Microinsurance—a note on the 'State of the Art'[1]

By Mirai Chatterjee

7.4.05

The Context

The past decade has seen the growth of microinsurance in many different countries. In India, too, several people's organizations and NGOs have been experimenting with microinsurance. While the long-term viability of these efforts is yet to be established, what is increasingly clear is that the poor are insurable.

Just as thirty years ago, in the early years of the microfinance movement, the poor, and especially women, had to prove that they are creditworthy and 'bankable', they have had to show that they are not to be dismissed as 'bad risk'.

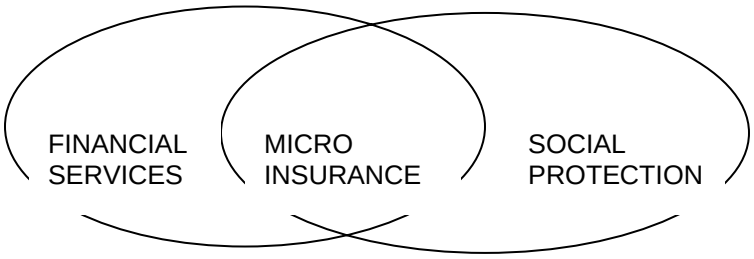
SEWA's experience with providing microinsurance services to women workers over more than a decade points to the fact that microinsurance must be integrated with both financial services (savings, credit and pension) and social services (health care, in particular) for effective delivery. Further, it must be made a component of any poverty reduction programme. It is this holistic and integrated approach which will eventually

[1] Vimo SEWA organized two workshops along with other practitioners; one at the national level in September 2003 and the other at the World Bank in September, 2004. Policy-makers and researchers were active partners throughout. These workshops, were followed by an Exposure-Dialogue Programme (EDP) organized at SEWA in October 2004 in which practitioners, policy-makers and insurers lived with insured SEWA members and attempted to understand vulnerability and risk from the perspectives of women workers of the informal sector.

All of these experiences and insights, and our own work of over a decade of work on microinsurance, have contributed to the issues raised in this note.

reduce vulnerability and stem the decapitalisation that occurs when risks and crises confront poor families.

Our experience leads us to an understanding of microinsurance that places it at the frontier of both financial services and social protection, incorporating elements of both. Like other microfinance services, it must be run in a financially viable manner, but it needs the universalisation that comes with the social protection approach. Universalisation—making insurance available to all citizens regardless of socioeconomic status-- or at least maximizing coverage to include as many citizens as possible, and especially the poorest, is not only equitable, but also makes 'good business sense' from an insurance viewpoint. The larger and more diverse the pool of insureds, the greater is the spread of risk and, consequently the greater the chances of viability.



The product

It is clear from the evidence on the ground that the poor face multiple risks—or perils, if we use appropriate insurance terminology. Our experience shows that the major insurable perils faced are:

- sickness
- death

- accidents
- asset loss—especially loss of animals, house, tools of employment and of standing crops.

Of all of these, coverage for sickness is the main priority, as it leads to large expenditures, loss of daily income and ultimately sale of assets to meet this crisis.

SEWA's experience points to the need to insure a package of perils—both life and non-life—which could develop slowly according to local people's needs and their ability to pay the required premiums. This package not only serves their immediate needs, but also helps in the viability of microinsurance, as we shall see below.

Type and quality of servicing

At SEWA, time and again we have seen that the poor, and particularly women workers, will pay towards the cost of services, if they are appropriate and of acceptable quality. This is true of micoinsurance as well.

In our experience, three aspects to the servicing of microinsurance are extremely important to members:

- Claims-servicing: This must be timely, with simple procedures and made available at women's doorsteps.

- Contact with the insured: As frequent contact as is possible, and at least twice before renewal of insurance is required; even if they do not face any crisis, members need to feel involved and connected—such face-to-face contact (individual, house-to-house or in small meetings) presents a good opportunity for preventive health education as well as education on insurance and our schemes.

- Cash-less systems for sickness coverage through tie-ups with hospitals:

Institutional arrangements

Currently there are three main methods of reaching the poor and providing microinsurance services in India:

1) Partner-agent model—here the insurance company bears the risks and the people's organization/NGO acts as an agent, collecting premium, linking with the insurance company and even processing and servicing claims.

