

Effective Micro- Insurance Programs to Reduce Vulnerability

Written by:

Richard Leftley and Shadreck Mapfumo,
Opportunity International Network

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INTRODUCTION

The provision of insurance products to microfinance clients is becoming increasingly common and much has been learnt over the last ten years about how to design products to better meet the needs of clients. This paper sets out to provide an overview of some of those lessons learnt.

The provision of any financial service to the poor must start with an understanding of client demand; the authors take this one step further and explain how client demand is tempered with other factors such as regulations, the operational environment and insurance supply. A product development process is outlined providing examples of how an effective product can be developed and implemented within a microfinance organisation.

The paper continues to look at some lessons learnt and some common features that are found in effective products. This is conducted both at the generic level for those features that are common across different types of products and then in more detail for each type of product (e.g. life, property, health etc).

Whilst the provision of insurance to the poor has mainly been via either mutuals / cooperatives or microfinance organisations using the “partner-agent” model; the authors argue that in fact there are a myriad of ways to provide the poor with access. The distribution chain is broken into distributor, administrator and risk carriers so that the reader can consider potential options.

The paper concludes by considering some of the issues that the industry faces as it seeks to expand beyond mainly life insurance via microfinance loans and into the provision of insurance to the mass market.

UNDERSTANDING CLIENT DEMAND

Insurance is fortunate in its position as the newest discipline within microfinance as it has an inheritance granted from its credit and (more recently) savings co-workers. Significant lessons have been learnt over the last 35 years in providing the poor with access to financial services and the need to be client rather than product centric. The necessary starting point for any insurance product is therefore client need or demand.

Some have questioned whether low-income households really need to gain access to insurance and spend their scarce income on premiums. In countering these arguments, one only has to imagine the range of risks that an individual with poor nutrition, reduced access to healthcare and informal housing (often located in risky areas) has to face to imagine why the poor may want to have access to insurance as well as other forms of risk mitigation.

In parts of Africa where HIV and AIDS are having their most significant effect our market research consistently demonstrates that over 40% of micro borrowers have experienced a death in their wider family over the last year. Life expectancy in those countries worst affected is now below 35 years old. Furthermore, the cost of these funerals equates to between three to six months of the families' disposable income (Survey conducted at CETZAM, Zambia in 2003). Against this frequency and severity it is perhaps no surprise that the poor are seeking mechanisms to mitigate their exposure to risk.

In India one client likened her life to the game of "Snakes & Ladders" where she was trying to work her way out of poverty and from time-to-time she gained access to credit, which acted as a ladder to speed her journey. But she was also aware of the snakes such as the cost of a funeral, theft from her home or business or failure of the rains, which caused her to use her

working capital for non-productive purposes and had the effect of worsening her poverty.

It would be false to claim that insurance was the answer to all of life's "snakes"; it certainly cannot claim to answer all of life's potential pitfalls. However, used in conjunction with other financial services such as credit, savings and remittances, as well as other informal risk mitigation strategies and social mechanisms, it forms an invaluable safety net to society.

CLIENT DEMAND LEADS TO EFFECTIVE PRODUCT DESIGN

It is our experience that in order to offer effective insurance to the poor a robust product development process must be followed which takes as its starting point client demand. But client demand in and of itself is not sufficient when designing a new product; factors such as the operational environment, regulatory environment and available supply of risk carriers must be borne in mind as well. The process needs to be iterative with checks along the way that competing factors have not pulled the end product too far from the client's need.

Clearly most clients would like to receive healthcare insurance which costs just \$0.5 per month with premiums being collected from their homes at times that are convenient. The infrastructure required to support this request would cost more than the premium and as a result it is not feasible to attempt to meet this need (regardless of the regulatory implications or the likelihood of finding a willing insurance partner to carry the risk). However, it may be possible to design a product that costs \$0.5 a month but requires for premiums to be paid through an existing infrastructure such as a loan repayment or deducted from a savings account. In this example the core client need is met but the product design takes into account other realities.

