

An Anatomy on Demand Side Perspectives of Micro Insurance

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1. Premise

Poverty is not just a state of deprivation but has latent vulnerability indicating susceptibility to high risk. Protection against such vulnerability has become an imperative need for the survival of poor. In the battle against poverty, Micro financial services of late proved to be a panacea for making a dent in Indian poverty canvas. **Micro financial services package includes Micro savings, Micro Credit, Micro Insurance**, payments and transfers of funds and other miscellaneous services required for the poor people. Although the poor is at the bottom of the pyramid face more risk, at micro level there are most disadvantaged people or the poorest people in rural area who are more vulnerable relatively to the same risk. In most of the Micro Finance Programmes, these poor people in general and poorest in particular are not included or not adequately covered. The benefit of protection through micro insurance has been denied to the poorest section. Notwithstanding the development efforts made in the last six decades, a sizeable majority of the population of the population, particularly vulnerable groups, continue to remain excluded from the opportunities and services provided by the financial sector. Eventually “**the inclusion**” concept has been increasingly recognized as an important factor to be considered in the development process. In June 2006, “**A committee on financial inclusion**”¹ has been constitute by Government of India with a view to correct the situation and extend the reach of the financial sector to such a groups by minimizing the barriers to access as encountered by them. To high light the extent of exclusion of people from **micro insurance services** in particular, the report of the above said committee quotes UNDP study titled “Building security for the poor –Potential and Prospects for Micro Insurance in India “as follows

“90% of Indian population –some 950 million people – are not covered by insurance and signify an untapped market of nearly US\$ 2 billion. This enormous ‘missing market’ is ready for customized life and non life insurance, but first, serious mismatches between the needs of the insured and the insurers must be overcome, pitting priorities against profit”. The Insurance Regulatory and Development Authority (IRDA) has come out a set of recommendations for widening the outreach of Micro insurance products to the rural poor and these should be implemented with a renewed zeal as providing **micro insurance is a necessary and essential adjunct in the inclusive process.**

The crux of the problem for exclusion in the financial sector,, is poor appreciation of the demand side perspectives of the insured particularly the vulnerable segments of population represented by poor and the poorest at micro level and lack of designing micro insurance product and services matching the needs of the target groups. As against the background, an attempt has been made in this paper to have an anatomy on the demand side perspectives of the micro insurance at micro level with some empirical findings and suggest some remedial measures for effective outreach of the excluded people.

The specific objective of the paper is to study in depth the perspectives of vulnerability from the demand side in poverty sector and suggest some strategies for micro insurance outreach in poverty sector.

2. Vulnerability

¹ Committee on financial inclusion, NABARD Mumbai 2006

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The need arose for micro insurance as these poor people are to be protected against two vital factors – vulnerability and risk at micro level

Vulnerability indicates highly susceptibility to risk of getting affected or attacked in the absence of protection leading to either loss of life or loss in their livelihood or both . Vulnerability affects every one. Even well paid civil servants may be vulnerable to layoffs and to becoming poor. People who live slightly above poverty line are at risk of slipping below it. For the poor, however, vulnerability is the major concern because downward fluctuations in income can push them below destitution. . Since this marginal community is hardly protected by any safety net adequately, they have to face manifold risks.

The understanding the risk from demand side therefore becomes imperative for better designing the policy and micro insurance products. For this development of a typology of risk and shocks to which people are vulnerable would be useful with a classification of them by **the levels** of at which they occur (micro, meso and macro) and by **the nature of the event** (natural, economic, social, political and cultural and so on).