2) Provider model—here a hospital run by an NGO develops and runs a microinsurance scheme, usually for health insurance.

3) Community-based health insurance: here a member-based organization manages a health insurance scheme and carries the risk but health care is provided by health care providers.

In other countries, Sri Lanka and Philippines to mention a few, people's organizations and NGOs register and start up their own microinsurance company or cooperative. They bear the risks themselves, but always reinsure with one of the large reinsurance global companies, like Swiss Re and Munich Re. For people's organizations and NGOs to have their own company, there have to be appropriate changes in the regulations, as we shall see later.

Obviously there are pros and cons to the different models mentioned above. Our own experience points to the fact that when workers run and control their own organization, and are themselves the share-holders and managers, then they run their services in an appropriate and viable way. SEWA Bank is one such membership-based, workers' organization which is growing and in a sustainable manner.

Having one's own organization can reduce the possibility of fraud and adverse selection—this has been the experience of organizations running their own microinsurance companies in other countries. Of course, risk management strategies like reinsurance and adhering to basic insurance principles for viability are essential.

Affordability and Willingness to Pay

When insuring the poor, affordability is a real issue. At the same time, the sums insured (coverages) have to be of an order that prevent the downward slide into poverty and indebtedness. For example, at least Rs. 5,000 is the amount our members cite as their minimum sum insured required during hospitalisation. Ten thousand rupees would be the ideal coverage. But these amounts would require premiums that are unaffordable at present, especially since members want and need other non-life and life coverage.

Along with affordability,' willingness to pay' is an important issue to understand. The premium may be affordable, but a member may not be willing to pay out the amount because she/he is not convinced about the necessity of such a pay-out or does not find it useful. In a situation of competing demands on scarce resources, there may be other priorities. Or an insured person may say, as they often do:
"Nothing has happened over the past few years since I've been insured. So I don't want to waste my money."

Belief in insurance and trust in the institution are two other important factors. We have also seen many instances, when a woman does not have the money needed to pay out her premium. But she borrows from neighbours, family friends or even the money-lender to meet her premium payment, if she is convinced of her need for insurance. We have seen several women even pawning their gold jewellery to come up with timely premium amounts.

Marketing

Marketing of microinsurance bears some similarity to marketing in the mainstream insurance industry, in that it has to be sold to customers. Microinsurance policies have to be sold to poor people, as they are sold to people of other income brackets. What appears to work best is the face-to-face and house-to-house selling of microinsurance. It is also the most expensive marketing method, pushing up transactional costs considerably.

Other ways of marketing microinsurance that we have used are:

- small and large meetings (sammelans)—these need to be held repeatedly
- gram sabhas or village-wide meetings
- linking with SHGs—livelihood-based groups, savings and credit groups and others to get a “chunk of insureds” on the one hand, and lowering transactional costs on the other
- developing special premium payment plans—monthly savings towards annual premium, one-time lump-sum payment which is put in fixed deposit (and the interest accrued is used to pay the annual premium), loans for fixed deposit-linked insurance
- linking with loanees of SEWA Bank
- linking with individual depositors of SEWA Bank and taking premium directly from their savings accounts with their consent
- linking with NGOs in other states
- linking with specific groups of workers—like members of a cooperative

Viability

Microinsurance can be viable. However, there are very few examples world-wide of large and viable microinsurance programmes, especially those including health insurance. Also, most microinsurance programmes tend to focus on life insurance which is easier to administer and can be viable faster than health insurance can. The viability of life insurance is due to the nature of this product, and that there is less possibility of moral hazard and fraud. Health insurance which is dependent on many variables, and most

importantly hospital care, is more volatile and prone to fraud and other adverse situations.

From our experience, if microinsurance is to be viable, the following have to be tackled:

- Outreach has to be large;
- Transactional costs have to be under control;
- Renewal rate of insureds has to be around 75%;
- Costs of medical care have to be contained;
- Adverse selection has to be reduced.

Transactional costs—especially if one is to reach the poorest and in the most remote of villages—are high. But as mentioned above, these can be offset by increases in outreach and balancing out by obtaining “chunks” of insurance from groups in other areas.