The core product development framework, which has been developed and used within Opportunity International for the development of insurance products, takes into account the following key stages:

1. **Client needs analysis** – this is normally conducted using a quantitative questionnaire designed to quantify metrics such as sum insured, income status, affordable premium spend, frequency of event, severity of event, client biometrics (age, family size etc), locations visited weekly and current purchasing habits. The questionnaire is designed, implemented and analysed prior to the first site visit using the organisations' loan officers to contact a sample of clients. During a site visit by the consultant the client need analysis is bolstered by using client focus groups with an aim of increasing understanding of factors such as comparative importance of price, claims payment speed and premium payment methods.
2. **Prototype design** – by combining the client needs analysis with information on the regulatory environment, the operational reality of the organisations involved and the likely requirements of the insurance company or other risk carrying vehicle, a consultant is able to design a prototype product for discussion. If the prototype is approved then it can be used in negotiations with the insurance company.
3. **Pricing** – this takes into account the risk premium that the insurance company requires in order to accept the policy as well as the cost of distributing and administering the product to the client. It is always helpful at this stage to draw a detailed workflow so that all parties are aware of their role and responsibilities. The price charged to the client needs to take into account the risk premium plus the cost of the distributor.

4. **Final product design** – using the output from the pricing stage the product design is finalised and such detail as what documents are required to make a claim and what client details are required at the policy formation stages by the insurance company are negotiated. The final product and its associated workflow are then presented to all stakeholders for their agreement. An operations manual for use by staff can be scripted using the workflow as a guide.
5. **Systems** – the product workflow needs to be used to specify the MIS requirements and these need to be incorporated into the distributor's system. The MIS must be able to track premiums received and the claims process as well as report to the insurance company as required.
6. **Staff training and pilot test** – using the operations manual a suitable staff training module can be designed which covers aspects of how insurance works in general as well as the specifics of the product to be introduced. The staff in turn is responsible for training the clients; marketing material such as handouts and pamphlets assist in this task. Generally the new product should be pilot tested for a minimum of six months before it is launched with reviews of performance during the pilot.

It should be clear that the process starts and is infused with the client's need; however, client need must be balanced against regulatory requirements as well as the insurance company's need as the supplier. There is often a fourth variable that also needs to be considered: the operational reality of the microfinance organization that is distributing the product. Any product must "fit" with existing products and processes at the MFI that is acting as distributor. A great example of this is an MFI that wants to sell endowment life policies with a term of ten years. The efficient way of collecting premiums is along with the loan repayments but clients rarely want credit over a ten year period and even if they did, there are inevitably times of "loan resting". When the client has no loan the MFI has to collect the

premium somehow and this inevitably requires an investment in infrastructure and personnel which is rarely sustainable. It would have been wiser to design a short term life product that matched the term of the loans provided or develop a method of collecting the premium via a savings account rather than the loan. The point is that whilst client demand is the most important driver, other considerations must also be fully taken into account when designing a new product. A successful product is one that starts with client demand, is modified by other variables but still manages to meet the majority (but certainly not all) of the client's needs when launched.

We have intentionally not made reference in the product development framework above concerning whose role it is to perform each of the distinct tasks. The Opportunity Network made a decision to hire a team of insurance professionals as staff to assist its microfinance partners globally and as a result much of the product development is conducted in-house. Many microfinance organisations will not have access to in-house insurance expertise or even affordable external consultancy and as a result these organisations may need to seek assistance from an insurance company in designing the product. It seems logical that the clients will be better served if the product is designed outside of the insurance company as this will minimise the potential for conflicts of interest.

However, the importance of having an insurance professional involved in the product design process cannot be heavily enough stressed regardless of whether they are in-house, external or linked to the insurance company. As a team we have experienced instances where a product has been designed in isolation of insurance expertise and the product has inevitably been illegal, immoral or financially unsustainable (and in some cases, all three).

COMMON FEATURES FOR EFFECTIVE PRODUCTS

Whilst it is important to follow through the product development framework, there are some common features or attributes that have emerged during our work of implementing micro-insurance products in ten countries over the last four years. It is interesting that many of these attributes can also be found throughout the “best practice case studies” completed by the CGAP working group on micro-insurance (see www.microinsurancecentre.org or the www.microfinancegateway.com websites for a full listing of these case studies).

1. Product simplicity – over the last thirty years there has been a steady move from single peril coverage toward comprehensive coverage offered by insurance companies. Rather than compete on price, insurers have chosen to protect earnings and compete on coverage instead which is why your household policy today covers everything from your belongings to your liability for damage to employees or social visitors as well as legal protection.