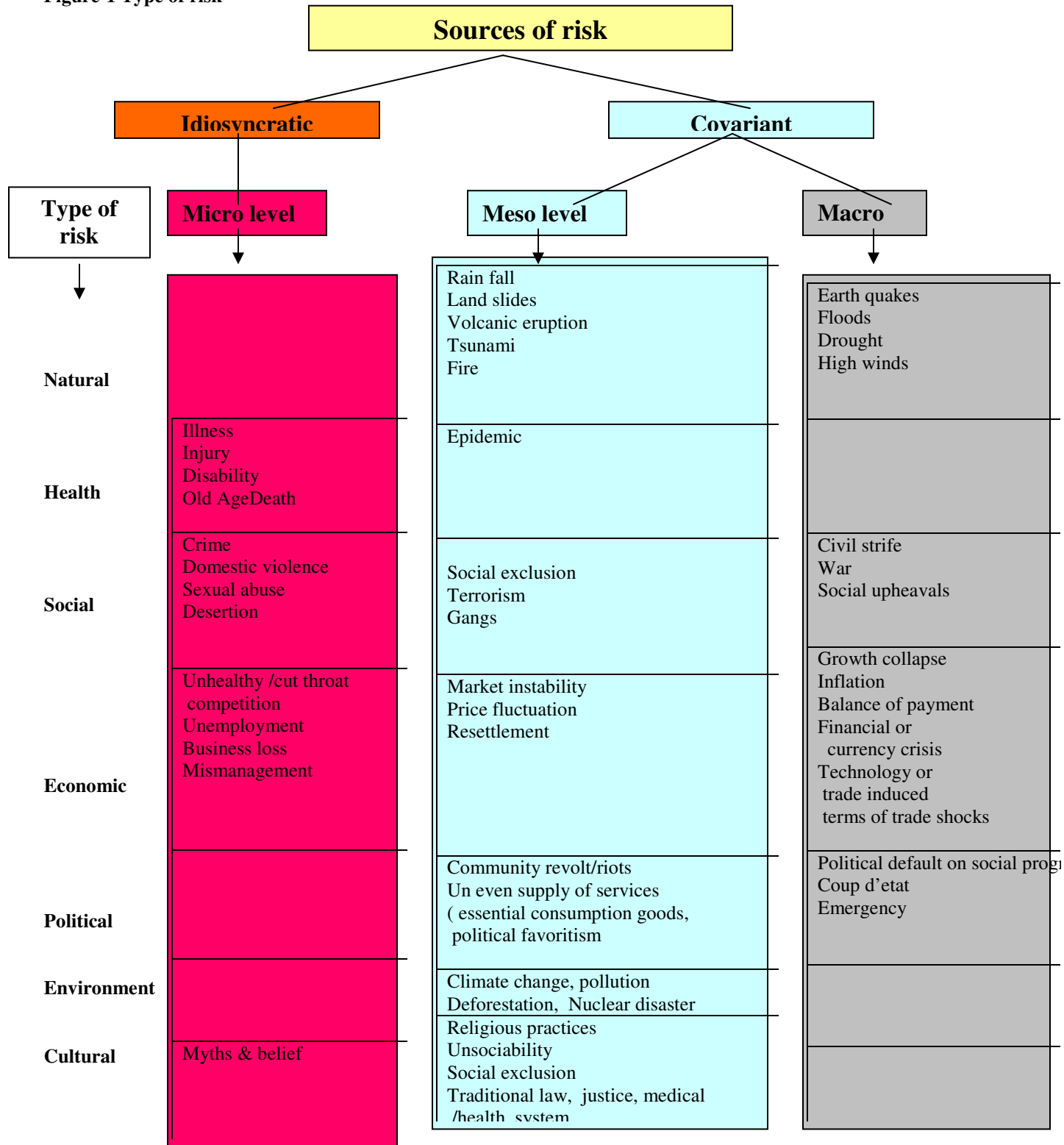
2.1. Micro level risks

Micro level risks/shocks are referred as idiosyncratic and they affect individual or households. Meso level shocks strike groups of households or an entire community or village. These shocks are common (or covariant) to all households in the group. Shocks can also occur at the national and international level. The distinction by level of risk is critical. A risk that affect an entire village, for example, cannot be insured solely with the village, but require pooling with areas not subject to the risk. In practice, many shocks have both idiosyncratic and covariant parts. Although most empirical studies find that the idiosyncratic part of income risk is large.² Income shocks from illness had the largest idiosyncratic component³. Knowing the source of shocks is important for preventing them, but identifying the source is not always straightforward. Many exogenous events can have similar effects on household's income. A macro economic shocks, hurricane, Tsunami, or civil war, flood, drought can all lead to sever decline in income and depletion of a household's asset base at micro level. The same macroeconomic shock or political upheaval affects the poor community in very different ways depending on how well the safety net and other institutions **include** them. Since these risks are multidimensional, an inter- disciplinary probe into the different sources of the risk would be informative for deeper analysis. The main sources of risk type wise and level wise are illustrated in Figure. 1.

