institutions to create health microinsurance products for low-income people in areas around hospitals. CIDR (Centre International de Développement et de Recherche) also worked to create community-based health microinsurance in areas North of Kampala with very poor people. By the end of the year 2000, both of these organizations had closed their direct operations with these community-based insurers as well as the apex organization that they had developed to oversee the individual projects. Although most of these community-based insurers are still in operation, they have limped along inefficiently and should certainly not be considered as models. The CIDR program has become more of an emergency loan provider than an insurer.

On the commercial path, the commercial insurer AIG (American International Group) Uganda in 1996 took on a product that one of the leading microfinance institutions was trying to get covered for its clients. After three years of offering the product, a group personal accident policy, to the MFI's clients, AIG Uganda expanded the product to most other large MFIs in the country. Some of MFI managers reported that this product became a key component of their credit products because borrowers came to expect such insurance with their loans. The success of this product, developed to provide cover for low-income clients and open a new market for commercial insurers, has become an international example of the potential for microinsurance. In Uganda, several other commercial insurers, noting the success of this product (not only in outreach, but also in profitability) entered into significant competition among themselves for microinsurance business. This competition has led to improved products and premiums that benefit low-income clients. Well over 1.6 million people in Uganda are now covered by loan-linked insurance products.

Another development along the commercial path took place in the health insurance field when one of the original hospital-based programs, Microcare, a health insurer, broke away from its linked hospital. Microcare did this because it recognized the importance of offering an array of provider options to the low-income market; an additional motive was to create a system of competition for patients among the providers. The management team of the program developed systems, policies, procedures and controls, and expanded their health microinsurance program using MFIs, schools for low-income children and other channels. Limited by its NGO status – unable to access reinsurance, and at risk by not being licensed – the management team of Microcare solicited private individuals and commercial investors to generate the capital to obtain a full insurance license. Although donor funding has helped Microcare move forward, its success is clearly an example of the power of an individual commitment.

# Country Profile: India

Macroeconomic / Social Statistics	
HDI Rank (2003)	127
Population	1.1b
GDP Growth Rate (2004)	6.9%
Proportion of Population living on less than USD1 per day (2004)	35%
Average Annual Inflation (2004)	5.3%
Adult Literacy Rate (2004)	61%
Primary School Completion Rate (2004)	81%
Under 5 Mortality Rate per 1000 (2003)	87
Total Workers Remittances (USD) 2004	21.7b



Captured Statistics on Microinsurance	
No. of health/life/property/AD&D insurance products	221 / 51 / 28 / 33
No. Commercial/Mutual/CBO/NGO providers	21 / 0 / 4 / 0
No. Regulated/Unregulated (insurance operations)	22 / 3
No. of donors working of microinsurance	13
No. of covered lives	30,111,690

## Insurance Industry Basics

Issues	Observations
Name of insurance regulatory body	Insurance Regulatory & Development Authority (IRDA)
Key responsibilities of the regulatory authority	Regulate, promote and ensure orderly growth of the insurance and re-insurance industries
Minimum capital requirements for insurance license	INR 1.0b (USD22.22m) NB: No waivers are granted to microinsurers
Other key requirements for an insurance license	The IRDA distinguishes between what it terms life insurance that includes endowment and annuities, and insurance for all other risks that fall under a general insurance category. In India, an insurer must form separate entities and cannot sell life insurance and general insurance together on the same policy. Also, foreign companies can only enter the industry in collaboration with the domestic companies
Other key requirements for regulatory compliance	Investment in the rural and social sectors (see Section 1.2)
Minimum capital requirement for a reinsurer	INR 2.0b (USD44.44m)
Number of regulated private insurers / value of annual premiums	Life Insurance 13 / INR 31.2b (USD693.41 m) Non-Life 8 / INR 22.6b (USD501.74 m)
Number of regulated public insurers / value of total annual premiums	Life Insurance 1 / INR 631.7b (USD14 037.24m) Non-Life 6 / INR 151.0b (USD3 355.41m)
Number and type of other regulated insurance organizations	None

## Example of an Indian microinsurance product

Yeshasvini Trust  
(Source: Ralf Radermacher, *et al* – November 2005)

Group or individual product	Individual / Household level
Term	1 year
Eligibility requirements	Cooperative society member and their family
Delivery model	Yeshasvini Trust partners with the Karnataka Department of Cooperation for distribution, and with the Family Health Plan Ltd. for third party administration.
Voluntary or compulsory	Voluntary, advised to join by coop secretary
Product coverage (benefits)	Predefined medical – surgeries and costs connected to common ward admission. Out-patient care is covered, but not related drugs
Key exclusions	All surgery not included on their list. Inpatient care without surgery
Pricing - Member pays	Y1 – INR 60 (USD 1.36) per insured, INR 30 (USD 0.68) subsidized by Government Y2 – INR 60 per insured Y3 – INR 120 (USD 2.72) per insured
No. of policyholders	1.45 million (2005)

### **India's microinsurance industry**

The insurance industry, private and public, in India started in the 19th century when the British government set up state-run social protection schemes for its colonial officials. Many of these schemes evolved into the companies that still operate to this day.

In 1956, the Indian government nationalized the life insurance industry. One of the reasons given at the time was a desire to spread insurance more widely. As Prime Minister Nehru noted in parliament, "We require life insurance to spread rapidly all over the country and to bring a measure of security to our people". The government combined 154 insurers and formed the Life Insurance Corporation (LIC) of India. Despite Nehru's hopes, in the decades following nationalization, insurance products continued to be designed primarily for those in formal employment – overwhelmingly men in urban areas. The poor, living mostly on agriculture, were for the most part overlooked by the new companies. There were a few crop insurance schemes run by the state, but generally these reached only a small percentage of poor households.

Though the poor were effectively excluded from insurance markets, at least one significant example of microinsurance stands out, which was to have some impact on the legislation that was to come. The Self Employed Women's Association recognized the importance of insurance for their low-income members in the early 1990s. Their successes and lessons helped to exemplify the importance of insurance within the low-income market. Their experiences helped to inform government plans in the early 2000s to expand insurance access by fiat to the rural and socially-deprived sectors of the economy.

In the early 2000s, the Indian government liberalized its insurance markets. In part, as means of alleviating fears surrounding foreign insurers, the government forced all new insurers to sell a percentage of their policies to the *de facto* poor. From having almost no access to microinsurance bar the work of CBO insurers and a few NGO insurers, commercial insurers eager to compete in the Indian market were suddenly scrambling over themselves to design and sell microinsurance products. India now has over 130 microinsurance products and reaches many millions of poor clients, through innovative schemes such as the fertilizer bag AD&D scheme described earlier.

Nothing globally has so dramatically changed the face of microinsurance as India's regulatory compulsion. Whether its costs outweigh its benefits remains an unanswered question.

# Country Profile: Sri Lanka

Macroeconomic / Social Statistics	
HDI Rank (2003)	93
Population	19.4m
GDP Growth Rate (2004)	5.4%
Proportion of population living on less than USD1 per day (2004)	5.6%
Average Annual Inflation (2004)	9.4%
Adult Literacy Rate (2004)	90.7%
Primary School Completion Rate (2004)	100%
Under 5 Mortality Rate per 1000 (2003)	15
Total Workers Remittances (USD) 2004	6.1b



Statistics on Microinsurance	
No. of health/life/property/AD&D insurance products	15 / 4 / 8 / 3
No. Commercial/Mutual/CBO/NGO insurers	3 / 3 / 0 / 3
No. Regulated/Unregulated (microinsurance operations)	3 / 6
No. of donors working of microinsurance	5
No. of covered lives	159,226

Insurance Industry Basics	
<i>(Source: ALMAO and YASIRU Sri Lanka - Sven Enarsson and Kjell Wirén)</i>	
Issues	Observations
Name of Regulatory Body	The Insurance Board of Sri Lanka (IBSL)
Minimum capital requirements for insurance license	LKR 25 million (USD250 000) for Life Insurance, LKR 50 million (USD500 000) for General Insurance.
Other key requirements	Only Limited companies can receive a license. Mutuels are not allowed.
On-going capital requirements	Solvency margin of 10% of gross premium in general insurance and 5% of actuarial value of liabilities in Long Term business.
Number and value of regulated private insurers	Total of 14: 11 composite companies, 2 Life and 1 General; Total Premiums LKR 29.6 billion (USD295 million).
Other regulated insurance organizations	45 Insurance Brokers
Unregulated organizations that offer insurance	Old ALMAO, Yasiru, SEEDS, Women Development Fund in Hambantota.
Certification requirements for agents	Only private persons can be appointed as agents. An insurer or a broker can appoint agents, who must pass an exam and pay a fee for a license.

Example of a Sri Lankan Microinsurance Product	
<i>(Source: ALMAO and YASIRU Sri Lanka - Sven Enarsson and Kjell Wirén)</i>	
Microinsurance Type	Life, Accident, Hospitalization
Group or individual product	Individual
Term	Annual
Eligibility requirements	Members above 18 years but not older than 65. No families with an income of more than LKR 3000 (USD30) per family member (the rule is not strictly applied in the field)
Renewal requirements	Premium payment not in arrears
Rejection rate	No rejections
Voluntary or compulsory	Voluntary
Product coverage	<input type="checkbox"/> Sum insured paid upon accident, disability or death of policyholder/covered persons <input type="checkbox"/> Daily or monthly amount during time of hospitalization <input type="checkbox"/> On termination of membership after at least 5 years; the amount on the member's account is returned
Key exclusions	Suicide and contagious diseases
Pricing – premiums	Monthly premiums from LKR 10 (USD0,1) to LKR 100 (USD1.0)
Pricing – co-payments and deductibles	No deductibles or co-payments
Pricing – other fees	No other fees

### **Sri Lanka: ready for takeoff**

There is much to suggest that Sri Lanka will dramatically increase its microinsurance provision over the next few years. Many of the key factors required for industry growth are in place – insurers interested in the low-income market, significant demand for risk management tools by the low-income market, and beginning efforts by potential intermediaries to sell and service microinsurance.

A recent microinsurance demand study, conducted for the Asian Development Bank in conjunction with the MicroInsurance Centre, found significant effective demand for hospitalization cover, breadwinner life insurance, and funeral policies. An extensive scientifically-generated sample of low-income people identified a need for greater insurance knowledge and called for greater effort on the part of insurers to prove their trustworthiness.

There is already a strong culture of insurance services among the poor in Sri Lanka. An ILO survey found a large number of small informal insurers providing some form of either microinsurance or other social security services. As the register of CBOs is incomplete, the real numbers are likely to be substantially higher.

On the micro level, there have been some useful attempts (though of questionable success) to bring microinsurance to larger numbers of people through two large innovative mutuals – ALMAO and YASIRU. These organizations have published an analysis of their activities that has greatly informed the practices of other insurers now considering entering the market.

On a macro level, Sri Lanka has had well planned donor intervention. A variety of Dutch donors have provided technical assistance and reinsurance to certain microinsurers. The ADB has launched a project to create incentives for commercial insurers to enter the market. The government of Sri Lanka is supportive of the microinsurance initiatives and is actively encouraging the development of the market, as is the Sri Lankan Insurance Regulator and the Insurance ombudsman.

