

MICROINSURANCE

Improving risk management for the poor

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The CGAP Microinsurance Working Group aims at facilitating coordination between initiatives towards the development of insurance products for low-income households. It is chaired by ILO and currently structured into four subgroups: Operations and Donor Guidelines, Demand, Regulation and Dissemination. The composition of the working group includes donors, insurers and other interested parties. Others are welcome, especially if they are willing to actively contribute to one of the subgroups. In order to share information about microinsurance initiatives, the working group issues this quarterly Newsletter.

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

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

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

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

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

Concept

Understanding the demand for microinsurance

The microfinance industry is particularly keen to learn more about insurance these days. Microinsurance is an increasingly common topic on conference agendas and a number of recent publications have documented emerging lessons in this nascent field (see the bibliography for a list of recommended reading).

The surge of interest reflects both the social and commercial objectives that embody microfinance. From the social perspective, many microfinance institutions (MFIs) have recognised that the vulnerability of low-income households is not eliminated by access to microenterprise loans alone. Microentrepreneurs remain vulnerable to a host of perils that insurance may help low-income households to manage. Furthermore, not all low-income persons are self-employed, so the provision of microinsurance, like savings services, can enable MFIs to broaden their impact in low-communities rather than just assisting microentrepreneurs.

From the commercial perspective, insurance can improve loan portfolio quality since bad debts can often be attributed to the death or illness of a client or a client's family member. Microfinance institutions are also interested in developing new products like insurance to serve new mar-

kets, to enhance customer loyalty, and improve competitiveness. Cross-selling—the practice of providing one customer with multiple services—enhances efficiency by reducing the acquisition cost of each product. A multi-faceted relationship with the client can also strengthen customer loyalty (or reduce desertion by making it expensive or difficult for clients to leave). In addition, MFIs expect that the premiums or agent's commissions from microinsurance could serve as a new source of capital or income.

Despite the persuasiveness of both the developmental and commercial arguments, critical questions remain unanswered: Do low-income people want insurance, and if so, what types of products are the most important to them? Is it appropriate to try and persuade insurance sceptics that premium payments are an appropriate use for their extremely finite resources? For which segments of the market might insurance be an effective means for managing risks, and for which risks?

To better understand the potential demand for microinsurance, it needs to be seen in the context of the alternatives, namely accessible savings and emergency loans.

Understanding the Demand for Risk-managing Financial Services

There are three categories of risk-managing financial products: liquid savings accounts from which clients can draw down to reduce the effects of an economic stress; emergency loans; and microinsurance, which might include coverage for death, illness, disability, theft and possibly drought or disasters. To explore the circumstances under which low-income persons or households might prefer one to the others, it is necessary to consider a range of social and economic issues including:

1) Alternative Coping Strategies

The demand for risk-managing financial services is partly a function of the supply. In general, the poor do not have access to savings facilities, emergency loans or insurance from formal or semi-formal institutions. So while they may have a need for the support provided by these services, they are unlikely to articulate a significant demand because they do not maintain any expectations that a bank or insurer would be willing or able to address their needs. The demand for risk-managing financial services therefore has to be inferred based on the cost and effectiveness of current risk coping strategies employed by the poor, including their reliance on informal financial services.

2) Type of Risk

With regard to formal and semi-formal financial services—if such services were available to the poor—savings and emergency loans would be considerably more flexible than insurance because they can ameliorate the effects of numerous economic stresses. [...]The risk pooling aspect of insurance works best for both provider and consumer when: a) the loss is relatively large and b) there is a low likelihood that the risk will occur (Brown and Churchill 1999). Insurance is therefore useful to cover funerals, expensive medical treatments or rebuilding a burnt house. If the loss were relatively small or likely, then savings or credit would probably be more appropriate.

3) Planning Propensity

Another factor influencing the respective demand for risk-managing financial services is planning. For saving or insurance to be risk-managing options, the decision to protect one's household from risk needs to be made in advance, to start paying premiums or to build up a savings reserve. Savings in particular requires a long-term perspective in which one is willing to forgo current consumption (or investment in income generating activities) to build up a sufficient buffer.

4) Poverty Level

There are two dimensions to planning: the willingness and the ability to prepare for future risks. Besides having sufficient

skills, the ability to plan depends largely on poverty level. For the poor, asset accumulation in the form of savings and/or insurance necessitates forgoing consumption today for greater security tomorrow. Therefore, for savings and insurance to be good options, the household will have to have some net income so that it can put money aside, in a bank or under a mattress, to buy an asset or pay a premium.

5) Cash Flow

The potential demand for risk-managing financial services is not related just to absolute poverty, but also to the level of income and expense variability. Saving and borrowing enable persons to allow consumption to be somewhat independent of income (Murdoch 1995). For the non-poor, the ability to smooth consumption often results in access to material possessions, such as a car or a house. For the poor, the emphasis is less on buying things—although that is certainly an objective—and more on risk and cash management, spreading expense spikes over time.