² Deaton, Angus, 'The analysis of household surveys: A micro economic approach. Baltimore: John Hopkins University press.1997

³ Dercon, Stefan and Pramila Krishnan. 1996 'Income portfolios rural Ethiopia and Tanzania' Mimeo Center for the study of African economics University of Oxford. 1996

Figure-1 Type of risk



Source: Adapted and modified from World Development Report 2000/2001 'Attacking Poverty' World bank
 At micro level, repeated shocks make consumption smoothing more difficult with repeated shocks, leaving the poor community unable to absorb subsequent shocks. Also

where illness follows natural disaster, the latter may have wiped out the poor's food supply, leaving them weak and susceptible to illness. Severity can range from catastrophic (natural disasters, prolonged disease like AIDS/HIV, death of bread winner,) to minor (a slight illness a few days without work-seasonal- for casual workers)

A final refinement is whether a potential shock affects all or just part of household's income source or asset. A partial risk such as illness may affect only labor income and not harvest, while the total risk such as disaster usually affects a household's entire portfolio. Partial risk can be mitigated if their covariance is lessened.⁴

2.2. Poor household's exposure to vulnerability

The nexus between poverty and vulnerability in the poor household is inextricable since the vulnerability in terms of risk and shocks they face have **household –specific (idiosyncratic)** and also common (co variant) components. As households become the most disadvantaged or the poorest segment in the poverty sector and approach a line of extreme poverty or destitute, they become very risk averse. The reason is that any downward fluctuation in income pushes the household below a survival point and this has to be avoided at all costs by ensuring some suitable protection measures.. Unfortunately, the poorer households often face the highest risk, while at the same time having the fewest resources to deal with that risk and forced onto the most marginal infrastructure, they far from health facilities.

Among others, **health risk** in terms of illness, killer disease like AIDS/HIV, injury and death strike rich and poor- but not alike. While some conditions are “equal opportunity diseases”., **most hit the poor**. Poor health and poverty constitute a vicious circle. The poor live and work in environment that exposes them to greater risk of illness or injury, and they have less access to health care. The poor's lower nutritional intake also makes them less productive and less able to participate in the labor market worsening their poverty⁵. The health risk of the poor is strongly connected to food availability, which is affected by almost all the risk faced by the poor: natural disaster wars, harvest risk and food price risk. Since the poor spend a large portion of their income on food, even small food price increases can have major consequences for food intake. Living conditions of poor households also aggravate health risk for children. In urban slums, children higher risk of diarrhoea (from water contamination) measles (from cramped housing conditions) and accident injury (from unsafe live hood condition). However in rural areas, where most of the developing world's poor live, the health risks are highest.

Extreme poverty deprives people of almost all means of risk by themselves. With few or no assets, self-insurance is impossible. With poor health and bad nutrition, group insurance mechanism are often closed off.

The poorest households thus face extremely unfavorable trade offs. When shock occurs, they must obtain immediate increase in income or cut spending or sacrifice consumption.. But in so doing they incur a high long term cost by jeopardizing their economic, and human development prospects. These are situations that lead to child labor, unemployment, illiteracy and malnourishment, with lasting damage to children and breakdown of families.

⁴ Sinha Saurab and Michael Lipton ‘ Damaging fluctuations, Risk management and poverty’ World Development Report 2000 Background paper. World Bank Washington D C 1999

⁵ Prasad Kamaeswar, Paolo Belli and Monica Das Gupta “Link between poverty Exclusion and Health” Background paper for the World Development Report 2001.Washington D.C 1999

2.3 Gender biased Vulnerability

Hard times hit vulnerable sections of a society the most. But within the society it is women are susceptible more risk. Gender biased vulnerability is seen both at macro level and micro level. To look **at global level**, the two recent studies, one by the United Nations Population Fund,(UNFPA) and other by The World Economic Forum(WEF) highlighted the persisting **gender inequalities** and these should not be overlooked. in the looming global economic downturn. . The UNFPA report - “Reaching a common ground: Culture, Gender and Human rights- points out that the crisis is both widespread and deep-rooted in many cultures. According to the report nearly 60% of the one billion poorest people are women and girls. In regard to maternal health, the most vulnerable area to women, it is reported that the percentage of births under the supervision of skilled attendants is a mere 47% in India compared with the global figure of 66%..The WEF’s report - “Global Gender Gap index”- places India as an abysmal 113 among the 130 countries. In the case of sub- index Health and survival, used by the report, India’s rank is very lower with 128.