Importantly, commercial insurers are testing the microinsurance market, Hayley's AIG has started to sell life insurance to tea estate workers. HNB assurance has begun to sell life and property insurance to the low-income clients of their partner bank. Insurers in Sri Lanka seem more eager than in most countries to enter the microinsurance market, seeing significant potential for corporate growth.

Efficient commercial microinsurance requires effective delivery channels, and it is clear that the rate of microinsurance expansion in Sri Lanka will be the pace of development of delivery channels. Strengthening intermediaries to sell and service microinsurance will help to dramatically expand microinsurance throughout the country.



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## Appendix 1: 100 Lowest Income Countries (by PPP GDP)

1. Sierra Leone	41. Sudan	84. Saint Lucia
2. Malawi	42. Bhutan	85. Samoa (Western)
3. Tanzania, U. Rep. of	43. Cambodia	86. Fiji
4. Burundi	44. Djibouti	87. Turkmenistan
5. Congo, Dem. Rep. of the	45. Pakistan	88. Bosnia and Herzegovina
6. Ethiopia	46. Guinea	89. Belarus
7. Guinea-Bissau	47. Cameroon	90. Algeria
8. Madagascar	48. Ghana	91. Saint Vincent and the Grenadines
9. Niger	49. Angola	92. Namibia
10. Eritrea	50. Zimbabwe	93. Gabon
11. Zambia	51. Viet Nam	94. Kazakhstan
12. Yemen	52. Lesotho	95. Colombia
13. Congo	53. Bolivia	96. Turkey
14. Mali	54. Georgia	97. Macedonia, TFYR
15. Kenya	55. Papua New Guinea	98. Dominican Republic
16. Nigeria	56. Honduras	99. Panama
17. Central African Republic	57. India	100. Belize
18. Tajikistan	58. Vanuatu	
19. Benin	59. Nicaragua	
20. Mozambique	60. Indonesia	
21. Burkina Faso	61. Syrian Arab Republic	
22. Chad	62. Azerbaijan	
23. São Tomé and Príncipe	63. Ecuador	
24. Rwanda	64. Armenia	
25. Nepal	65. Sri Lanka	
26. Uganda	66. Egypt	
27. Côte d'Ivoire	67. Morocco	
28. Moldova, Rep. of	68. Jamaica	
29. Senegal	69. Guatemala	
30. Togo	70. Guyana	
31. Comoros	71. Jordan	
32. Haiti	72. Philippines	
33. Uzbekistan	73. Albania	
34. Kyrgyzstan	74. Paraguay	
35. Solomon Islands	75. Swaziland	
36. Lao People's Dem. Rep.	76. El Salvador	
37. Mauritania	77. Venezuela	
38. Bangladesh	78. China	
39. Mongolia	79. Lebanon	
40. Gambia	80. Cape Verde	
	81. Peru	
	82. Dominica	
	83. Ukraine	

Source: UNDP Human Development Index, 2005

## Appendix 2: Microinsurance questionnaire



This questionnaire is part of a global survey being conducted among the 100 poorest countries to assess the provision of microinsurance in the world and to enhance the knowledge of microinsurance programs. The study will be used to identify gaps in information on and availability of microinsurance. You are urged to complete the information requested here as accurately as possible. It will only take a few minutes and the study will benefit the microinsurance industry as a whole.

The information contained in the questionnaire can be gathered through direct interviews with microinsurance providers or from secondary data sources such as published reports as appropriate. **If you interview the microinsurance provider directly, stress that the results treated with strictest confidentiality and only the analyzed results will be released.**

The form below can be filled in and emailed to the MIC, attention of Nina Shand or you can fill in the details online.

"Microinsurance" will be defined generally for this project as insurance products that can be accessible either by price or delivery channel to the market of people earning less than (approximately) USD 2 per month. For example, an insurer in Laos provides non-specialized microinsurance products (basic life and property for motorcycles and three wheeled vehicles) to the low-income market, some through NGOs, for less than USD3 per year. This would qualify even though for the most part, these are not specialized microinsurance products. Certainly specialized microinsurance products would be included. The difficulty will be disaggregating the "microinsurance" (explicit "microinsurance" or implicit – traditional products that are simply cheap enough that low-income people might be able to afford them) from the rest of an insurers portfolio. Here the researcher will need to use their best professional estimation skills.

Make sure that all the fields are filled in correctly. This survey should be completed based on insurance providers including organizations that are not primarily insurance organizations but provide insurance products (including government, informal, regulated and unregulated, care or service provider, or others).

Please provide all costs in US dollars using the exchange rate of the day that the data was collected in the document or interview.

## 1 About the insurance risk carrier

Initials of researcher completing the form			
Name of country (data to reflect ONLY insurer operations in this country)			
Name of "Insurer"			
Date of when information was collected (mm /dd/yyyy):			
Source of information used to complete format (enter from list Options for data sources)			
If you have used a secondary data source such as a document or official record, make sure that you record the full details of the document on the reference form and ensure that the document and reference form are submitted to MIC. Also, record primary source information (name and contact information for the source) on that form.			
Insurer's Approx. total annual premiums / contributions in USD (include year) (includes all premiums paid to the insurer including microinsurance and other insurance premiums.		Amount	Year
Address and Contact Details of Insurer's in-country head office (This is for the one entity noted above as the insurer. In terms of government social security, this should represent the one government department or agency noted as the insurer.)	First address line		
	Second address line		
	City/Town/Postal code		
	Telephone: (format = +country - city - number) (.....)		
	Email:		
	Web site:		
Would you best describe the insurer as informal or formal? (Tick only one)	Informal (not regulated)	<input type="checkbox"/>	
	Semi-formal (insuring company is regulated, but not their insurance operations)	<input type="checkbox"/>	
	Formal (insurance risk operations regulated)	<input type="checkbox"/>	
Which of the labels best describes the insurer (tick the one most appropriate label)	Commercial Company	<input type="checkbox"/>	
	NGO	<input type="checkbox"/>	
	Government Agency (social security / protection)	<input type="checkbox"/>	
	Parastatal Insurer (majority owned by government)	<input type="checkbox"/>	
	Community-Based Organization	<input type="checkbox"/>	
	Informal Society or Business	<input type="checkbox"/>	
	Mutual (not "community-based" but formal with professional insurance management))	<input type="checkbox"/>	
	Takaful insurer	<input type="checkbox"/>	
Reinsurer	<input type="checkbox"/>		
Does the insurer reinsure their microinsurance activities? (Tick if yes, add name of reinsurer)			<input type="checkbox"/>
Does insurer wish to be included on the MIC Mailing List and receive additional information about the study? (Tick if yes)			<input type="checkbox"/>

From interviews with the microinsurer, how far does it agree with the statements below related to their market? Tick the relevant box. Tick only one box for each statement. (Not Social Security) (This is only for interviews and not to be inferred from other sources unless there is a direct quoted statement that reflects a response to the specific question)	Strongly Agree	Mainly Agree	Neither Agree or Disagree	Mainly Disagree	Strongly Disagree
Economic policies are favorable for the microinsurance business	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial regulations are favorable for the microinsurance business	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Its domestic microinsurance business will grow >10% in the next year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Its domestic microinsurance business will grow >100% in the next 5 years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Likewise, rate the following possible reasons that might be hindering expansion into the low-income insurance market:					
Lack of demand for insurance products from the potential clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ignorance about insurance in the potential client base	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of affordability in the potential client base	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of reinsurance support to insure the poor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insurer perception that they can not offer microinsurance profitably to this market	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are there regulations in the country that hinder or promote the expansion of microinsurance? (Up to five responses from the code table below)					

Options for regulations that Hinder or Promote microinsurance expansion			
H1	Difficult policy requirements	P1	Specialized microinsurance legislation provides separate requirements for microinsurance (such as reduced solvency or
H2	Solvency requirements make microinsurance non-viable	P2	Regulations require insurers to provide microinsurance
H3	Reinsurers not allowed to re-insure unregulated "insurers" (such as community-based microinsurance)	P3	Clear manageable mutual insurance laws
H4	Other hindrance	P4	Other promotion

Options for data sources					
S1	Direct insurer responses	S8	Team Member Professional Contacts	S15	Interviews
S2	Published books	S9	Unpublished academic works	S16	Conference documents
S3	Published magazine articles	S10	Peer reviewed journal articles	S17	Publicly available consultancy reports
S4	Newsletters	S11	Newspaper articles	S18	Consultancy Reports not available to the general public
S5	Other unpublished articles	S12	Inferences / Personal experiences of team members	S19	Data obtained through networks
S6	Online discussion groups and online conferences	S13	Reports of International Insurance Bodies	S20	Directory/Listings
S7	Internet sites	S14	Government documents	S21	Other

Complete the following information of a separate page for each insurance product that the organization provides.

## 2 About the Insurance Products

Is the product a lead one? (tick if yes)		<input type="checkbox"/>
Name of the Microinsurance product or social security scheme		
Type of Insurance Product (Enter code from list below)		
Policy type	A. Group	<input type="checkbox"/>
	B. Individual	<input type="checkbox"/>
	C. Both	<input type="checkbox"/>
Policy term (use codes) (N/A for social security)		
What year was product introduced?		
What is the product's target group (see code list below)?		
What are total premiums received for this microinsurance product in 2005?		
What are total premiums received for this microinsurance product in 2004?		
What is the typical premium paid by the typical policyholder for the typical sum assured for this class of business in USD in 2005(or contribution for social security)?		
What is the typical policy sum assured of the typical policy for this class of business in USD in 2005?		
Total number of people covered by the policy at the end of 2005 (Includes family members if covered)		
Total number of people covered by the policy at the end of 2004 (Includes family members if covered)		
Total number of individual policies in force at the end of 2005		
Total number of individual policies in force at the end of 2004		
Enter the three main channels used to deliver the microinsurance product (enter code from the list below)		1 2 3
Approx % of clients by employment category		%(percentage)
Category of clients	A: Public Sector	
	B: Unemployed	
	C: Private Sector / NGO	
	D: Informal Sector	
Approximate % of client group which is poor (with a daily income per head of 2 USD dollars or less)		
Does the insurance project have donor support? (Tick if yes)		<input type="checkbox"/>
Which donor supports the product? (n/a if no donor support)		
Approximate annual donor support in USD (Enter 0 if none)		

## List of Options

Type of Insurance Product (Code based on the lead product if the cover has multiple covers. If general health is offered typically this is the lead product.)									
Life		Accident & Disability		Health		Property		Index	
1A	Credit Life	2A	Any Cause	3A	Primary		Livestock	5A	Rainfall
1B	Credit Life Plus	2B	Work	3B	Hospitalization		Crop	5B	Price stabilization
1C	Funeral	2C	Travel	3C	Comprehensive		Home	5C	Other
1D	Term	2D	Other	3D	Targeted benefits*		Other possessions**		
1E	Endowment			3E	Other		Motor		
1F	Pensions						Other		
1G	Investments								
1H	Continuing family benefits								
1F	Other								
If you discover any type of insurance product that is not on this list, please inform MIC immediately.									