6) Social Conditions

While a thorough opportunity cost analysis of the three risk-managing financial services would help to identify the best option from an economic perspective, the choice between credit, savings and insurance may depend more on social and cultural considerations than costs and benefits.

7) Education, Biases and Risk Tolerance

On a personal level, the demand for saving, credit and particularly insurance also depends on one's education, biases and tolerance for risk.

Although savings and credit are fairly familiar to most people, many low-income people are not familiar with the risk-pooling concept or they have an incorrect understanding about insurance.

Improving Risk-managing Financial Services

The demand for insurance and other risk-managing financial services is influenced by complex factors. Perhaps the best way to really understand how persons in low-income communities would utilise these services is to make them available and see how different segments of the market juggle credit, savings and insurance. To date, microfinance has not been successful in helping persons to cope with risks after they have occurred. Improving risk-managing financial services such as savings, emergency loans and insurance might help to better respond to the poor's needs.

Extract from "Is microinsurance a priority for the poor? Understanding the demand for risk-managing financial services" - C. Churchill, 2003.

Case Study

CIDR's experience with health mutual in Guinea

Context

In 1997, the CIDR (Centre for International Development and Research - a French NGO), conducted preliminary studies on the potential and feasibility of a mutual health insurance system managed by the village communities of Guinea Forestière.

Three main feasibility categories were studied:

- Economic factors: levels, structures and annual variations in revenues and their potential for growth.
- Social factors: the capacity for initiative and organisation, attitudes towards

making provision for the future and the level of solidarity.

- Health factors: typology of exclusions, accessibility and quality of health services.

A programme was launched in 1999 in the belief that there was a sufficiently strong economic and social capital within these communities, on which to base a mutual network.

One main constraint identified was the existence of underdeveloped health care delivery in which public services played a monopoly role; a public hospital per prefecture and a regional hospital in the town of N'Zérékoré.

To start the project, the Pilot Program identified two prefectures. The prefecture of Yomou was chosen because of the very positive attitude of the Director of the hospital towards the mutual societies and the prefecture of N'Zérékoré, because of the possibility to test the insurance health systems in an urban environment with a regional public hospital.

One issue to be resolved was the negotiation with the hospital to ensure better health care delivery to the members of the mutual society (a.o. concerning the availability of medicines and an end to double billing).

Implementation

The programme was launched in six villages with the organisation of several groupings of mutual members in each village which managed their health credit fund at a local level.

The second stage consisted of unifying the groups into village mutual societies in order to negotiate a system of third party payments with the hospitals of Yomou and N'Zérékoré. This was considered, by the members, to be the first step towards the launch of a health insurance product. The negotiations with the actors of the health offer constituted a time of growth for these newly created mutual societies. The CIDR played an advisory role to the management of the mutual societies and acted as mediator with the public health system. A system of third party payments and conditions of delivery were negotiated.

Intermediary Results

Less than one year after the creation of the first groups, different health insurance products managed by the village mutual societies, covering large

risks and complementary services to each mutual society (simple child deliveries, transport) were launched.

In these first mutual societies, health credit fund managed by the groups constituted an additional guarantee to the coverage offered by the mutual society.

The following year, health credit fund managed by the groups and health micro insurance were offered at once to the villagers. Nevertheless, one part of the groups subscribed only to the insurance. The continuing process of establishing mutual benefit societies formed from socially-based mutual society groups, a level of local risk management and a negotiation approach by the mutual societies with the public health offer, had a positive effect on membership, which occurred during a favourable economic climate. After two trials, the village-based mutual societies registered an encouraging rise in business, with strong internal growth and a satisfactory level of membership renewals.

Perspectives

Following the second year of operations, the establishment of a guarantee system was discussed as a precautionary measure. The way in which the guarantee system could function has been defined by representatives of the mutual societies which are now organised in a regional network with a community status.

The setting of a realistic membership fee, together with a growing understanding of how best to use the services offered, has enabled the mutual societies to establish their own reserves. These were also made possible thanks to a fixed tariff for services offered by the two hospitals and the prior screening by a manager of the village mutual society. For the moment, the village mutual societies do not need to resort to a guarantee system, although extending the guarantee is being studied. The support given by the Ministry of Health during this time should not be underestimated. It has contributed to the improved relations between the hospitals and the mutual societies, one of the factors considered particularly important in a local context.

Some results after three years

Indicators	Y 2000/2001	Y 2001/2002	Y 2002/2003
Number of mutual societies	6	10	12
Number of beneficiaries	1 622	4 197	5 644
Rate of renewals		94 %	82 %
Rate of internal growth		69 %	23 %
Rate of market penetration (rural zone)	8,5 %	12,6 %	14,4 %
Rate of claims	42 %	34 %	39 %
Level of reserves		142 %	302 %

Source: Bruno GALLAND et Claude MEYER – CIDR – cidr@compuserve.com

Terms and definitions

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.