At micro level, the observation made in the earlier paragraph has treated the household as the unit of impact and decision. Yet within the house hold the risk sharing among the members, may not be equal. The burden of household response may fall disproportionately on weakest members especially **women and children**. Some studies⁶ have found that women suffer more than from adverse shocks. In India rising food prices led to larger reduction in nutrient intake for women than men. Religious and Cultural factors (fasting, taking the food served on plain ground- intake of polluted food to satisfy the deity -, more sharing the available food to men and children during food shortage on so on) can also cause health risk.: divorced and widowed women in South Asia often face higher mortality risk than married women because they are denied access to their late husband’s property.⁷ ‘Women seem to be particularly vulnerable in situation like drought, theft, fire accidents etc., especially if there is a lack of social safety nets. In this case keeping up loan repayments might become difficult and debtors enter a poverty trap’⁸. “Rural poverty and vulnerability of rural women go together. Perhaps this appears that they are inseparable. This solution may reflect the feminization of poverty particularly in many Asian countries. Further there has been a long neglect of the particular gender because whenever the basic principle of ‘redistribute justice and equity are voiced , the problem is addressed to the poor as a whole and the special or unique needs of the poor women are sidelined or neglected”⁹. This factor also causes ‘exclusion ‘ in the development process. Further the children in poor households are also vulnerable to fluctuations in household income and consumption. . Because poor households tend to have many children, children are exposed above average to both poverty and vulnerability than their counterpart in other groups.

2.4. Strategy for managing Vulnerability

The poor are very aware of the risks to which they are exposed. Dealing with these risks is often a matter of life and death. Households use both informal and formal strategies to manage risk. These strategies can be further classified as risk reduction and mitigation

⁶ World Development Report 2000/2001 ‘Attacking poverty” World Bank Washington 2001

⁷ ibid 4

⁸ Isabelle Guerin & Jean-Michel Servet Ed. “ Micro finance: From Daily survival to social change. French Institute of Pondicherry 2003 page 29

⁹ Rengarajan. V. Dr. “ Women’s technological empowerment and sustainable development: replicable modes, International seminar, M.S.Swaminthan Research Foundation Chennai 1997

measures (ex-ante strategies) which consists of action taken in anticipation of a shock and coping measures which consists of action taken in response to a shock.. Risk reduction aims at reducing the probability of shock or negative fluctuation. Individual or household are seldom in a position to take such action. The action at meso or macro level is required to reduce the risk. The risk mitigation aims at decreasing the impact of a downward fluctuation through portfolio diversification and **micro insurance**. Another strategy (ex-post) is **risk coping one** aiming to relieve a shock after it occurs. Actions by individuals include sale of asset, loans, child labor etc

The details of mechanism of managing risk is furnished in table 2

Table 2 Mechanism for managing risk

Strategies	Informal mechanism		Formal Mechanism	
	Individual/household	Group based	Market based	Publicly provided
Risk reduction	-Preventive Health practices -Migration -Less risky income sources	-Collective action for infrastructure -Common property resource management		-sound macro economic policy -Environment policy -Public health policy -Education and training policy Free nutritious noon meal for school children Special health care programmer for women -Infrastructure and labor policy Safety net through- NREGA 100 days employment gurantee programme to unorganized workers
Risk mitigation Portfolio diversification Insurance	-Crop and plot diversification -Income source diversification -Investment in physical and human –capital Marriage and extended family Share crop tenancy Buffer stocks Rearing livestock Granary for cereals for futuire consumption	-Occupational association -Rotating savings and credit associations -Self Help Group(SHG) -Investment in social capital(net work, associations,rituals,reci procal gifts giving in social ceremonies)	Savings Micro finance Old age annuities Accident &disability insurance Gender based Insurance Group insurance Child based insurance Live stock insurance	-Agricultural extension -Open up trade opportunities -Protection of property rights -Pension system -Unemployment insurance -Health and disability insurance Labor insurance
Risk coping	-Sale of assets -Loans from money lenders Reduction -Child labor -Reduced food consumption	Transfer from network of mutual support	-Sale of financial assets -Loans from financial institutions	-Social assistance -work force -subsidies -social funds -cash transfers

Source: Adapted and modified from World Development Report, World Bank 2000/2001

In the context of presence of greater vulnerability in livelihoods of the most of the marginal community in the informal sector , management of risk in the informal sector merits more attention. The simple expansion of statutory coverage of formal sector social insurance programs (pension, unemployment insurance disability insurance) to small enterprises will **not meet the risk management needs of informal sector**. Social security schemes are needed to accommodate the lower contributory capacity and greater earnings volatility of self employed and informal workers.