\*(pregnancy, AIDS, or other focused coverage) // \*\*(cars, motorcycles, tuktuks...)

Policy Term			
1	Linked to loan or other product term	5	Yearly renewable term
2	Fixed limited term, up to one year	6	Limited term 1-5 years
3	Limited term 6-20 years	7	Limited term more than 20 years (endowments will often be here)
4	Whole of life	8	Other

Target Group / Target Market Codes			
T1	Not defined	T7	Unemployed
T2	Low-income	T8	Self-employed
T3	Women	T9	MFIs (such as credit life and disability)
T4	Men	T10	People with the potential for a specific illness (such as HIV/AIDS)
T5	Pregnant women	T11	Retirees
T6	Children	T12	Other

Insurance Delivery Channel			
A	Insurance directly through specialized tied agents (agents working for the insurer but focused only on microinsurance)	J	Funeral parlours
B	Insurance through dedicated/specialized microinsurance agents or "micro-agents" (not MFIs)	K	Delivered through Community-based groups
C	Insurance embedded in other products. (Such as microinsurance that comes with a loan for no additional cost)	L	Delivered to members (such as for mutuals)
D	Microinsurance sold by conventional insurance agents	M	Microfinance Institutions as agent
E	Employer selling employee insurance (or buying insurance on behalf of their employee)	N	Non-insurer providers (formal programs offered by hospitals, for example)
F	General Insurance broker	O	Informal microinsurance
G	Specialized microinsurance brokers (focusing primarily on microinsurance products)	P	Civil society organizations (like Women's Unions)
H	Government departments	Q	Mandatory participation (such as some social security programs)
I	Retailers (shops, churches, other non-financial institutions) (Not funeral parlours – see "J")	R	Other

## Appendix 3: Regulations Questionnaire

		<b>Microinsurance Regulation Questionnaire</b> <b>GLOBAL SURVEY OF MICROINSURANCE</b>
Initials of researcher completing the form (select from list)		
Name of country (Select from the list)		
Name of the supervisory body (enter text)		
Date of when information was collected (mm /dd/yyyy):		09/13/2006
What acts and regulations govern insurance? Write the names of the legislation and attach documents to bibliography if you have a version of the legislation		
Are there separate acts for life and non-life insurance? (tick if yes)		<input type="checkbox"/>
How does microinsurance fit into the regulatory structure at present? (Tick only one option)	Special microinsurance legislation	<input type="checkbox"/>
	Microinsurance is mentioned in general insurance legislation	<input type="checkbox"/>
	No legislation explicitly covering microinsurance	<input type="checkbox"/>
Is there regulation around insurance distribution? (Tick only one option)	None	<input type="checkbox"/>
	For brokers only	<input type="checkbox"/>
	For agents only	<input type="checkbox"/>
	For both brokers and agents	<input type="checkbox"/>
Which of the follow forms of Insurance company ownership are permissible? (Tick all options that apply)	Domestic private companies	<input type="checkbox"/>
	Government or publicly owned	<input type="checkbox"/>
	Private foreign part owned	<input type="checkbox"/>
	Fully foreign owned	<input type="checkbox"/>
What are the barriers to new entrants into the market? (tick all the restrictions that apply)	Scale requirements	<input type="checkbox"/>
	Financial Reserve or capital requirements	<input type="checkbox"/>
	Restrictions on private sector insurance provision	<input type="checkbox"/>
	Restrictions on NGO formation or provision of microinsurance	<input type="checkbox"/>
	Red tape and bureaucratic hurdles to formation or licensing	<input type="checkbox"/>
	Lack of applicable legislation	<input type="checkbox"/>



## Appendix 4: Countries without identified microinsurance

Region	Country	Population estimate 2004 (million)	Comments and caveats
Eastern and Southern Africa	Ethiopia	70.0	Researchers found the existence of large informal funeral insurance schemes called Iddirs.
Eastern and Southern Africa	Sudan	35.5	Researchers found the existence of large informal funeral insurance schemes called Iddirs.
Eastern and Southern Africa	Mozambique	19.4	Researchers uncovered the existence of only one microinsurance scheme in Mozambique, run by Banco Oportunidade De Moçambique and providing only credit life insurance
Eastern and Southern Africa	Angola	15.5	No information on microinsurance found
Eastern and Southern Africa	Zimbabwe	12.9	No information on microinsurance found
Eastern and Southern Africa	Eritrea	4.2	Researchers found the existence of large informal funeral insurance schemes called Iddirs.
Eastern and Southern Africa	Lesotho	1.8	No information on microinsurance found
Eastern and Southern Africa	Swaziland	1.1	Although no single insurer was identified, a report commissioned by Finmark Trust reported that "In the long-term insurance market, a number of players are competing for the lower end of the market." <sup>21</sup> The report did not give details on specific insurers.
Eastern and Southern Africa	Djibouti	0.8	No information on microinsurance found
Eurasia	Turkey	71.7	No information on microinsurance found
Eurasia	Bosnia and Herzegovina	3.9	No information on microinsurance found
North Africa and Middle East	Algeria	32.4	No information on microinsurance found
North Africa and Middle East	Morocco	29.8	No information on microinsurance found
North Africa and Middle East	Yemen	20.3	No information on microinsurance found
North Africa and Middle East	Jordan	5.4	No information on microinsurance found although the MicroFund for Women is developing a life insurance product with Women's World Banking
North Africa and Middle East	Lebanon	3.5	No information on microinsurance found
Oceania	Papua New Guinea	5.8	No information on microinsurance found
Oceania	Vanuatu	0.2	No information on microinsurance found

<sup>21</sup> Insurance Scoping Study: Botswana, Lesotho, Namibia & Swaziland, 2004, Genesis Analytics, published by the FinMark Trust.

<b>Region</b>	<b>Country</b>	<b>Population estimate 2004 (million)</b>	<b>Comments and caveats</b>
Oceania	Samoa	0.2	No information on microinsurance found
South Asia	Bhutan	0.9	No information on microinsurance found
W & C Africa	Niger	13.5	No information on microinsurance found
W & C Africa	Chad	9.4	No information on microinsurance found
W & C Africa	Equatorial Guinea	9.2	No information on microinsurance found

## Appendix 5: Respondents to the regulation questionnaire

Insurance regulators overseeing the following countries responded

- |                                 |                          |                          |
|---------------------------------|--------------------------|--------------------------|
| 1. Albania                      | 24. Dominica             | 50. Lesotho              |
| 2. Algeria                      | 25. Dominican Republic   | 51. Macedonia            |
| 3. Angola                       | 26. Ecuador              | 52. Mali                 |
| 4. Armenia                      | 27. Egypt                | 53. Mongolia             |
| 5. Azerbaijan                   | 28. El Salvador          | 54. Morocco              |
| 6. Bangladesh                   | 29. Eritrea              | 55. Namibia              |
| 7. Belarus                      | 30. Ethiopia             | 56. Nepal                |
| 8. Belize                       | 31. Fiji                 | 57. Niger                |
| 9. Benin                        | 32. Gabon                | 58. Nigeria              |
| 10. Bhutan                      | 33. Gambia               | 59. Pakistan             |
| 11. Bolivia                     | 34. Georgia              | 60. Panama*              |
| 12. Bosnia and<br>Herzegovina   | 35. Ghana                | 61. Papua New Guinea     |
| 13. Burkina Faso                | 36. Guatemala            | 62. Peru                 |
| 14. Burundi                     | 37. Guinea               | 63. Philippines          |
| 15. Cambodia                    | 38. Guinea-Bissau        | 64. Senegal              |
| 16. Cameroon                    | 39. Guyana               | 65. Sri Lanka            |
| 17. Cape Verde                  | 40. Honduras             | 66. Sudan                |
| 18. Central African<br>Republic | 41. India                | 67. Syrian Arab Republic |
| 19. Chad                        | 42. Indonesia            | 68. Tanzania, U Rep of   |
| 20. China                       | 43. Jamaica              | 69. Togo                 |
| 21. Colombia                    | 44. Jordan               | 70. Turkey               |
| 22. Congo, Dem Rep of<br>the    | 45. Kazakhstan           | 71. Uganda               |
| 23. Côte d'Ivoire               | 46. Kenya                | 72. Vanuatu              |
|                                 | 47. Kyrgyzstan           | 73. Zambia               |
|                                 | 48. Lao People's Dem Rep |                          |
|                                 | 49. Lebanon              |                          |

## Appendix 6: Product analysis

**Gap Addressed:** As shown in Table 9 at the start of the In-country Insurer section, hardly any poor people in the world's poorest 100 countries have any form of insurance of any type.

There is a case to be made for the provision of all product types, but in practice, products are recommended based upon what is demanded and what it is feasible to supply. The following list sets out the most common microinsurance products, with a discussion of their pros and cons. A selection of these could be developed into product templates in the feasibility study.

### Life insurance

**An ideal and simple risk to insure, with proven demand and impact, easy to scale**

<b>Intervention level</b>	Micro
<b>Lives affected</b>	★★★★★
<b>Term of commitment</b>	<b>Until commercial market stabilizes – 2 to 10 years</b>
<b>Term to results</b>	1 year
<b>Difficulty</b>	★★
<b>Risk</b>	★

**Gap addressed:** Most low-income households, particularly agrarian households, are labor rich and asset poor. When they lose a member of the household enterprise, they lose one of the few 'assets' they have. Relative to other microinsurance products, life insurance has the widest coverage by far. But in total only 1.78% of the world's poor were found to have life insurance cover – 63.7 million poor policyholders in all the countries surveyed, with the bulk of these in India and China.

### Description

Life insurance is the ideal insurance risk. The financial consequences of death are substantial particularly for the poor; the event cannot easily be manipulated by the policyholder; the demand exists; the capacity required to deliver it is reasonably simple, and it is relatively simple for clients to understand. The proof is that it is often the first kind of insurance that spontaneously develops, through informal funeral societies.

Life cover can be provided either to the principal policyholder alone, or it can include the family or extended family. The latter is more effective in managing the burden of mortality on a household. Having the family as the policyholder is, however, a little more complex to control and manage (though this has been done successfully), and it is, of course, more expensive. The choice may need to be left to the end clients. Credit life that covers only the principal borrower, while widely implemented by MFIs, actually provides very little, and is perceived by clients that way. Credit life including extended

family cover is more meaningful, and is perceived by clients to offer better value for money.

To maximize coverage, the product should aim for minimal underwriting (the screening that needs to be done by the insurer) and minimal exclusions. But the product should still allow for adverse selection (the tendency in insurance for the worst risks to apply for cover) and moral hazard (incentives for the policyholder not to manage his or her risks carefully now that they are covered).

### **Intermediaries and leverage**

Life insurance provides significant opportunities for leverage. Existing insurers may be willing to extend their product ranges to low-income life cover. Multinational insurers could potentially provide quick access to many countries. Reinsurers are almost certainly willing to support such products, and could provide much assistance in risk rating. There is a variety of existing life products that can be customized and adapted, and there are established methods of delivery that may or may not be used. Thus, while there is room for innovation, there is much to draw on from many countries.