Whilst this has benefited consumers in the developed world it presents a first-time insurance buyer in the developing world with a problem. Not only do most potential clients not understand insurance, but the coverage and its conditions can be overwhelming. As a product designer for the low-income market, the challenge is to convince the insurance company to simplify their products back to the essential coverage. There are a myriad of reasons for insisting upon this:

- a) A simple product with less coverage is easier to explain and has fewer conditions to explain to staff and clients than a more complex product.

- b) Fewer conditions mean that the claims process is easier and quicker to administer. This reduces the transaction cost and increases claims payment speed.
- c) A simple product is easier to understand and if a client understands the product then they are more likely to be satisfied with it. A complex product that performs as intended can still leave a client dissatisfied as they did not know what outcome to expect.

By way of example, most insurers are willing to cover total permanent disability as a rider on a life insurance policy for a minimal premium. Whilst it might seem like a good idea to secure “free” cover for a client for the peril of disability it is notoriously difficult for a poor person to secure the formal medical records required to make a claim. In one case, it would have cost the client more to secure the doctor’s report than the value of the payout. The end result is client dissatisfaction as the whole community becomes aware that an individual is disabled and that the insurance has failed to payout – this kind of negative publicity can have a huge effect on what was otherwise a functional life insurance product.

Other examples include insurers offering a reduction in the premium if existing illnesses are excluded or if they are excluded for a defined period (sometimes referred to as “contestability”). Whilst the reduced premium may be attractive it is hard to explain this exclusion to clients and even harder for them to prove that they were unaware of the illness upon making a claim because the poor rarely have access to formal medical records. This type of condition is relevant for the CEO taking out a high value policy, but it is simply irrelevant for a poor farmer seeking a \$500 life policy. The burden of proving the illness is simply not worth it for the client or the insurer and so it is better to simplify the product and simply have all causes of death covered.

It has been interesting observing insurers in sub-Saharan Africa try to exclude HIV and AIDS as causes of death, gradually coming to the truth that hospitals do not list AIDS as a cause of death on death certificates. Most insurers have now priced coverage for AIDS into their coverage and simply cover all causes of death. There simply is not enough of a margin on a micro-insurance policy for the insurer to check up on the cause of death so it is better to just price it into the product.

2. **One price fits all** – in a similar vein to keeping the product simple, it is advisable to try and secure a single price for a product regardless of the sex or age of the client. In life insurance it is typical for insurers to use different rates to reflect the age or sex of an individual seeking coverage in accordance with expected mortality. Trying to explain this to clients and have loan officers' use the rating tables inevitably leads to mistakes and confusion.

By using a group policy and keeping the sum insured low often it is possible to use the average age and demographic for the client group and convince an insurance company to provide a single rate. This is desirable as it is much easier to administer and explain to clients.

Whilst the example given relates to life insurance the concept also holds true for property or healthcare insurance where insurers often take location or age respectively into consideration.

3. **Choose the correct distribution mechanism** – the margins involved in selling a policy with a monthly premium of between \$1 and \$2 mean that it is currently impossible to sell insurance directly to individuals; they have to be grouped somehow to provide an economy of scale. (Note: We say "currently" because it is possible that advances in technology will permit new methods of distributing financial services which will reduce transaction costs to a level that permit sale of very low cost insurance to

individuals). This is why the MFI has proven to be such an important link in the provision of insurance to the poor as they group together a large number of the poor and have an existing infrastructure that can be leveraged. The weakness is that the insurance product has to fit within the products being offered by the MFI. Most MFIs provide credit, but some do also provide deposit accounts to their clients.

A savings account is a much better vehicle for the collection of premium than a loan because loans tend to be for shorter periods of time and savings accounts provide a very cheap method of collecting premiums on a monthly basis. One of the criticisms levelled at micro-insurance by the clients when linked to the loan is that clients want to purchase the cover even when they do not have a loan, as bad things happen regardless of whether they have a loan.

For those MFIs that do not have the ability to collect clients' savings, the option of providing cover between loans will require additional infrastructure in order to collect premiums and administer the product. Care should be taken to ensure that this is financially sustainable and in line with the organisation's mission.

4. **Compulsory or voluntary products** – it is understandable that donors place pressure to see products being sold on a voluntary basis as this would appear to be most in line with providing choice to clients. The reality is that it is much cheaper to provide micro-insurance on a compulsory basis.