Source: <http://www.microinsurancecenter.org/index.cfm?fuseaction=glossary.welcome>

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.

Source: <http://info.insure.com/glossary.cfm>

Reinsurance: A form of insurance that insurance companies buy for their own protection. One or more insurance companies assumes all or part of a risk undertaken by another insurance company.

Source: <http://www.microinsurancecenter.org/index.cfm?fuseaction=glossary.welcome>

Selected Info

Latest publications

Mutual health organization (MHO) – Five years experience in West Africa - Concerns, controversies and proposed solutions. G. Huber, J. Hohmann, K. Reinhard – GTZ, 2003
<http://www.gtz.de/health-insurance/english/products.htm>

Making insurance work for microfinance institutions. A technical guide to developing and delivering microinsurance. C. Churchill, D. Liber, M.J. McCord, J. Roth – ILO, 2003
<http://www.ilo.org/public/english/support/publ/pindex.htm>

The lure of microinsurance: Why MFIs should work with insurers, M.J. McCord, Microinsurance Centre Briefing Note #1, 2003
<http://www.microinsurancecenter.org/index.cfm?fuseaction=resources.documents>

Microinsurance in Burkina Faso. M. Aliber, A. Ido – ILO,
<http://www.ilo.org/public/english/employment/finance/download/wp29.pdf>

Focus on a webpage

The Center for Health Micro-Insurance (CHMI), based in the Philippines, is committed towards the promotion of health micro-insurance technologies to cooperatives, local government units, microfinance institutions and other social organizations. Through <http://www.iphm.org/chmi/services.php> you will access their services including training kits, distance learning program as well as information about some health micro-insurance players in Asia.

About an insurance company

Allianz Bajaj Life Insurance (India) has launched "InvestGain", a unique life insurance plan where sustenance of income is gained in the same plan that also pays a lump sum. The most significant benefit of InvestGain is the monthly Family Income Benefit. This benefit:

- Sustains the family by compensating the loss of income due to death or accidental permanent disability by paying 1% of the sum-assured every month.
- Is guaranteed for a minimum period of 10 years, which allows the family to cope with loss of regular income.

The InvestGain Plan is available in four packages offering protection up to four times the basic sum assured. Moreover, the plan participates in the profits of the company and therefore, grows with time. Info: vijay.sinha@allianzbajaj.co.in

Product highlight

Microcare, based in Uganda, operates in greater Kampala and South Western Uganda. Its product focuses exclusively on group schemes for the low-income market. It covers all normal in-patient and outpatient services including: medicines, surgery, paediatric, gynaecology, obstetric services, diagnostic testing, and basic dental treatment. The main exclusions are chronic medications and infertility investigation and there is a \$200 ceiling limit per admission. As a matter of policy Microcare does not screen clients for particular diseases or exclude according to diagnosis. Policy documents are simple for insured to read and understand. Premiums are currently about US\$1.25 per person per month covering the risk premium. Full cost premiums, which Microcare is moving towards, will likely double that. Microcare has a strong system of computer and staff based controls to minimize the cost of fraud. Source: microcare@africaonline.co.ug

News from the Working Group

- Working Group started the "Good and Bad Practices" project which includes:

1. The development of Microinsurance **Donor Guidelines** to improve the efficiency, effectiveness, impact and sustainability of donors interventions related to microinsurance products for low-income households. The intention is to issue the document by November 2003. Info: zahid@icmif.org

2. The analysis of fifteen **case studies** of microinsurance operations managed by mature organizations offering health insurance and/or complex life insurance products. The objective is to identify key lessons learned and a set of good and bad practices. The synthesis document will be written to meet the needs of practitioners and it will include numerous detailed examples that are drawn from the case studies. Info: mjmccord@bellsouth.net

- Participants are welcome to contribute to the following subgroups: the Demand sub-group (contact: moniquec@microfinanceopportunities.org) and the Regulation sub-group (contact: Svenja.Jungbluth@gtz.de).

The Working Group is composed by the following members:

F Bakx, Rabobank Foundation - R Boulter, DFID - T Bullens, Interpolis Re - C Churchill, ILO - M Cohen, Microfinance Opportunities - A de Ville, ADA - S Enarsson, Swedish Cooperative Centre - J Gallardo, World Bank - S Hashemi, CGAP - S Jungbluth, GTZ - M McCord, MicroInsurance Centre - S Patel, ICMIF - Z Qureshi, ICMIF - G Ramm, GTZ - B Randhawa, World Bank - J Roth, ILO - C Sander, Bannock Consulting - E Stark, USAID - G Strand, SIDA - S Trommershaeuser, GTZ - L Vandeweerd, ADA - C Vega, World Bank - J Wimaladharma, DFID - K Wiren, Folksam - E Wohlner, Independent Consultant.

To join the Working Group, please contact churchill@ilo.org