Having perceived the demand side perspectives of the poor who live in vulnerability, an empirical understanding of vulnerability at field level from the field survey would be more useful for designing appropriate strategy for Micro insurance programme towards addressing reduction poverty.

3. Empirical evidence from case studies

An attempt has been made in the following paragraphs to briefly highlight the nature and extent of vulnerability and deprivation of the poor households covered in the case studies conducted by the author in 2007 in Tamilnadu in India . The names are changed purposely. The field data, pertaining to selected sample households, are arranged in a tabular column for convenience in Table 3.

Table 3 Nature and extent of vulnerability and deprivation in sample poor households in Tamilnadu, India

Sl No	Profile of Household	Vulnerability		Nature of Deprivation	Implication at poor household level
		Level of Risk and type	Nature of risk		
1	Villupuram, district Ms Kamala, married to a handicapped widower with two girl children , agricultural labor	Micro level- idiosyncratic	<u>Environmental</u> -Drought no rainfall, no agricultural operation <u>Health</u> Handicapped and prolonged disability	Low Income generation-	-Additional burden to women, migration -Health disorder Undernourishment to children -higher Debt level due health care
2	Ms Nagammal Small business/vegetable selling	Meso level	Economies/market fluctuations Competition	Low Additional income generation	Unsteady income Unsteady consumption Over dues in loan repayment
3	Komala, agricultural labor/dairying Compelled to get loans for milch animals by services without any proper training for dairy business	Micro Idiosyncratic	Old age &lack of skill in dairy management Economics –maintenance of animals costly	No income generation due to loss in dairying	Domestic violence Heavy loss of income Poor consumption Increase in debt Poor turned poorer

4	Mr Ramdorai Small farmer with 3 daughters He is affected with AIDS due to illicit relations-Despite health care he died. His 2 nd daughter got AIDS spread through her father. His wife became widow struggling to meet the both ends meet with 3 daughters Sought Micro finance assistance	Micro Idiosyncratic	Health Infection to family members Prolonged treatment without recovery	Income generation with heavy expenditure for inadequate health care	Huge deficit family budget due to medical treatment Health loss to family members Fear of further spread (AIDS) among household members Debt increases Reduced consumption to women Afraid of Social ostracism
5	Mr Arun small farmer and small brick kiln owner Got HIV+ by illicit relation in the near town.-concealed to his young wife- spent lot of money to local native doctor(witch craft) in vain. His wife sold brick kiln and sought micro finance for health care of her ailing husband but despite of it he died .she has become widow to take care 3 children	Micro Idiosyncratic	Health Affected by HIV+ Myths in Local health practices by witch craft/black magic	Income earning Food consumption Proper health care	His wife became widow Heavy burden to meet both ends meet due to demise of bread winner Loss of asset Children Drop out from school and becoming child labor
6	Ms Dhanam Loss of livelihood by Tsunami Having 14 year old daughter with heart disease Sought micro finance through NGO and other rehabilitation aids Facing with financial liability and health care cost for her daughter	1 Meso Risk affecting Seashore villages /communities	Environmental- Natural Health Prolonged treatment Myths in native health system	Loss of income generation and health	Heavy burden to meet both ends meet Loss of asset Mental agony with unhealthy daughter Running pillar to post for assistance
7	Thiruvannamali district Mrs Padma- a casual worker-deserted by her husband since she gave birth 4 girl children including a blind child. struggling with low wage income to eke out a life , heavy expenditure for health care to blind child	Micro Idiosyncratic	<u>Health</u> Health care to blind child <u>Social</u> Desertion by her husband	Income Consumption Education to girl children	Due to meager income reduced consumption and mal nutrition school drop outs and prolonged health care to sick child
8	Annamalai –small farmers and running Chit company(rotation of finance) due to business loss migrated to Chennai town- started liquor shop	Micro Idiosyncratic	<u>Economics</u> Competition Lack of business acumen <u>Climate/environment</u> Monsoon failure	Income loss Employment loss	Migration Struggling for existence Vulnerable to risk in new place Loss of education to