In 2002 when CETZAM launched its "Ntula" funeral benefits insurance in Zambia the product was compulsory except for those clients served by the branch in Livingstone where the Trust Bank Group was free to decide as a group whether they wanted insurance. Initial take up was just in excess of 20% of the client base, but the loss ratio; the ratio of premiums

to claims, was severely affected. For those branches with compulsory insurance the loss ratio was around 60% whereas in Livingstone the loss ratio was in excess of 400%. Claims paid outstripped premiums by four times because when given the choice only the groups with sick members of families opted to buy the insurance. This is termed “anti-selection” and the effect is inevitably to significantly increase the price for those that need the insurance most.

Over time clients see the benefits of insurance as families from their community are affected and receive claim payments. The most dramatic example of this is in the Philippines where Opportunity International’s partner, TSKI reported that one of the main reasons clients gave for joining their credit program was to gain access to the compulsory insurance.

If a significant number of clients can be reached (in excess of 200,000) then it is possible to offer insurance on a voluntary basis without the loss ratio being adversely affected. For most MFIs this scale of outreach will not be possible and as a result it is recommended that products be implemented on a compulsory basis. In addition to the negative effect on pricing, a voluntary product also requires additional investment in systems to ensure that the MFI is able to track who is due to pay premiums as well as who has paid premiums in order to determine which clients and their families are covered and which are not.

PRODUCT DESIGN LEARNINGS

In addition to the general product features listed above, it is helpful to consider specific issues that relate to different product lines.

1. **Credit life** – whilst credit life is perhaps the simplest and most common product offered by MFIs there is a surprising amount of variation that can be achieved. Credit life is purchased to protect the lender against the

death of the borrower; it does benefit the family of the borrower, but only indirectly.

- d. **Flat or declining balance?** Credit life can be purchased either on a flat or declining balance basis and experience has demonstrated that flat balance works best for a microfinance portfolio. Flat balance provides coverage for the disbursed loan principal for the full term of the loan, regardless of how much is paid back by the client. Declining balance provides coverage in accordance with the loan repayment schedule. Experience has demonstrated that in many cases the client becomes sick, falls into arrears and then dies. If coverage is on a declining balance then the insurance company pays the value according to the repayment schedule on the day the client dies which inevitably leaves the lender with a deficit. Whilst flat balance is slightly more expensive, the lender is guaranteed to always be able to cover the outstanding loan regardless of whether the loan is in arrears on the date of death. This simplifies the transaction as the borrower and lender know that the loan is always covered when the client dies.

- e. **What to do with the surplus?** By arranging cover on a flat balance basis there will normally be a claims surplus. For example, if a client with a \$100 loan dies having paid back \$80 then the MFI receives \$100 from the insurance company and is left with a surplus of \$80 which can be used to repay any accrued interest and late payment fees. When Opportunity International MFIs first introduced flat balance credit life they would refund any claims surplus to the bereaved family. However, there were instances where within a group one client died early in the loan cycle and so the family received a small payout and one client died at the end of the loan and the family received a much larger payout. Such “discriminatory” behaviour in the eyes of the community was

unacceptable as it appeared that the MFI was placing a differential value upon the lives of the clients. The unexpected payout to the family was also seen as “charity” and the MFIs were besieged with relatives seeking a hand-out. A decision was taken to retain any claims surplus in a fund and to use the fund to run periodic trainings within the community on a range of issues from HIV / AIDS to book-keeping classes.

- f. **What to cover under credit life?** In some countries insurance companies will offer a range of coverage within a standard credit life policy. These include disability as well as terminal illness. Experience has shown that these add-ons are often difficult to claim under for either the client or the MFI. It is easier and cheaper to just purchase cover for death in our opinion.

- g. **How to collect premiums?** Premiums can be collected in a variety of ways, but the favoured approach is to load the cost into the interest rate charged on the loan. The advantage of this approach is that the client can be told of the benefit of the product rather than insurance has been purchase by the lender on his or her life (which is often daunting for a borrower). The disadvantage of loading the interest rate is that it can make the loan less competitive and the MFI must finance the premium as the insurance company often wants to be paid upfront and by collecting through the interest rate the MFI is exposed to non-payment via loan default. The alternative is to seek an up-front fee from the client for credit life but clients inevitably take the fee from the disbursed loan which means they have less working capital and are hence less likely to be able to repay the loan.

- h. **Extensions** – It is worth negotiating with the insurance provider to allow automatic extensions to the credit life policy in the event that

the borrower is in arrears and the loan remains active past the maturity date. If the client dies after the maturity date then the MFI is not covered normally. By arranging an automatic extension clause an additional premium can be paid for the remaining period (i.e. until write off).