Delivery leverage can be accomplished through a large variety of channels ranging from employer groups to MFIs, retailers, and community based organizations. These options are discussed more fully in the section on delivery. Box 5 provides an example of innovative funeral insurance, taken from the landscape survey.

#### **Box 5: Example of a life insurance product in Zambia**

Madison Insurance Company developed partnerships between itself and a variety of MFIs in Zambia where, as in much of Africa, funeral insurance is a core demand. To meet this need, Madison created a life insurance product with a one-year renewable term. The policyholder did not require any underwriting but had to be a borrower of the MFI (Madison effectively relied on the MFI to underwrite its clients for this product). The premium is USD 0.75 for the borrower and less for additional members of his or her immediate family. The benefits are USD 108 for the borrower, USD 86 for the spouse and USD 54 for their children or dependents. The premium is deducted from the loan before it is disbursed.

### **Existing efforts**

There are signs of life product activity amongst commercial insurers in several markets – particularly in India and China where the sheer scale of the potential markets has attracted the attention of insurers, and also (in India) as a result of the regulatory compulsion.

Credit life insurance has long been sold through MFIs, and some are introducing more comprehensive forms of insurance with more meaningful protection beyond merely the lender's credit book.

There is widespread experimentation with forms of delivery, discussed more fully under delivery below.

### **Sustainability**

Unlike health insurance, life insurance does not have major sustainability problems. Introducing life cover does not generally create behaviors that increase the risk. Fraud, adverse selection, and moral hazard in this market are well understood and can be managed fairly easily.

One area that does require significant attention, however, is consumer awareness and education. Most low-income people in poor countries do not understand the basic mechanisms of insurance, and indeed are often not aware of insurance at all. Expanding access is one thing, but ensuring that the market takes up what is being made available is another. Extensive work is required to prevent consumer dissatisfaction, apathy, or ignorance. The interventions around this are discussed in the section on mass education options.

It is very likely that a portfolio of low-income life insurance risks would rapidly reach the point where a commercial insurer would be willing to take them over and run them on its own. Ongoing technical assistance may be required around complex issues like HIV and AIDS. However, the key issue for microinsurance life products is not the risk pricing, since the risk pricing is normally only 10% to 20% of the final premium. The key element is funding a low cost delivery, administration and client servicing channel. One should bear in mind, though, that should cheaper delivery options be found, the risk component will again become more critical.

### **Risks**

- Take-up failure by poor potential clients is a risk, and needs to be addressed through market awareness raising and education.
- Adverse selection and moral hazard exist, but are well understood and readily managed, although failure to manage these risks could lead to losses.
- Fraud is most critical in relation to dependants' lives insured, where policyholders may try to submit claims for sick relatives or friends, or materially non-disclose pre-existing conditions. This can also be managed with appropriate technology and procedures.
- As with all insurance products, there are catastrophe risks – tsunamis and similar disaster situations. These can be managed with reinsurance.

Most commercial insurers have the capacity to run short-term group products. Longer-term products require some additional expertise, and actuarial skills may not be available in the country. Support may be provided through technical assistance or via reinsurers.

The research team cannot imagine that insurers would not be willing to take this risk: many are already doing so.

In summary, life insurance meets a very real need and is readily manageable and affordable. It forms the most natural entry point into the microinsurance market.

## Accidental death and dismemberment insurance

**A simple risk, with proxy health elements, but providing incomplete protection**

<b>Intervention level</b>	Micro
<b>Lives affected</b>	★★★★★
<b>Term of commitment</b>	<b>Until commercial market stabilizes – 2 to 10 years</b>
<b>Term to results</b>	1 year
<b>Difficulty</b>	★★★
<b>Risk</b>	★★

### Description

Accidental death and dismemberment policies provide a defined sum assured, payable on accidental death, with a defined percentage of that sum paid for defined dismemberment conditions such as blindness, loss of a leg, and other permanent disabilities. The advantage of the product is that claims are mostly objectively verifiable. They are not affected by such unpredictable factors as HIV and AIDS, which can dramatically affect the non-accidental life cover.

The downside of these policies is that they are incomplete when provided in isolation. Deaths due to malaria, AIDS, TB, and digestive tract infections are a very significant portion of deaths in developing countries, and a major source of hardship to poor households.

For both these reasons (simplicity and incompleteness), the benefit can usually be provided at low cost.

### Intermediaries and leverage, risks, sustainability, other comments

Many of the considerations pertaining to accidental death and dismemberment policies are the same as for life insurance. The accidental death portion is generally less risky, since it excludes the more variable and uncertain burden of disease-related mortality. The dismemberment portion is marginally more difficult.

Dismemberment or physical disability benefits may provide an easy initial entry point to the provision of health-related insurance to low-income clients. Although not nearly as comprehensive as health benefits, they meet specific needs, and can be supplemented with savings accounts or defined-benefit type health insurance plans.

## Health insurance

As mentioned in the landscape survey, health risks are a primary concern of poor people. However there is nothing to suggest that health insurance is the best means of addressing health risks. More effective ways are *ex-ante* through the provision of clean water, vaccines, mosquito nets and other preventative measures, or *ex-post* through state provision of health care services, credit, and savings schemes. The research team found 50 social security health products spread among 40 of the 100 countries, providing variable quantity and quality of cover.

Table 9 above lists the volumes of health cover. It is possible for health insurance schemes to play some role to reduce risk for the poor, but for each country there will need to be serious consideration given to whether this is feasible, given the infrastructure, and whether it is sensible, given potentially cheaper and more beneficial ways to spend money on improving health.

The difficulties involved in the provision of health insurance become clear when one considers the varieties of health insurance. The principal types of benefits can be classified as follows:

- **Comprehensive indemnity cover**, which indemnifies both the expenses associated with both high-frequency low-cost events like visits to the doctor, as well as less frequent high-cost events like hospitalization. A sub-category of this cover is **major expense indemnity cover**, which indemnifies against only the less frequent, high-cost events that are more random.
- **Health savings accounts**, which provide a saving and budgeting facility suitable for the low level, uninsurable costs, but with no insurance element. Although not an insurance product, health savings accounts are sometimes linked together with other types of health insurance to create a more comprehensive package.
- **Critical illness or dread disease cover** which pays a fixed amount (often a percentage of a defined sum insured) on the diagnosis of significant conditions like cancer or major heart disease, both as compensation for pain and suffering and also to fund changes in lifestyle or other expenses.
- **Defined benefit major medical cover**, which pays a fixed amount (again often a percentage of a sum insured) on undergoing specific defined procedures such as appendectomy or the amputation of a limb.

### Donor activity in health insurance – community based health insurance

Few insurers are willing or able to provide health insurance to small numbers of people, especially in remote places. The response by some donors, especially in West Africa, has been to establish community-based health insurance schemes. These are essentially health insurance mutuals run by non-professional staff.



The research team has two significant concerns with this approach to micro health insurance. First, health insurance is difficult to manage, even for professional insurers. The risks of fraud, adverse selection and moral hazard are difficult to control and the products are difficult to price. It is not realistic to expect CBO members with low levels of formal education to do what insurance professionals struggle to do.

Secondly, these health insurance schemes do not generally have a large scale reach. This is due to a number of factors, including a lack of interest among members in growing larger, and an inability of the non-professional staff to cope with the management of a large scheme.

## Healthcare cost indemnity insurance

**Long-term, risky, complex, subject to abuse and fraud, historically many failures**

<b>Intervention level</b>	Micro
<b>Lives affected</b>	★ to ★★★★★
<b>Term of commitment</b>	Forever
<b>Term to results</b>	2
<b>Difficulty</b>	★★★★★
<b>Risk</b>	★★★★
<b>Existing efforts</b>	★★

### Description

Comprehensive indemnity cover provides direct indemnity against the costs of low-frequency high-cost events like hospitalization, which are genuinely insurable (being at least largely random) and of low cost, high-frequency events such as visits to the doctor or purchase of medication, which are often significantly under the control of the patient and the provider.

It is possible to separate out the high-level insurable events such as hospitalization and develop insurance packages that focus just on these, leaving the uninsurable day-to-day expenses either to individual management or to be funded through a vehicle such as a savings account (see next option).

### Intermediaries and Leverage

There is very little to leverage off here. This option requires a well-developed private healthcare infrastructure and there is very little such infrastructure or capacity in place in most of the poorest countries. There are almost no skills in this area in the commercial insurance sector, and reinsurers mostly have little or no interest in this risk. There is mixed experience in the donor-driven CBO health insurance sector, and nothing of any significant scale.

### Existing efforts

Existing efforts are confined to limited coverage by many small CBOs in West and Central Africa, and a few commercial enterprises.

### **Box 6: Case Study – Microcare Uganda**

Microcare Uganda is an oft-cited (because it is so rare) example of indemnity health insurance for low-income families. Built into the scheme are financial disincentives for abuse (clients make co-payments when accessing clinics), and control is through on-site desks staffed by nurses at all clinics. The nurses validate membership using photo IDs and network links to the central database, and pre-authorize any healthcare to be accessed by the member. In this way claims are notified and loaded even before the services are accessed. Active case management is applied.

In the early years, Microcare learnt the hard way of the importance of controlling adverse selection in membership, when healthy lives opted out of voluntary schemes, and sick

ones remained, leading to per-member cost spirals.

Microcare has experimented with a number of delivery channels including MFIs and low-income employee groups. While very promising in many respects, the Microcare model has yet to reach significant scale, and the long-term implications remain uncertain. There is evidence of rising utilization amongst long-term policyholders, perhaps indicating the development of a culture of claiming. Time alone will tell.

The landscape survey found that there were no models of private low-income health indemnity microinsurance that had reached any significant scale. Indemnity health insurance in most developed countries and even middle-income countries like South Africa is confined to the wealthy, who wish to 'buy up' from basic state services.

### **Sustainability**

Sustainability is a key concern. Health indemnity insurance is a long journey with no defined end point. The relationship between public and private health care provision continues to be explored in all countries – developed and undeveloped – and sooner or later it cannot avoid becoming involved in the healthcare delivery itself through disease management, HMO (health maintenance organization) models and other forms of managed care. It is resource and technology intensive, and requires extensive operations on the ground and significant in-country capacity, which in many countries will be non-existent.

### **Risks**

This intervention faces a very high risk of medium-term failure for many reasons.

- Indemnification of high-frequency, low-level healthcare expenses is a very difficult undertaking. It is extremely prone to fraud by both patients and providers, particularly in low-income settings where neither doctors nor patients have much money.
- Even without fraud, the research team has seen that in many countries and schemes, over time, a culture of claiming develops, leading to cost spirals. People then either try to claim more (to get value for money), and low-risk, healthy lives drop out the scheme, causing the costs of the remaining risk pool to spiral still further in an adverse selection loop. The schemes then either collapse, or are forced to introduce complex risk-management procedures and healthcare delivery systems such as HMOs.
- The eventual impact of scheme collapse and the withdrawal of coverage can be extremely destructive to the community and the healthcare and insurance industries, not to mention individuals who may suddenly find themselves without any healthcare at all.
- Even separating out the high-level insurable events and providing a hospital indemnity plan is risky, creating all sorts of incentives for healthcare providers to increase costs and over-service. This cover cannot be considered without appropriate use of technology and resource intensive claims and risk management.