	with funds raised by borrowing and sale of assets & jewels, But again business loss, Revival of farming in native village with micro finance assistance but harvest failure due to no rain fall-vulnerability continues.				children
9	Mr Chandran Hawker selling clothes in the villages, due to continued illness for his wife heavy spending for health care, availed micro loans for treatment of his wife and son's education . struggling to face competition in his business	Micro Idiosyncratic	<u>Health</u> Cost of health care <u>Economics</u> Competition	Income and consumption	Deficit home budget Loss of asset Prolonged illness incurring heavy expenditure , increased debt burden Micro finance assistance smoothens the burden
10	Mr Sivan Small grocery shop-prolonged illness, died and his wife has to run the shop without any skill and educate his son. Struggling to run the shop in the midst of competition	Micro Idiosyncratic	Health Economics Lack of business skill Social ostracism	Income consumption	Loss of asset Business loss More burden to women Widow handling the shop in the village single hand experiencing difficulty during serving business with male clients and male competitors
11	Salem Group of 15 poor women collectively running Mat weaving unit. With financial assistance from the bank. Due to lack of training in the trade and competition , supply of poor quality raw material the unit incurred loss and was closed.	Meso	Economics competition unemployment	Income loss Consumption loss Employment loss	he group incurred loss and debt level increased A few of them opted for some wage employment The group (self Help Group) collapsed

4.Lessons

The lessons, drawn from both theoretical and empirical observations made on the risk and vulnerability factors from the demand side, are presented below which provide a base for working out strategies for micro insurance programme

1. The vulnerability of the marginal community is found more in their susceptibility to **health related risks** at household level and within household there is gender inequality with **women sharing more health risk**.
2. The **unprotected health risks** ultimately lead to deprivation in income consumption and employment in marginal community

3. The **covariant risks** like drought at macro level and epidemic at meso level also push the poor further into poorer category, as they could not withstand against the forces of these vulnerabilities.
4. In the informal sector where most of the marginal community is found, the **cultural risks** in the form of traditional belief and myths influence very much the behavior of the poor in their livelihood activities and health system as well pushing them into vulnerability.
5. **The management of risk** at micro level appears to be absent there by necessitating ex-anti strategies for risk reduction and risk mitigation and ex-post strategies for risk coping

Based on the above facts, reflecting the demand side perspectives, following strategies for providing protection to the target group through micro insurance services are suggested

5. Future strategies

The demand side realities at micro level clearly point out the need to design demand oriented products and services and active involvement of both public (government. bank. Insurance Co) and private (NGO/ VO/SHGs) institutions for effective 'inclusion' of the most disadvantaged section of the poor. For this following strategies are suggested

5.1 Demand oriented Micro insurance products

The most of the poor households, as empirically observed in table 3, face health risk leading to both income employment and consumption loss. Since health risk is found significant in poverty sector as evident in the above anatomy, there is a need to synchronize the activities for both **reduction of health risk** by government medical institutions and **protection** through Micro health insurance by the insurance players with a demarcation of target group depending on the degree of vulnerability. Since the poorest face more vulnerability than the poor in health dimension in the poverty sector, the inequity in access to health care exists..The poor segments may therefore be classified **in two categories** – **the poor** who may need protection measures through MI products with lower premium and **the poorest** through MI products with free premium.

Towards protecting the poor from health risk by the government, , in the case of Tamilnadu the State government has made a number of steps for providing primary health care services for rural poor such as upgrading the primary health centers with more beds and modern equipments , 24 hours delivery care services, appointment of more health inspectors, nurses, doctors, provision maternity cash benefits to each pregnant women, comprehensive free health campaign (in Tamil 'Varumun kappom' – prevention before attack of disease) for screening communicable and non-communicable diseases. Etc

In regard to the **poorest segments**

.Towards reduction of Health risk for the poorest people need to be taken care of **by public sector as charity measure** by improving institutional strengthening and outreaching through Para medical force and providing **free micro insurance** assistance as incentives like subsidy/ premium assistance like that of free nutrition food to poor children in school, free land, Television set, gas stove subsidized rice Rs1 per kilo gram in Public Distribution system (as in the case of Tamilandu,) free medical care with nutrition tablets to pregnant women etc