- i. **Medical questionnaires** – Most insurance companies have a limit under which medical examinations are not required. However, a lot of insurers still insist upon a medical questionnaire to be completed by each client. This can be very burdensome for an MFI and it is worth negotiating with the insurance company to remove this requirement if at all possible.
2. **Term life** –often referred to as “funeral benefit” insurance; this cover is designed to pay a benefit upon the death of the client and is sometimes extended to include spouse, children and even parents.
- a. **Make premiums affordable** – the best way to make premiums affordable is to collect them regularly. Typically premium collection on a monthly basis is the best solution for client, MFI and insurance company.
 - b. **Consider the term as a month** – if the premium is not linked to the loan then you should expect that some clients will purchase insurance for the shortest possible period. If premiums are collected monthly then the product should be viewed as a monthly renewable term contract; if the client pays at the start of the month then they have coverage for that month and so on. Too often the product is sold annually and premiums are collected monthly which may not fit in with seasonal income flows of the target market and can lead to stress in trying to collect premiums that are late.

- c. **Anti-selection** – Opportunity partners have used two approaches to reducing anti-selection. Firstly, the product can be made compulsory for all borrowers although this is only advisable if the product is only to be offered to borrowers. Secondly, a short “waiting period” can be introduced, typically two weeks or one month. The waiting period can also be used to discourage lapses as a client should be educated that if they miss a payment they will have to undergo the waiting period when they start paying premiums again. It is critical that the waiting period is long enough to discourage those that seek to abuse the product but short enough to not be seen as prohibitive.

- d. **Make it easy to make a claim** – the best way to drive up administrative cost and ensure that your clients are dissatisfied is to have elaborate claims verification processes. Negotiate with the insurance company to ensure that the documentation that is required is going to be available from the client base. If an insurance company wants a copy of the birth certificate but the low-income clients do not have the documents then they will not be able to claim and the clients will focus their dissatisfaction upon the MFI, not the insurance company. By making the products simple (i.e. you are dead then we pay) and reducing the scope of coverage (it is hard for a loan officer to assess if someone is sick, but easy for them to see that someone is dead) costs reduce and satisfaction increases.

- e. **Minimise the number of exclusions** – find out which exclusions the insurance company cannot delete and negotiate to remove any which do not apply. Clients find a long list of exclusions to be hard to understand.

Effective term life insurance: TSKI, Philippines

Taytay Sa Kauswagan Inc or "bridge to progress" was established on 1st September 1986 and is registered in the Philippines as a non-stock, non-profit Christian development organization based in Iloilo City. In 2004 TSKI along with other members of the APPEND network approached Opportunity to develop a new life insurance product to replace the in-house "Mutual Aid Fund".

In order to design the new product, quantitative and qualitative market research with clients from APPEND partners was conducted during June with 782 clients from OMB, TSKI, ASKI, HSFPI, RSPI and DSPI. The main findings of this research were as follows;

1. The average family size was five; being two parents and three children
2. Almost all respondents wanted life insurance for the whole family
3. Analysis of incomes demonstrated that respondents were living on or below the "poverty line" defined as \$1 (PHP55) per day per person
4. Half of the respondents estimated that the cost of a funeral was less than PHP35,000 (\$636)
6. 15% of respondents indicated that they had experienced a death in the family in the past year
7. Respondents wanted to receive a benefit upon death of PHP100,000 (\$1,818) for themselves; PHP60,000 (\$1,090) upon death of their spouse and PHP50,000 (\$909) upon death of a child
8. 41% of respondents were willing to pay between PHP50-P75 (\$0.9 - \$1.36) per month for funeral insurance; 59% were willing to pay more

These market research findings were used to design a product which was tendered to a range of local insurance companies. The final product was launched with the following features:

Coverage: Losses arising from death only. Covers client, spouse and maximum of three children or parents if client is single. Compulsory for all borrowers.

Term: Insurance term linked to the loan term, being six months.

Benefit: PHP 100,000 paid upon death of client, minus any outstanding loan; PHP 50,000 upon death of spouse and PHP 25,000 for death of child or parent.

Age / health limitations: Client 18-65; Parents less than 65; child 6 months to 21 years but must be living at home. All must be "in good health and performing normal duties", but no medical check or questionnaires.