- There are significant risks that the capacity to delivery the insurance and manage the risk will not be found in the countries where it is needed.
- It is very likely that no commercial insurance partners will be found that are willing to take this risk, limiting options for the insurance vehicle.
- It is possible that the cover will not be useful in many countries because the basic healthcare infrastructure simply does not exist, particularly outside major urban areas.
- It is very likely that even if the product can be set up, the cost of delivery and of the insurance itself will render the product unaffordable to the poor target market.

### **Other comments**

Health indemnity insurance cannot be considered without a very thorough analysis of the risks and delivery mechanisms, and the long-term implications of intervention. In general, the research team is of the view that there are far easier, more valuable and less risky interventions possible. For the massive scale this type of insurance is not a suitable route to pursue. Healthcare objectives to assist the world's poor may be more effectively achieved through interventions such as strengthening public sector healthcare systems.

The pros and cons of the simpler health products are discussed below.

## Health Savings Vehicles

### Support and financial discipline for routine expenses, no help for major events

<b>Intervention level</b>	Micro
<b>Lives affected</b>	★ to ★★★★★
<b>Term of Commitment</b>	?
<b>Term to Results</b>	1
<b>Difficulty</b>	★
<b>Risk</b>	★
<b>Existing Efforts</b>	★

### Description

A health savings account is a simple vehicle to assist clients to save for relatively small and unpredictable healthcare costs. It is most effective for providing protection against routine costs that are not likely to exhaust the account. While low levels of utilization and continued contributions over a long period may lead to a significant reserve against large unexpected healthcare costs, a health savings account does not provide any real protection against significant expenses: once the account is depleted, there is no protection remaining at all. It is therefore mostly useful in conjunction with either an indemnity, or a defined benefit plan for serious hospitalization or catastrophe events.

The out-of-pocket expenses associated with relatively minor health conditions are unpredictable. This product provides a way of smoothing these expenses as well as potentially building up a reserve against long periods of future ill health or need. It is also valuable in funding the costs of accessing the public healthcare system (time away from work, transport costs, user fees, and bribes).

### Intermediaries and leverage

Savings accounts can leverage off any formal bank or micro deposit-taking institution. Where transaction accounts are available, they can dramatically increase the efficiency of the premium payment and claims settlement processes. However, availability of these accounts to low-income people, especially rural low-income people, is limited.

### Existing efforts

Many microinsurance schemes do not use the savings account approach. However, the research team is aware that some donors have been experimenting with this design, although not yet on any significant scale.

### Risks

- There is a low risk of scheme failure, because the product is not vulnerable to the vagaries of indemnity insurance. The client 'owns' the savings account, and has no incentive to abuse it. Poor people often appreciate the discipline of enforced saving, and value the reserve for future health costs.

- The client has an incentive not to allow the provider to take advantage of over-service, so abuse by the providers and impact on the private healthcare delivery system is minimal.
- The scheme is not reliant on significant external partners to shoulder risk.
- The scheme is vulnerable to not meeting the need: fixed savings accounts can be depleted by spikes in healthcare need and fall short of providing full cover.

**Other comments**

While valuable in isolation, this approach reaches optimal effectiveness when coupled with some form of hospitalization or catastrophe cover, whether indemnity or defined benefit.

## Defined benefit health (major medical, hospital cash, critical illness)

### Contribution towards healthcare costs or associated losses for major healthcare events

<b>Intervention level</b>	Micro
<b>Lives affected</b>	★ to ★★★★★
<b>Term of commitment</b>	?
<b>Term to results</b>	1
<b>Difficulty</b>	★★★★
<b>Risk</b>	★★★
<b>Existing efforts</b>	★

### Description

These three different products are grouped together because they offer a defined benefit payable on the occurrence of a defined event, rather than indemnification against healthcare costs.

- **Major medical** insurance pays a percentage of a defined sum assured on undergoing a defined surgical procedure, e.g. appendectomy.
- **Hospital cash** pays a defined amount per day spent in hospital over and above an initial excess.
- **Critical illness** pays a defined amount on the diagnosis of a specific condition such as cancer, full blown AIDS, or coronary heart disease. It often includes a dismemberment benefit, e.g. amounts are paid for blindness or loss of the use of limbs.

The defined benefit nature of these products limits the incentive for providers to over-service, although in poor settings it is possible that providers will then try to match their charges to the insured benefits of the member if these are known to exist – this tendency was seen in South Africa some years ago. This means that there could be some impact on healthcare utilization patterns.

The claim events are limited to objectively verifiable events that can be validated by a claims manager although at times significant medical expertise may be required. They remain vulnerable to fraud if not well managed.

These products go some way towards meeting either or both of the healthcare costs and indirect costs (loss of labor time) associated with major medical events. Critical illness benefits are not generally intended to meet healthcare costs (although they may be used that way), but rather to fund changes to lifestyle resulting from major events such as the loss of a limb.

### Intermediaries and leverage

Savings accounts can leverage off any formal bank or micro deposit taking institution. Where transaction accounts are available, they can dramatically increase the efficiency of

the premium payment and claims settlement processes. However, availability of these accounts to low-income people, especially rural low-income people, is limited.

### **Existing efforts**

The landscape report did not yield any instances of such microinsurance products.

### **Risks**

- There is a lower risk of scheme failure for defined benefit insurance compared to indemnity insurance because the delivery system is less impacted and the benefits are markedly less vulnerable to fraud and abuse, though the possibility of abuse must still be carefully monitored.
- Adverse selection is a real concern, and medical underwriting is probably important, particularly for individual policies. Large compulsory group policies may circumvent that difficulty.
- These products provide more comprehensive protection to clients against catastrophic medical expenses than savings accounts alone, although they do not address day-to-day expenses.
- These schemes may struggle to find insurers willing to shoulder the risk, and also to find reinsurance. While they are fairly successful in some parts of the world (they did very well in South Africa until regulatory interference limited their sale), some reinsurers take a dim view of any form of health insurance.
- These schemes are vulnerable to not meeting the need: there is no protection or assistance in managing routine healthcare expenses, and it is almost certain that the fixed benefit will not correspond exactly to the healthcare costs actually paid.

### **Other comments**

The research team believes that, in conjunction with savings accounts, defined benefit insurance provides the most promising avenue to explore in the area of health insurance. While far from ideal or comprehensive in its protection, it is more readily manageable, and more likely to be sustainable.

These comments are made mindful of whether private-sector insurance is in any event the correct way to address the healthcare needs of poor people.

#### **Box 7: Anecdote from Uganda: how poorly managed health insurance can kill**

One of the team members undertook a review of a health CBO in Uganda, a poorly managed small rural mutual health insurance scheme. In Uganda at the time, in order to use government health facilities, users were required to pay a user fee. Donors devised a health insurance mutual to help members cover these user fees.

The scheme was supposed to print photographic IDs but did not manage to do so promptly. Therefore, the mutual members (with donor consent) asked the health insurance providers to accept a printed receipt as proof that the premium had been paid allowing for a waiver of the user fee. Unscrupulous members of the health insurance



scheme started to print receipts for non-members; even worse, a secondary market developed at village level for the receipts.

Most of the villages felt certain that at some point during the year, malaria would strike their households. So, armed with illegally purchased receipts, they cleared the local clinics out of anti-malarial drugs. The government practice was to restock the clinics on a routine 'as needed' basis to avoid stockpiling, so for a long period all the clinics were cleared of anti-malarial drugs.

When the team member went to review the scheme he visited a hospital where there was a toddler about to die of malaria. When he enquired why the child was not treated, the nurse informed him that 'members' of the health insurance scheme had taken all the anti-malarial drugs and that there was nothing she could do to save the child.

### **Concluding thoughts on health insurance**

No country – developed or not – has found a solution to health insurance. Getting involved in this area means committing to an unpredictable process. 'Simple' health insurance schemes like hospitalization cover, dread disease cover, and the use of insurance combined with a health savings plan may be possible in some countries, but for poor countries it is recommended that such plans are carefully assessed on a case-by-case basis. A feasibility study is necessary to ensure that the benefits gained are at least equal to the benefits of other health development interventions.

## Agricultural (Property) insurance

### Risk management is a crucial component of agricultural development

<b>Intervention level</b>	Micro
<b>Lives affected</b>	★★★★★
<b>Term of Commitment</b>	?
<b>Term to Results</b>	Medium
<b>Difficulty</b>	★★★★
<b>Risk</b>	★★★

**Existing gap:** The survey showed only 5.4 million policy holders with crop insurance and a miniscule 40 000 with livestock insurance. This is despite the fact that the vast majority of the poor in the world's 100 poorest countries live in the countryside and are dependent in some way on agriculture.

### The need for agricultural insurance

John Weeks (1971, pp. 29-30) in his analysis of the adoption of new technology by very poor African households, summarized their dilemma as follows:

Innovative behavior, particularly in agriculture, involves risk and uncertainty ... there is no previous experience upon which to predict the outcome ...those at the lower end of the income and wealth distribution apply not profit maximization, but a survival algorithm, they will not tend to innovate...This risk-avoidance arises from the negative weight in their objective functions given to potential losses they might incur if a new technique is tried.

Thus fear of failure entrenches poverty. It follows that if poor farmers can manage their risks then they will be more willing to undertake higher-risk higher-return ventures.

### Risks

Government and other development agents, conscious of role that risk avoidance plays in poor farmers' lives, have attempted to help farmers alleviate these risks. Most of their attempts have failed. The main difficulty seems to have been fraud. Animals are mobile and it is relative easy for policyholders to hide animals or even slaughter them and pretend that they are stolen. The moral hazard problem with livestock insurance is that it "dulls the edge of husbandry".

These risks can be countered in some cases. SHEPHERD, an NGO in Tamil Nadu (India), provides livestock insurance and has had little problem with fraud because it is taboo to slaughter livestock in Tamil Nadu for religious reasons. This example is culturally specific and not replicable. But in Burkina Faso, an NGO that provided livestock insurance overcame the fraud problem by providing insurance to groups and requiring the whole group to pay an excess on any single member's claim. The scheme was relatively successful although somewhat costly.

Crop insurance also has significant problems of moral hazard (those with insurance are less motivated to take care of their crops) and adverse selection (only the farmers who doubt their ability to raise and store a crop might apply for cover). Compelling all farmers in a large area to insure has been suggested as a way to overcome adverse selection, but this route introduces political problems.

### **Weather index insurance**

Weather index insurance, described earlier in the landscape section, is a promising means of overcoming moral hazard and fraud by linking insurance benefits to an objective index like rainfall. Over the last several years, the World Bank has worked with a range of partners in pilot projects in several countries. Initial results have been mixed, although some of the programs seem promising both in demand and sustainability.