Towards protection against health risk, a comprehensive micro insurance linking life and non life is to be designed for protecting the poorest people. **A multi purpose micro**

insurance product (like Kisan Credit Card for agricultural to buy various types of agricultural input besides credit with one time submission of relevant documents) may be considered to cover the multi - risk for the following asset besides life for the insurer
1) residential building and the hut in the case of the poorest, farm and non farm equipments, irrigation pump and pump house/shed, hand loom, bullock cart,, petty shop, and similar income generating assets including livestock

For effective outreach at micro level particularly to **women population** , the players in Micro insurance could involve federation of SHGs, , women forums and like women forums and support them through capacity building programs on designing **pro women micro insurance products** and distributing the same as agent at grass root level

2. **Free insurance package** could be linked to Government development programme or formulate exclusively insurance programme for this target group. In this regard, cashless health Insurance scheme, named as “**Rastrya Swasthya Bima Yojana**” (RSBY) merit attention here. By a large the scheme covers unorganized workers who are provided a **smart card** which facilitates **cashless health insurance** cover up to Rs 30,000.to cover hospitalization for range of illness. Here there is a need to identify the eligible beneficiary preferably belonging to the poorest facing vulnerability in health. In the context of difficulties in reaching the benefits of welfare scheme to people, the introduction of smart card technology could be an effective way of addressing the inequities in access to health care in the rural arena. This micro insurance package largely benefits the beneficiaries identified under government programme The **National Rural Employment Guarantee Act (NREGA)**. One of the most significant proposals in the bill is to provide each and every unorganized workers in the country with a **smart identity card** that would have a portable identification number enabling to be used for a variety of purposes Thus a domestic help (servant maid.) or a worker at a construction site with no permanent address (migrant) would be able to use such a card for obtaining **social security benefits including micro insurance** which would go a long way in coping the risk among the marginal group. This type of linking micro insurance package with employment oriented program for the poor segments who are vulnerable to various risk, would ensure a type of guaranteed protection to income risk well health risk to the target group.

For effective implementation for “inclusion”

For successful implementation of the scheme with this new technology, built –in – safe guards are crucial as the manner in which the state and private healthcare providers attune themselves to the technology. In the longer run, there should be check on the temptation of hospitals to resort to an overuse of medical tests taking undue advantage of the insurance cover. **It is important that the political parties should not influence** the process of identification of the beneficiaries for the above programme. Effort should also be made to include the deserving people in the programme, who are left out of the programme.

5.2 Micro Insurance delivery mechanism- partner –agent model

There is a imperative need to nurture social capital (SHG) particularly in the marginal community by both formal and informal mechanisms as it facilitates protecting the poor from the risk to income shocks. In south India the formation of Self Help Group (SHG) by NGOs among the poor women in particular with adequate policy support from the state government, yield promising result towards prevention of economic risk at micro or

households level. Micro finance programs (savings and credit) are encouraged in SHG system do more than help households cope with risk in the process of income generation and help the poor smooth consumption during a crisis. But it is inevitable to protect the income generating asset –be it livestock or micro enterprise through micro insurance and the life of the poor.

The banks and Insurance companies in the formal system also make arrangements with NGO/SHG as partner in the non formal system for conducting their financial products both micro credit and micro insurance integrated to support the poor there by protecting them from livelihood and life risks in rural area.. The state government provide conducive climate for strengthening the social capital under capacity building programme in term of assistance for training the group members, skill up gradation and marketing their products. This model for the delivery of micro insurance involves no risk and there is limited administrative burden for the supply side.

. However the **micro finance products** need to be redesigned to suit the needs of the poorer house holds with the focus on **linking with micro insurance**. The loan size and repayments need to be made more flexible and correspond to the income flows and repayment capacity of borrowers. As risk reduction and coping strategy, micro finance products should include **micro insurance** component along with micro savings and micro credit so that the poor clients would not have to take out loans to cope with health risks such as illness and death, and this would increase the program effectiveness (India – The Self Employment Women’s Association (SEWA) provides micro finance programmes including insurance as social security scheme. This strategy should be widely adopted in all pro poor financing programmes.)

5.3.. Group insurance for coping the risk.

Public works programmes, while they can be designed to be self-targeting through wage rates, are not necessarily an expensive way of delivering the insurance benefits to the poor. A well designed and well funded workfare programme is a mixture of risk mitigation and risk coping. In this regard **The National Rural Employment Guarantee Act (NREGA)** covering the unorganized workers in the informal sector, in the entire country India merits attention as this provides protection for employment, income and health risks for the target population.