Premiums: Calculated as PHP 1.06 of the sum insured for six months paid to Insurance Company and PHP 90 administration fee paid to MFI per loan cycle regardless of number of people covered.

Contestability: No claim contestability for existing illnesses, but one year contestability for suicide.

Documents required to claim: Death certificate, birth or baptismal certificate and claim form.

To date the product has also been implemented at Opportunity Microfinance Bank (OMB) and KMBI as well as TSKI in the Philippines. At the end of 2005 there were in excess of 260,000 active policies with 1,349,000 lives insured.

3. **Endowment (long-term life) insurance** – the key difference between an endowment and a term life policy is that the former offers an investment return so if the policyholder survives the term of the policy then a lump sum is paid upon maturity. An endowment policy has a period of typically between 5 and 25 years compared to a term policy that is normally an annual policy. The added length is required to enable an investment return to be realised on the premiums. Endowment insurance

is popular in some countries including India and some Eastern European countries.

There has been a vigorous debate amongst practitioners about the role of endowment insurance for the poor. Its detractors point to a number of shortcomings in the product as applied to the low-income market such as:

- a) **Effect of inflation:** in many developing countries the high inflation rates over a five to twenty-five year period that the endowment is in force mean that the maturity value of the policy is significantly eroded. This inevitably leaves the client dissatisfied as he is not able to purchase the large capital item he had hoped to purchase when he first took out the policy. There are numerous examples of people paying into a policy and hoping to buy a house in twenty years time and when the policy matures the effect of inflation means the payout will not even purchase a bottle of Coca-Cola.
- b) **Concerns over mis-selling:** there is concern that this type of insurance is sold by enticing the client with the maturity value in today's values rather than providing the client with a projection of what that maturity value would be worth in today's money after the effect of inflation. This comes about due to lax consumer protection laws in many developing countries.
- c) **Seasonal incomes:** the poor do not have a steady income flow yet the monthly premium payments must be made or else the policy will lapse and the client may lose all of his premiums. Some companies have provided grace periods to allow for this seasonality in income flow, but there is some concern that the on-going burden to pay premiums leads to a high lapse rate amongst the poor making endowments an unsuitable investment vehicle for them.

d) **Difficulty in collecting premiums:** as with any micro-insurance, the costs lie in collecting the premiums. It is typical for intermediaries selling endowment policies to be remunerated significantly in the first few years of a policy and as the client becomes used to paying premiums the commission's tail off as the client makes premium payments at the insurance companies' offices or via direct debit from a bank account. Intermediaries' remuneration is often stipulated by the industry regulator and this can mean that the intermediary makes it hard for a low-income client to make premium payments after the first few years as the agent is no longer receiving commission income and the low-income client does not have physical access to the insurers' office or a bank account. Clients simply give up trying to pay premiums and the policy is surrendered as it is too hard or too costly to make the payments.

In contrast the proponents of endowment insurance point to the fact that the product is sold voluntarily and that this is simply client demand being demonstrated. They also argue that endowment policies provide an essential savings mechanism for the poor who often lack access to a formal bank and are more likely to have access to a life insurance salesman than a bank account. It would seem best to de-link savings and insurance. In a perfect world the banks would mobilise an agency network to collect savings and the insurance companies would protect against risk (mortality), but in reality few banks are reaching the rural poor – hence the continued demand for endowment policies as a method of saving.

4. **Property insurance** – typically demand for property insurance is low due to there being a lack of awareness of the risks posed as well as a low level of legal ownership of land and buildings without which it is hard to provide cover. The requirement by some lenders for secured loans for property

insurance to cover the collateral requires a product to be established with a friendly insurer that is willing to accept items in bulk with premiums paid monthly.

- a. **Ownership** – it is critical to establish what proportion of clients actually own the building (home or business premise) that is to be insured. It is difficult to cover the building if the client does not own it. Title deeds will also be required, so it is imperative to check what percentage of owners have these documents prior to launching the product.
- b. **Building material** – insurers will normally only cover buildings constructed from brick or concrete with a roof that is NOT thatch. Research should be conducted to see if this is applicable to the client base.
- c. **Group policy** – whilst it is often difficult to purchase cover for contents only, the likelihood of it being offered increases if the premium volume on the policy is maximised by using a group policy.
- d. **Reduce costs by reporting monthly** – agree with the insurance company that a schedule of items will be submitted at the end of each calendar month along with a single premium payment.