Weather index insurance is closer to a derivative than to traditional insurance. Typically, the farmer is free to purchase as much cover as he or she wishes, and when the index is calculated at the end of the year, the payment received is a function of the amount of cover purchased rather than the actual loss suffered. This makes claims payment very easy, as it does not require any claims validation beyond ensuring that the measurement of the index is correct. In effect, farmers do not need even to submit claims. At the end of the term, if the trigger has been met or exceeded they receive a payment.

These characteristics make weather index insurance an ideal product to be sold by MFIs. However, it need not be restricted to MFIs. In the feasibility study, other delivery options could be explored. A number of insurers already working on pilot projects, or have expressed an interest in them, including ICICI Lombard (implementing in India), Swiss Re, Munich Re and Allianz.

#### **Box 8: Weather index insurance in Malawi allows farmers to seize new opportunities**

A large number of groundnut farmers in Malawi wished to change their production to a higher yield variety but did not have the funds to do so. These farmers had difficulty obtaining credit because banks had had experience of farmers not paying back loans during droughts.

To help make the farmers creditworthy, the Insurance Association of Malawi, with technical assistance from the World Bank and Opportunity International, designed an index based weather insurance contract. The insurance would pay out if the rainfall needed for groundnut production in four pilot areas was insufficient. Once the contract was in place, two banks, the Opportunity International Bank of Malawi (OIBM) and Malawi Rural Finance Corporation (MRFC), agreed to lend farmers the money necessary to purchase the high yield variety seed.

A number of questions need to be answered before weather index insurance can be scaled up:

- What kinds of incentives could be created to promote weather index insurance?
- What is the current distribution of weather risk between individual farmers and

- their immediate communities, insurers and banks, reinsurers and governments and the international community? Is it optimal? Can it be changed, and will changing it affect the demand for weather insurance indices?
- What obstacles stand in the way of applying weather index insurance on a large scale?
    - Lack of technical insurance skills?
    - Lack of meteorological infrastructure?
    - Inability to compile and analyze the meteorological data?
    - Lack of interest or other reluctance by insurers?
    - Difficulty in marketing the product? Might farmers hedge their risks through other means?
    - Inappropriate legislation?
    - Insufficient capital to start this insurance?
    - Lack of interest or other reluctance from reinsurers?
    - Might disaster relief or food aid undermine the market for reinsurance?
    - Lack of ability to sell the indices on the financial markets?
  - Can the market for weather index insurance be extended beyond farmers to help ensure its sustainability? Likely markets would be microfinance providers (MFPs), importers, governments, utility companies, and food processing companies that have forward contracts with farmers.

### **Agricultural insurance substitutes**

As with health insurance, one needs to ask broader questions about how necessary agricultural insurance is, compared to options which may improve or safeguard agricultural production.

The use of insurance as an *ex post* risk management instrument can also be substituted for by reducing the risk *ex ante*, for example, with a forward contract in which the seller commits to delivering specified goods at an agreed time. With fixed price forward contracts, the price the producer receives is determined in a contract between buyer and seller. Forward contracts are relatively common in less developed countries with poor farmers, primarily with cocoa, sugar and coffee crops (UNCTAD Secretariat, 2001).

With sharecropping, as the name implies, the farmer has a contract with a landowner to rent land in return for a share of the crop at harvest. Such an arrangement spreads the farmer's risk more than a simple rental agreement, and acts as an insurance substitute. There are several types of sharecropping which allocate risk in different ways. In the type just mentioned, the landowner assumes some of the quality and quantity risk. Another type includes a fixed rent (in cash) due when the crop is harvested. In any type, the landowner may supply some of the equipment, or the landowner may set a minimum quality and quantity of the crop to be delivered. Each of these varieties has different risk allocation effects.

As Sharma and Dréze show in their study of sharecropping in a north Indian village, when insurance and credit markets function poorly, sharecropping arrangements can generate efficiency gains (Sharma and Dréze, 1996). Similarly Evans et al. (1991) found

that non-farm income can be used as a substitute for insurance, enabling farm households to carry out risky innovations.

Other direct *ex-ante* measures can manage the weather risks – for example better water storage and storage of cattle feed in the case of drought, or ploughing that facilitates water run-off in the case of excess rainfall.

## **Appendix 7: Delivery channel analysis and options**

**Gap Addressed:** While there are isolated instances of interesting innovations in delivery, the landscape report reveals that on the whole, microinsurance is being distributed through fairly traditional means – 33% through NGOs such as trade unions (most of these through the 28m strong All China Trade Union Federation), 22% through MFIs and other financial service providers, 18% through mutuals and 10% through agents. Only 2% of products were provided through more innovative delivery channels such as retailers.

As noted in the landscape section, delivery is probably the main key to the widespread scaling up of microinsurance. This section explores the pros and cons of various methods of distributing microinsurance.

Delivery opportunities vary widely from country to county. In one country there may be a strong post office network that could be leveraged to distribute microinsurance, but a weak cell phone network, whereas in another country the opposite set of conditions may exist. The best combination of channels would need to be explored in detail, country by country, in the feasibility study.

In general, it has not proved very difficult to entice potential distributors to become microinsurance channels. There are various advantages for them, namely:

1. A new source of income through commissions.
2. Some insurers offer their distributors discounted insurance for their assets.
3. The creation of micro-agents among members of the delivery organization, with the inducement being a new source of income for members. This is discussed below in connection with using religious institutions as delivery agents.
4. Extra risk management tools for the distributor.

### **Criteria for the evaluation of delivery options**

Microinsurance is a low-cost product. To be sustainable it has to be sold in high volumes to cover for its low premium price as well as fixed costs of designing and managing the product. Because of the need for big volumes, the common model of selling insurance on a one-to-one basis will not work. Microinsurance needs rather to be sold through partner groups or organizations that have aggregated large numbers of low-income people.

When selecting a partner there are a number of key considerations:

#### **Trust and interest**

As an intangible product, insurance requires the trust of the policyholder. Thus to be effective, an insurer needs to partner with a distributor who is trusted by potential policyholders.

The institution, for its part, must have an interest in becoming an agent or a reasonable

prospect of being convinced of the idea.

### **Financial systems**

The agent needs to have a financial system in place to account for premiums. This may seem obvious, but the point needs to be made because sometimes the only organizations found that reach significant numbers of low-income people are informal organizations. If informal agents are used, they will need some formal structure to help them account, e.g. the micro-agents in TATA-AIG are linked to an NGO that helps aggregate premiums and pay benefits.

### **Benefit payments**

By definition, microinsurance policyholders are poor and therefore have limited resources to cope with losses while the claims are settled. Ideally, life insurance benefits should be paid by the agent, who then claims from the insurer. This is done for example by ASA, an Indian NGO distributor of microinsurance. This system is feasible because benefits are typically quite low. Co-variant events can be excluded from the payment regime.

### **Collection of premiums**

It has proved quite difficult for distributors to collect premiums if the premiums are not additions to an existing payment for another good or service, e.g. union subscriptions, church membership fees or a microfinance loan. For example TATA-AIG attempted to sell long-term policies through MFIs, but this failed because after clients repaid their loans, it was difficult to collect remaining premiums.

### **Financial discipline**

The distributor must actually hand over the premium to the microinsurer as per the agreement. While a seemingly obvious point, many distributors do not do this consistently. There is a temptation for some distributors to either spend premiums (the worst case) or be late in transferring them. If informal agents or small retailers are used, they need to be carefully supervised. Cases have been known where agents do not hand over premiums at all, and even pay out 'benefits' to clients themselves.

### **Delivery channels**

#### **MFIs**

The landscape study showed that 22% of all microinsurance products were distributed through MFIs. There is probably more scope for MFIs as delivery agents, but there are limitations. In India for example, research team members report that the MFI channels are fully utilized. In Kyrgyzstan, on the other hand, they are not used in this way at all despite a significant presence of MFIs. Using MFIs as delivery agents has significant limitations, most notably with respect to products that do not directly link to an MFI product. As noted above, it is also difficult for MFIs to sell microinsurance policies with terms that exceed MFI loan terms because of the later premium collection difficulties.

## **Religious institutions**

Many religious institutions have a long history of providing or facilitating the provision of some form of financial service, e.g. funeral insurance in many parts of sub-Saharan Africa and savings services in South Asia. These institutions can have huge memberships, and tend to be trusted by their members. Depending on their size, they are often in a position to pay benefits immediately and then seek reimbursement from insurers. Some research team members report that it can be difficult to get powerful religious organizations to stick to their agreements. One of the insurers in the landscape review TATA-AIG in India worked with churches in South India to develop a system of micro-agents. This is described in more detail in the following box.

### **Box 9: Micro Agents: The tupperware model of microinsurance delivery**

Tata-AIG in India has developed an innovative system of micro agents to deliver term and endowment policies to the low-income market. In this model, the insurer identifies religious institutions or NGOs that have good relationships with the community and forms partnerships with them. In return for a consulting fee, the institutions suggest individuals who could be good agents to sell microinsurance policies. If the recommended micro-agents are accepted, they are asked to form peer groups, known as community rural insurance groups (CRIG).

The CRIG is registered as a partnership firm and normally consists of five low-income women living in close proximity, of whom the leader is licensed as an agent. Women are preferred because they tend to work with, or 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 license, and makes an investment in training her. The CRIG, as a registered enterprise, obtains a corporate agent's license under the insurance regulator's guidelines. The members of the group all sell policies for their own account, but the leader with the license fills in the forms and submits the policies to the company under the guidance of the religious institution or NGO. In return for this task, the institution/NGO receives an additional commission percentage from Tata-AIG. (Roth, 2005)

## **Cell phones**

Using cell phones as a delivery channel is being considered by Opportunity International in Uganda, and the MTN cell phone network in South Africa. Cell phones can be used to pay premiums through the use of prepaid cards, and can be used to notify the insurer of claims. If these initiatives are successful, then they will effectively solve a key delivery concern – that the agent hands over the premium promptly. In South Africa, where banking and insurance transactions with cell phones are being considered, it would be possible to deduct premiums from a bank account and pay claims into the account using a cell phone.



## **Retailers**

Retailers present an exciting new opportunity for the mass delivery of microinsurance, and the landscape study revealed that 2% of all microinsurance products were distributed through 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 of these is the first, bundling insurance with another product, so that when the product is purchased, the insurance is automatically purchased. With some (but not all) bundles, there is a direct link between the product and the insurance.

In general, these options require retailers operating a branch network. This is common in countries such as South Africa and India but it is unclear how many of the world's 100 poorest countries would be able to replicate this system.

Let us now look more closely at each of the four options.

### **Bundled insurance linked to the product sold**

An example of this is found with the South African furniture group Ellerrine Holdings, with 1,220 stores across the country. The stores are targeted at lower-income consumers and sell household goods, mostly furniture and household appliances. Insurance policies are bundled when goods are sold on hire purchase (a rent-to-own leasing agreement).