The unorganized workers, who form 94% of the total work force in India, find seasonal employment and live in facing the vulnerability of income and employment loss. Towards protecting the poor from this vulnerability particularly the government of India has enacted National Rural Employment Guarantee Act for ensuring 100 days of employment per family in this sector every year with fixed minimum wage rate per day. Further one of the most significant proposals in the bill is to provide each and every unorganized workers in the country with a **smart identity card** (as referred to above) that would have a portable identification number enabling to be used for a variety of purposes Thus a domestic help (servant maid.) or a worker at a construction site with no permanent address (migrant) would be able to use such a card for obtaining **social security benefits including micro insurance** which would go a long way in coping the risk among the marginal group.

The successful implementation of the programme in a wider area largely hinges on efficiency in the delivery of the micro insurance services at various levels without nepotism and corruption. The future strategy should more focus on effective monitoring and checking corruption at lower levels with a kind of ‘**social audit**’ by the beneficiaries

themselves as it has become a necessity for ensuring out reach of benefits to all the deserving disadvantaged groups sustainably in rural arena.

5.4. Awareness campaign-

5.4.1. Protection against ill effects of traditional health practices

On supply front, the formal and non formal (NGO) mechanisms would certainly help in mitigating health risk among the poor community.. However in the demand side, the myths and belief of marginal community in traditional or native health care system like local prohibits, sadhus, tantrics, quacks, witch craft black magic, talisman, offerings to God in myriad forms including causing injuries to one's physical body, walking on the fire, animal sacrifices for health cure, religious medical system as in tribal community, have an over riding impact making the poor always in vulnerability in health sector.

Making an effective advocacy programme and awareness campaign should change the atavistic attitude of the poor, followed according to their values on myths and beliefs. They should be motivated to realize the values of the modern health care system and development programs linked with micro insurance. Ultimately they should be protected well by formal health care system as it would alone cover larger area and mitigate their health risk in the poverty segments in country like India. In this regard. The protection measures through micro insurance to the target population could be a complimentary one

5.4.2. Ignorance of insurance formalities.

Another important observation in the field is presence of ignorance or neglect of the insurer on the norms (maintenance of insurance documents) and procedure for making the claim the benefits of the micro insurance. For instance in the case of **livestock insurance**, the ear 'Tag', fixed on the ears of the livestock (milch animals) which are insured, are to be produced to the authorities but since it is reported lost in many cases rendering the poor insurer difficulty in claiming the insurance benefit.. Further in most of the cases in demand side the insurer believe that only the milch animals, purchased out of bank loan need to be insured although another animal owned by him without knowing impact of epidemic livestock diseases if any affecting all the livestock in the area. whether the animal is purchased out of loan or not, defeating the very purpose of insurance scheme. It is therefore emphasized that the target beneficiaries should be enlightened on the **demand side responsibilities** which include various procedural aspects right from application, mode of premium, safe maintenance of documents / materials linked to insurance , claims procedures, reporting authorities and period for claim, settlements procedures etc., , documents required for claiming , their rights and ethical practices (avoidance of bribe) etc., Simplification of procedures suited to the demand side also may be considered by the supplier.

Awareness campaign on the values of modern practices covering both the aspects briefed above are therefore to be held intensively as well extensively for mitigating the health risks and protection through micro insurance products (life, non-life, free premium, cashless group and , single, household package etc) in rural pockets where the poorest population is concentrated through all media involving all the players in Micro insurance arena.

6. Conclusion

The Millenniums Development Goals (MDG) aim to significantly reduce extreme poverty, disease and literacy by 2015. The target cannot be met unless the speed of implementation is substantially accelerated according to UN Secretary General who asserted recently. Among other development inputs, deployed for attacking poverty,

Micro Insurance remains 'Cinderella' without utilizing its vast potential adequately in the said task .in terms of reaching and matching needs of the poorest segments. In the context of diversified nature of vulnerability and degree of risk faced by the poor, '**one size fits for all**' solution is to be eschewed. Taking cognizance of demand side realities, as observed in the paper, three urgent tasks namely 1)Designing appropriate micro insurance product and services matching the needs of demand side 2)linking them with pro poor welfare programmes like NREGA and 3)making micro insurance as integral component of micro finance activities , merit the attention of the policy makers and players in the field as it would protect the poorest from various kinds of risk and facilitate for making a dent in Indian poverty canvas..

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