Effective property insurance: CETZAM, Zambia

CETZAM is a non-government organization (NGO) headquartered in Lusaka, Zambia. CETZAM was founded in 1995 by a group of Zambian business leaders committed to fighting poverty through micro enterprise development. In 1996 Opportunity and CETZAM formed a partnership with the aim of CETZAM becoming a sustainable, formal, regulated financial institution providing microfinance services to the economically disadvantaged of Zambia.

In September 2002, CETZAM opened a new branch in the capital city Lusaka. The group lending market was already saturated and so a decision was made to offer individual loans. The new individual loan product required collateral in the form of either buildings or contents and CETZAM realized that most of its clients did not insure their belongings.

The fact that the collateral could be damaged, destroyed or stolen was a concern to management and a decision was made to implement property insurance to protect the collateral. A fixed rate for building and contents was negotiated with Madison Insurance Company and the cost of the insurance was loaded into the interest rate of the individual loan. The effect on the interest rate charged was an increase of 0.25% flat per month.

The Insurance Company required that CETZAM submit a schedule of collateral covered under this binding agreement at the end of each calendar month. The schedule includes details of the property insured that month along with a calculation of the premiums due. The sum insured used for the insurance is the full value of the property even though CETZAM lends based upon a percentage of the collateral's value. In effect the property is over-insured as far as CETZAM is concerned but this guarantees that CETZAM will receive full repayment of the outstanding loan and interest in the event the

property is damaged even taking into account the deductible (co-payment) that is due for each claim.

The product has been popular with clients as they do not like purchasing insurance and are happy for CETZAM to do it on their behalf and the clients have recognized that the rate charged is much lower than if they had to purchase the insurance themselves as a group volume discount has been secured by CETZAM.

5. **Health insurance** – the provision of health insurance has always provided the greatest challenge in micro-insurance because it requires not only an insurance company (or suitable risk vehicle), but it also requires a willing network of clinics and hospitals to provide consultations and dispense drugs.

a. **Adequate systems** – the sheer volume of claims that a health insurance scheme has to handle means that the majority of its costs will lie in administration. Investment in a suitable system will not only reduce fraud but also transaction cost. Being able to reduce the time it takes to refund clinics for their costs will also be important in ensuring that the scheme has willing medical partners.

b. **Adequate controls** – fraud will always be a significant problem for health insurance programs. Due to the number of claims that each individual can make over a year it is essential that controls are in place to check that the correct person (and not a relative) is receiving treatment. Fraud can also come from a clinic over treating patients or over-charging for treatments as the clinic has an interest in boosting its income. The only way to overcome fraud is to invest in a suitable MIS system that includes client identification and provides oversight of each clinic's activities. Those that favour

the mutual model would point to social intervention as being the best control on fraud by making the community responsible for its own control (but this does by definition limit the potential scale).

- c. **Anti-selection** – if steps are not taken to reduce anti-selection then the effect on the loss ratio can be severe as clients buy the insurance when they are sick and stop paying when they believe they have been treated. Some ways of reducing anti-selection for healthcare insurance include;
 - i. **Waiting periods** – this is a fixed period from the start of the insurance where the client is not allowed to make a claim or is restricted to emergency treatment only (i.e. not for existing illnesses). The reason for a waiting period is to stop a client from joining the insurance to get treated for an existing illness. They are also effective at reducing drop-outs as clients know they have to endure the waiting period if they stop paying and wish to re-join at a later date.
 - ii. **Co-payments** – this is a fixed sum or percentage of each claim that the client has to pay. They are effective at ensuring that clients only seek medical assistance when they really require it but the downside is that the client may not be able to make the co-payment and as a result be excluded from treatment for which they qualify. Co-payments also require the clinics to handle cash which introduces a new potential for fraud.
 - iii. **Group schemes** – by requiring a whole group, such as a village or a borrowing group to purchase health insurance together the insurer can be sure to get a cross-section of

well and sick clients. This does require additional coordination.

- iv. **Minimum periods** – it is standard for health insurers to want clients to purchase a minimum period of insurance to ensure that clients do not join, get fixed and then leave. This is normally a year’s premium which can be impossible for a client to pay upfront.