Selling *de facto* compulsory bundled policies has the obvious advantage for retailers that they do not need to do any selling to the policyholder. The 'tick-the-box' nature of the transaction means in many instances that they do not even 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% of low-income clients at retail stores regularly pay for purchased items in monthly installments and have bundled insurance. Research shows that less than 8% of those individuals are aware that they have insurance.

### **Bundled insurance unrelated to the product sold**

Here the insurance product bears no relationship to the good or service sold. In India, the fertilizer-bag Sankat Haran Policy sold by Iffco-Tokio (discussed earlier) is an example. Essentially the scheme sells pre-paid insurance. 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.

This model is only appropriate for microinsurance products with single premium

payments. It is unlikely that products offering anything other than minimal coverage could be sold in this fashion. If they were, the insurance component would increase the cost of the good or service to a point where a customer who did not want insurance may be disinclined to purchase that good or service.

### **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 in the form of an extended warranty on the item. A South African retailer, Makro, which sells consumer durables, provides such voluntary extended warranties. The premiums of some of these warranties are sufficiently low to appeal to the low-income market. For example, a two-year warranty extension costs USD 47 for refrigerators priced below USD 943.

This kind of warranty could be beneficial for microenterprises, as many consumer durables purchased from retailers are used in informal household enterprises. Refrigerators are commonly used to run informal catering businesses or to retail meat bought from wholesalers. It may be difficult for low-income consumers to purchase independently offered extended warranties, and so the option of being able to purchase it with the product is effective.

### **Voluntary insurance unrelated to the product sold**

The South African supermarket chains Shoprite and Pep Stores target low-income consumers. Inside each store, 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 licenses and utility bills. Some 220 third parties are represented at these counters. During the 2004/05 financial year, the number of transactions conducted at 'Money Market Counters' reached around 21 million per month. This is very convenient for potential clients who come to the supermarket as consumers.

Another advantage of selling voluntary products through a retailer, or any other organization with many low-income customers or members, is that the delivery 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 delivery costs. Indeed, in some developed countries, for example the United Kingdom, supermarkets often sell the cheapest life insurance policies.

One concern with voluntary insurance products sold by non-specialized distributors is that the consumer is often buying an important product with life consequences. The terms and conditions may be presented to the customer by a store attendant, or simply be hidden in a welter of other information. Even though the terms and conditions are on the policy document, this is not an appropriate means to educate the microinsurance customer. Nor does this transaction method facilitate questioning by a potential client about the terms of policy.

### **Undertakers**

In some sub-Saharan African countries where funerals are very costly, undertakers run in-house funeral insurance schemes or act as agents for insurers, to help their clients cover funeral costs. Research done by a member of the project team in one small town in South Africa indicated very high levels of trust in undertakers. There is no reason why the use of undertakers as agents should be restricted to countries in which funerals are significant and costly events. The main problem with using undertakers will probably lie in ensuring that premiums are handed over promptly to the insurer.

### **Lotteries**

The research team did not know of any existing uses of lotteries as delivery points for microinsurance. It is certainly worth exploring, as it meets many of the requirements for a delivery channel. Lotteries have a relationship of trust with their clients (assuming they are run honestly), they would have a financial interest in becoming agents, they reach large numbers of low-income people and they have a long term history of taking regular payments for goods and services.

### **Post offices**

Most of the poorest 100 countries have a well-distributed network of post offices. These are particularly useful in the delivery of insurance in rural areas. Funeral insurance is currently being sold in South Africa by post offices. A similar funeral insurance agency is being piloted by the post office in Senegal and actively considered by ING Vysya Life Insurance in India.

### **Remittance services**

The World Bank estimates that workers and others sent \$122 billion of remittances from developed countries to developing countries in 2004 – far more than the total development aid for that year. Remittance agents meet many of the criteria necessary of good delivery channels – trust, good financial systems, large numbers of low-income clients and financial discipline. They are already being used as a microinsurance channel, an example of which is described in Box 10 below.

#### **Box 10: Western Union and AIG**

Western Union recently went into partnership with American Life Insurance Company General Insurance Division (ALICO General Insurance), a member AIG, in the UAE. They provide AD&D insurance to low-income migrant workers who come from the South Asian countries of India, Pakistan, Nepal, Bhutan, Bangladesh, and Sri Lanka. The policy called 'Continuity of Income' is available to all UAE customers sending money via Western Union. When the transfer is made, customers have a choice to purchase AD&D insurance against loss of income due to accidental death or disability. It is short-term insurance that is valid for 35 days after the transfer is made.

### **Employers and trade unions**

In developed countries the classic delivery channel for insurance products for the poor has been to reach workers through employers and trade unions. Most employment in developing countries takes place in the informal sector, limiting this potential outreach. Nevertheless in these countries there is certainly a role for employers and trade unions to

reach employees, who often earn very low wages. As we have seen, the world's second largest microinsurance product is distributed through the All China Trade Union Federation, covering 28 million lives.

Employers can pay premiums (with their employees' consent) through payroll deductions, while trade unions can pay premiums by adding the premium to the union subscription fee. The key advantages of these channels for insurers is that (a) they can sell group insurance and in so doing reduce adverse selection problems and (b) they can collect the premium in a single lump sum from the employer/trade union and reduce transaction costs. From the policyholder's perspective, an advantage is that their employer or trade union is often able to negotiate a discount on the insurance premium because of the large number of workers.

**Box 11: Hayleys AIG tea plantation employee insurance in Sri Lanka**

Workers in tea plantations in Sri Lanka expressed concerns that while they could foretell natural death and plan for it, the impact of accidental death was often devastating. In response to this concern, the workers, their employers and Hayleys AIG developed an accidental death policy for the plantation workers. The cover is annual and is deducted directly off the payroll. For a premium of LKR 600 (USD 5.5), each members gets LKR 500 000 of accidental death cover.

## Microinsurance Glossary

- Accident:** An event that is unforeseen, unexpected, and unintended.
- Accidental death benefits:** A provision added to a life insurance policy for payment of an additional benefit in case of death that results from an accident. This provision is often called "double indemnity."
- Acquisition Costs:** Costs incurred by an insurer or their agent in attracting customers. These costs typically include: sales force salaries and overhead, marketing and advertising costs and other costs incurred prior to when a prospect agrees to purchase a policy.
- Actuary:** A person who calculates insurance and annuity premiums, reserves, and dividends.
- Advance Premium Mutual:** Mutual insurance company owned by the policyholders that does not issue assessable policies but charges premiums expected to be sufficient to pay all claims and expenses.
- Adverse Selection:** Tendency of persons with a higher-than-average chance of loss to seek insurance at standard (average) rates, which, if not controlled by underwriting, results in higher-than-expected loss levels
- Agent:** An insurance company representative who solicits, negotiates or effects contracts of insurance, and provides service to the policyholder for the insurer, usually for a commission on the premium payments.
- Aggregate excess policy:** In an aggregate excess policy, the reinsurer will pay claims beyond a certain value
- Alternate delivery system:** Health services that are more cost-effective than inpatient, acute-care hospitals, such as skilled and intermediary nursing facilities, hospice programs, and in-home services.
- Annuities:** Annuities are contracts sold by life insurance companies. In their simplest form, one pays a sum of money (either a lump sum or a series of payments) and the insurance company makes periodic payments to the policy holder, beginning on the date contracted and continuing for the rest of the insured's life. Unlike mutual funds or unit trusts, variable annuities have insurance provisions and guarantees to preserve the value of the principal paid into the annuity. They also generally carry higher fees than mutual funds.
- Association group:** A group formed from members of a trade or professional association for insurance under one master health insurance contract
- Beneficiary:** The person or financial instrument (for example, a trust fund), named in the policy as the recipient of insurance money in the event of the occurrence of an insured event.
- Benefits:** The amount payable by the insurance company to a claimant, assignee or beneficiary under each coverage.
- Broker:** A sales and service representative who handles insurance for clients, generally selling insurance of various kinds and for several companies. Brokers resemble agents, except for the fact that, in a legal sense, brokers represent the party seeking insurance rather than the insurance company.
- Cancellation:** The discontinuance of an insurance policy before its normal expiration date.

**Capitation:** Method of payment whereby a physician or hospital is paid a fixed amount for each person in a particular plan regardless of the frequency or type of service provided.

**Cede:** To transfer all or part of a risk written by an insurer to a reinsurer.

**Ceding company:** An insurance company that yields part of its risk to reinsurers.

**Claim:** A request for payment of a loss that may come under the terms of an insurance contract.

**Clawbacks:** Commission paid out to an agent and retrieved by the insurer due to policy cancellation of the original commission resultant policy prior to full payment of the policy by the policyholder.

**Commission:** The part of an insurance premium paid by the insurer to an agent or broker for services in procuring and servicing the insurance policy(ies).

**Comprehensive medical expense insurance:** Insurance that provides coverage, in one policy, for basic hospital expense and major medical expense.

**Co-payment:** Mechanism, used by insurers to share risk with policyholders and reduce moral hazard, which establishes a formula for dividing the payment of losses between the insurer and the policyholder. For example, a co-payment arrangement might require a policyholder to pay 30% of all losses while the insurer covers the remainder.

**Cost containment:** Reduction of inefficiencies in the provision, consumption, allocation, production or servicing of insurance services. For example, inefficiencies can occur when health services are used inappropriately; when insurance policy servicing could be delivered in a less costly manner; or when using a different combination of resources could reduce costs.

**Covariance:** The tendency for either i) many households to be affected by a risk at the same time or ii) several risks to consistently occur together (at the same time or under the same circumstances).

**Covariant risk:** A risk, or combination of risks, that affects a large number of the insured items/people at the same, for example an earthquake, or a major flood.

**Coverage:** The scope of protection provided under a contract of insurance, and any of several risks covered by a policy.

**Credibility theory:** A branch of actuarial science that tests the validity of data.

**Credit Life Insurance (or "Outstanding Balance Life Insurance"):** Insurance coverage that repays the outstanding balance on loans in default due to the death of the borrower. Occasionally, partial or complete disability coverage is also included.

**Deductible(s) (or "Excess"):** Mechanism, used by insurers to share risk with policyholders and reduce moral hazard, which establishes an amount or percentage which a policyholder agrees to pay, per claim or insured event, toward the total amount of an insured loss.

**Delegated underwriting:** The delegation of the insurance underwriting decision to a lender, on loans made by that lender. "Contract underwriting" is a variant of delegated underwriting.

**Disability:** Physical or mental condition that prevents a person from performing one or more occupational duties temporarily (short-term), permanently (long-term), and / or totally (total disability).

**Disability benefit:** A feature added to some life insurance policies providing for waiver of premium, and sometimes payment of monthly or lump sum income, if the policyholder becomes temporarily, totally and / or permanently disabled.

**Dismemberment:** Accidental loss of limb or sight.

**Delivery / Distribution Channel:** Type of process used to deliver insurance policies to clients. Direct marketing and agents are two examples of different distribution channels

**Distributor:** Institution that handles the sales and servicing of insurance policies, but does not necessarily 'produce' the products themselves, or retain the risk of the insurance policies.

**Endowment:** Life insurance payable to the policyholder if living, on the maturity date stated in the policy, or to a beneficiary if the insured dies before that date.