For the viability of health insurance, containing costs of medical care is essential. This can be done through developing tie-ups with providers (public, charitable trust and private hospitals) with a careful watch on quality. The latter includes ensuring that rational medicine is practiced, preferably according to fixed, globally-accepted protocols for various diseases.

Our recent experimentation with hospital tie-ups so that insured members obtain timely and good care and without paying out (cashless system) themselves, is providing some indications as to how health insurance can be organized in a manner that is workable

and useful to the insured members. Under the system we are experimenting with, members call up when they are hospitalized at a facility with which we have a “tie-up”. The SEWA Insurance (Vimo SEWA) organizer (staff person) then visits the patient in the hospital, ascertains her expected costs with the help of the doctors, and makes a part payment (80%) on the spot. The rest of the charges are paid out at the time of discharge and submission of all relevant documents.

Another strategy which has worked well for us is selling a family package, whereby in one contact the entire family is insured. Through this method, the whole family obtains protection from risks, and costs are lowered due to the increased outreach obtained by insuring many persons within one household. This year the number of family packages at VimoSEWA trebled, from 2000 to 6000—perhaps some indication of its popularity.

Data Base for Microinsurance

In order to develop microinsurance products, a proper data base is required. This is needed both to develop appropriate products for insured members and to ensure the right pricing of these products.

At the level of a microinsurance programme, a computerized database helps to track each person, ensure her renewal and also to understand her insurance profile, case and claim history.

A major obstacle to the developing of microinsurance is the lack of such a data base in most countries. Certainly in India this is true. Insurance companies are trying to build up

their data bases so that proper actuarial calculations form the basis for pricing of products and overall development of the insurance business.

It has taken us four years to build up a data base that not only serves the purposes mentioned above, but also helps us in strengthening the management of services at VimoSEWA. The data is collected by grassroots level women through the filling of receipts provided to the insured woman and her family members. It is a work in progress, as we learn to be more accurate in data collection and recording,so that we can serve the interests of our insured members better.

We are also decentralizing our data base district-wise, so that each area will maintain its own data set, and this will be available a touch away for the members.

Enabling Policy Environment

The importance of an enabling environment in support of microinsurance cannot be over-emphasised.

The IRDA's policy directive to private insurers to reach the poor by fixing a percentage of their business to be conducted in the rural and social sectors has had positive impact, in that it has resulted in their partnering with MFIs and NGOs to reach the poor.

The Insurance Regulation and Development Agency (IRDA) is trying to develop regulations for microinsurance that facilitate the growth of this service and also control for the entry of exploitative, unscrupulous elements. The challenge is to ensure the

healthy growth of microinsurance and to see that clients interests are safeguarded. Currently a process of discussion and debate is underway.

SEWA has been having discussions with the Government of India and the IRDA to reduce the capital requirement for microinsurance institutions. The capital requirement for insurance companies is Rs100 crores or about US$ 20 million. This makes it virtually impossible for poor people's organizations or those serving them to develop their own microinsurance organization. The IRDA is not considering reduction of capital because it does not see any viable microinsurance organisations at this time.

The microinsurance organizations, for their part, argue that if this is lowered, viable organizations can be created over time. This has been the experience of several other countries, with different capital requirements (see appendix).

What is also being discussed is the possibility of the government matching the premium contributed by the poor, so that appropriate coverage can be made available. This has been done for years for the formal sector workers who constitute hardly 8% of the Indian workforce at present. SEWA believes that the governments should similarly match premium contributions for workers from the informal sector. Some suggestions in this regard are as follows:

- Give the matching premium as a lump sum to people's organizations (unions, cooperatives, SHG federations) and NGOs, in order to ensure that they actually reach the poor. Systems will, of course, have to be developed to ensure proper audit and accountability.

- Develop an implementation mechanism that involves the above organizations, rather than subsidizing premiums through government departments and insurance companies which have limited outreach and services vis-a-vis the poor.

This note tries to present the “main features of the “state of the art”, as we have understood it both from our own daily microinsurance practice and experiences, and those of others in India and abroad. It hopes to contributes towards an understanding of how we can support and assist the poor, and especially women, in their struggle against vulnerability, risk and poverty.