**Estate:** The assets and liabilities of a person left at death.

**Excess (or "Deductible"):** Mechanism, used by insurers to share risk with policyholders and reduce moral hazard, that establishes an amount or percentage which a policyholder agrees to pay, per claim or insured event, toward the total amount of an insured loss.

**Exclusions (or "exceptions"):** Specific conditions or circumstances listed in the policy for which the policy will not provide benefit payments.

**Experience:** The record of claims made or paid within a specified time period.

**Experience rating:** The process of determining the premium rate for a group risk, wholly or partially on the basis of that group's experience.

**Experience refund:** Amount returned by an insurer to a group policyholder when the financial experience of a particular group (or class to which the group belongs) has been more favourable than anticipated.

**Face Value:** Amount to be paid out by an insurance policy if either the insured event occurs or the policy matures (for endowment policies)

**Flat schedule:** A type of group insurance schedule under which everyone is insured for the same benefits regardless of salary, position, or other circumstances.

**Fraud:** Intentional perversion of truth in order to induce another to part with something of value.

**Grace period:** A specified period after a premium payment is due, in which the policyholder may make such payment, and during which the protection of the policy continues.

**Group Creditor Life Insurance:** Life insurance provided to debtors by a lending institution to provide for the cancellation of any outstanding debt should the borrower die. Normally term insurance limited to the amount of the loan.

**Group Insurance:** Insurance written on a number of people under a single master policy, issued to their employer or to an association or other organization with which they are affiliated.

**Group life insurance:** Life insurance on a group of people under a master policy that usually does not require medical examinations. It is typically issued to an employer for the benefit of employees, or to members of an association or some other related group, for example, a professional membership group. The individual members of the group generally hold evidence of their insurance.

- Health insurance:** Coverage that provides benefits as a result of sickness or injury. Policies include insurance for losses from accident, medical expense, disability, or accidental death and dismemberment.
- Home Service:** Form of insurance distribution system in which all aspects of insurance provision (marketing, sales, premium collections, claims verification and distribution) are performed by a roaming 'agent' who visits customers in their homes or place of work. Home service distribution was popular in North American and Western European countries in the early 1900's.
- Health maintenance organization (HMO):** Organization that provides a wide range of comprehensive health care services for a specified group for a fixed periodic prepayment.
- Hospital indemnity insurance:** Health insurance that provides a stipulated daily, weekly, or monthly payment to an insured person during hospital confinement, without regard to the actual confinement expense.
- Individual insurance:** A policy that provides protection to a policyholder and/or his or her family; sometimes called personal insurance as distinct from group and blanket insurance.
- Industrial Life Insurance:** One name for life insurance policies sold to middle and low-income customers in small policy amounts with weekly or monthly premium collection at the policy owner's home.
- Informal insurance provider:** An insurance risk holder that is not regulated under an insurance act, and is not supervised by an insurance supervisory body.
- Institutional Risk:** Risks faced by insurer as a consequence of offering insurance. For example, insurers risk experiencing losses on their portfolio if claims or administration costs exceed expectations or if premium revenues fall below expected levels.
- Insurable interest:** A financial reliance you have on someone (such as a spouse) or something that can be covered by insurance. For example, you need an "insurable interest" in someone in order to buy a life insurance policy on that person's life.
- Insurable risk:** The conditions that make a risk insurable are (1) the peril insured against must produce a definite loss not under the control of the insured, (2) there must be a large number of homogeneous exposures subject to the same perils, (3) the loss must be calculable and the cost of insuring it must be economically feasible, (4) the peril must be unlikely to affect all insureds simultaneously, and (5) the loss produced by a risk must be definite and have a potential to be financially serious.
- Insurance:** A risk management system under which individuals, businesses, and other organizations or entities, in exchange for payment of a sum of money (a premium), offers an opportunity to share the risk of possible financial loss through guaranteed compensation for losses resulting from certain perils under specified conditions.
- Insurance density:** Average insurance spending per capita in a given country, calculated by dividing direct premiums by the population.
- Insurance penetration:** The proportion of direct premiums in a country to GDP.
- Insured:** The individual(s), businesses, other organizations or entities protected by an insurance policy in case of a loss or claim.
- Insurer:** The party to the insurance contract who promises to pay losses or benefits.



**Lapse:** The termination or discontinuance of an insurance policy due to non-payment of a premium.

**Lapsed policy:** A policy terminated for non-payment of premiums.

**“Law of Large Numbers”:** Concept that the greater the number of exposures (for example, lives insured), the more closely will actual results approach the results expected from an infinite number of exposures. Thus, the larger the number of people in the insured risk pool, the more stable the likely results of risk event occurrences.

**Limited Policy:** A contract that covers only certain specified diseases, accidents, or other losses.

**Loan Insurance:** Insurance coverage that repays the outstanding balance on loans in default beyond a specified period, regardless of the cause of default. Also called “credit insurance” but not to be confused with outstanding balance life insurance.

**Life expectancy:** The average number of years of life remaining for a group of people of a given age according to a particular mortality table.

**Master policy:** A policy that is issued to an employer or trustee, establishing a group insurance plan for designated members of an eligible group.

**Microcredit:** Credit products appropriate for low-income people.

**Microinsurance:** Insurance products appropriate for low-income people.

**Moral hazard:** Hazard arising from any non-physical, personal characteristic of a risk that increases the possibility of loss or may intensify the severity of loss for instance bad habits or low integrity. An example might include failing to properly care for an insured goat because it is insured, thereby increasing the chance it will die of disease.

**Morbidity:** The relative incidence of disease.

**Mortality:** The proportion of deaths to population.

**Mortality table:** An actuarial table based on mortality statistics over a number of years.

**Mutual Insurer:** Insurance in which the ownership and control is vested in the policyholders, who elect a management team to conduct day-to-day operations.

**Non-contributory plan:** Group insurance plan under which the holder of the master policy does not require the insured to share in the cost of the policy.

**Outsourcing:** The practice of subcontracting work to outside individuals or firms. Many insurance activities are effectively and efficiently outsourced, such as sales and service, actuarial evaluation, and even some risk (to reinsurance).

**Outstanding Balance Life Insurance (Credit Life Insurance):** Insurance coverage that repays the outstanding balance on loans in default due to death of the borrower. Occasionally, partial or complete disability coverage is also included.

**Parastatal insurance providers:** Insurance companies wholly-owned or majority-owned by a government.

**Partial disability:** A disability that prevents a person from performing one or more functions of his or her regular economic activity.

**Payment delay:** Average days from the submission of an insurance claim to payment of that claim.

**Payout period:** The period during which one receives the income from an annuity contract.

- Policy:** The printed document issued to the policyholder by the company stating the terms and conditions of the insurance contract.
- Policy term:** The period for which an insurance policy provides coverage.
- Premium:** The sum paid by a policyholder to keep an insurance policy in force.
- Primary insurer:** An insurer that directly assumes liabilities by issuing an insurance policy to the insured.
- Property insurance:** Insurance providing financial protection against the loss of, or damage to, real and personal property caused by such perils as fire, theft, windstorm, hail, explosion, riot, aircraft, motor vehicles, vandalism, malicious mischief, riot and civil commotion, and smoke.
- Protection:** Ability of an insurance product to provide compensation for losses incurred. Protection can be full or partial.
- Rate-Making:** The process of estimating the expected costs involved in providing insurance coverage in order to set appropriate premium rates.
- Reimbursement:** Often related to health insurance, reimbursement is the payment by an insurer of the expenses actually incurred and paid by the insured as a result of an accident or sickness, but not to exceed any amount specified in the policy, and covering only those expenses noted in the policy. Reimbursement is usually based on receipts.
- Reinsurance:** A form of insurance that insurance companies buy for their own protection. One or more insurance companies assume all or part of a risk undertaken by another insurance company.
- Reporting delay:** Average number of days from the occurrence of the insured event to the submission of the completed claim covering that event.
- Reserves:** An amount representing liabilities kept by an insurer to provide for future commitments under policies outstanding.
- Rider:** An amendment to an insurance policy that modifies the policy by expanding or restricting its benefits or excluding certain conditions from coverage.
- Risk:** The chance of loss. Also used to refer to the insured or to property covered by a policy.
- Risk classification:** The process by which a company decides how its premium rates for insurance should differ according to the risk characteristics of individuals or items insured (for example, by age, occupation, gender, and state of health) and then applies the resulting rules to individual applications. (See underwriting.)
- Risk exposure:** The possibility of financial loss based on the probability of an event occurring.
- Risk Management:** Systematic process for the identification and evaluation of pure loss exposures faced by an organization or individual, and for the selection and implementation of the most appropriate techniques for treating such exposures.
- Risk Pooling:** Spreading of losses incurred by a few over a larger group, so that in the process, each individual group members' losses are limited to the average loss (premium payments) rather than the potentially larger actual loss that might be sustained by an individual. Risk pooling effectively disperses losses incurred by a few over a larger group.
- Risk Premium:** The portion of the premium that is used to fund claims and is equal to the expected claims.

**Self-administration:** Maintenance of all records and assumption of responsibility, by a group policyholder, for those covered under its insurance plan. Responsibilities include preparing the premium statement for each payment date and submitting it with a check to the insurer. The insurance company, in most instances, has the contractual prerogative to audit the policyholder's records

**Settlement:** Payment of the benefits specified in an insurance policy.

**Stop-loss policy:** An agreement from a reinsurer to cover total claims over a certain agreed upon value of an aggregate pool of policies

**Takaful insurer:** An insurer that follows Islamic financial principles.

**Term insurance:** A plan of insurance that covers the insured for only a certain period of time (term), not for his or her entire life. The policy pays death benefits only if the insured dies during the term.

**Time limit:** The period of time during which a notice of claim or proof of loss must be filed.

**Total disability:** A disability that prevents a person from performing any and all occupational duties. The exact definition varies among policies.

**Underwriter:** (1) A company that receives the premiums and accepts responsibility for the fulfilment of the policy contract. (2) The company employee who decides whether or not the company should assume a particular risk. (3) The agent who sells the policy.

**Underwriting:** Process of selecting risks for insurance and determining in what amounts and on what terms the insurance company will accept the risk.

**Unearned Premium:** The portion of a premium that a company has collected but has yet to earn because the policy still has unexpired time to run.

**Uninsurable:** High-risk persons, items, or activities, which fall outside the parameters of risks of standard underwriting practices.

**Unit(s):** That which is being insured.

**Universal life insurance:** Unlike traditional cash-value policies (known as "whole life"), universal life policy returns were freed from long-term, fixed-rate contracts and replaced with policies whose returns were tied to short-term interest rates and periodically adjusted. In addition, the policyholder can change premiums and death benefits.

**Waiting period:** The length of time an insurance client must wait before their insurance becomes effective.

**Weather based index insurance:** A way of linking benefit payments for crop and other losses to an objective index such as rainfall. This is technically not 'insurance' because there is no formal link between the benefit and the loss.

**Whole life insurance:** A plan of insurance for life, with premiums payable for a person's entire life.