- d. **Customer service** – is essential for all products but especially for healthcare due to the large numbers of claims that any one individual is likely to make during the course of the policy. For those health insurers that have put their own staff in the clinics with which they partner it is essential that these representatives provide excellent customer service and that the clients feel as if they are getting access to the services for which they have paid in a timely fashion. Failure to do this will result in high levels of client dissatisfaction and client drop-out.

Effective health insurance: Microcare, Uganda

Microcare is a unique business initiative to deliver affordable access to quality health care in Africa. Built on a creative multidisciplinary team approach, Microcare combines commercial insurance and health care management expertise with a custom made database system that enables ordinary people to obtain reliable healthcare through micro-insurance.

The Microcare system allowed Aon to grow its health management business rapidly. In 2004, having successfully obtained support from the DfID funded Financial Deepening Challenge Fund, the decision was taken to transform Microcare into a commercial health management and insurance business. Aon took on the role of supervising this transformation and handed over its

own health management clientele to Microcare in July 2004. In December 2004 Microcare became a licensed insurance company in Uganda.

Microcare contracts quality health service providers, both private and government. The private clinics and hospitals are either not for profit 'mission' hospitals or for profit clinics owned and managed by an experienced doctor. By supplying a regular stream of patients, whose treatment will be paid for on time, Microcare is providing a reliable cash flow to the health service providers enabling them to maintain high quality services. This also allows the providers to plan ahead and expand. Through this relationship Microcare can define expectations regarding quality of care and negotiate prices with the service providers which, ultimately, translate into savings on premiums for clients.

Microcare is a data driven organization and strict systematic controls are critical, both to capture accurate information and successfully prevent fraud and abuse. Client identity verification is achieved by two means: firstly the client's photo and general profile is accessible from the Microcare database and secondly each client carries a Microcare smart ID card which has their photo and details printed on it.

At each of the main contracted health service provider hospitals and clinics there is a Microcare nurse running a computerized check-in desk. Each check-in desk is networked to the central office database. When clients presents themselves they must first show their ID card for swiping by the Microcare nurse who visually confirms their identity against the photo on the ID card and the picture on the database and then checks validity of entitlement and coverage against the database records.

After being examined by the clinician the client must return to the check-in desk to have the transaction details recorded including the clinician's name, the diagnosis, any tests done and all drugs prescribed. Once these details are

captured in the database a medical treatment access card (MTAC) is printed in triplicate.

This control results in substantial savings in claims which ultimately translates into more affordable premiums. It also enables clinical audit, where the performance of individual clinicians can be assessed and quality of service ascertained. Finally this control system provides the actuarial data and the assurance of cost containment necessary to secure the support of leading international re-insurance companies.

As a health insurer with established groups of long term clients Microcare is committed to prevention, both as a means of claims reduction in the long term and as a beneficial service to clients. Malaria and HIV AIDS have been the principle diseases targeted in the first year of operation of the preventive health department. To control malaria Microcare distributes insecticide treated mosquito nets to clients on renewal. To deal with HIV/AIDS Microcare has already brought a number of client groups through HIV awareness, voluntary counseling and testing leading to commencement of anti-retroviral therapy for those clients who need it. Presently Microcare is piloting health insurance that includes HIV anti-retroviral treatment.

6. **Crop insurance** – is essential if micro finance is going to have a significant impact in the rural economy. Lenders are understandably nervous about lending to those in the rural areas, especially small-hold farmers, due to the climatic risk and its potential effect upon loan repayment. Yet rural clients make up the majority of the World's poor so finding a way to reduce risk and hence facilitate lending to these regions is important.

Due to the small sum insured, and hence small premiums, it is not cost effective for an insurance company to send a loss surveyor into the rural

area to judge if a claim is payable. In order to overcome this, weather derivative products have been developed which use an index such as "rainfall" or "gate-price" to judge whether a farmer or group of farmers is due a pay-out. Crop insurance is notoriously difficult to put into place due to its technical complexity; generally the following range of requirements is needed in order to implement a product:

- a. **Willing risk carrier / insurance market** – in some of the largest or most developed insurance markets it is possible to find insurance companies that are willing to offer crop insurance; but in the majority of countries the insurance companies view crop insurance as high risk and most refuse to offer terms. The first task is therefore to convince an insurance company or group of insurance companies in a country to consider offering coverage. If this is not possible then it may be necessary to establish a specialist vehicle such as a "Protected Cell Company" to carry the risk (Protected Cell Companies are covered in a later section of this document).
- b. **Qualified actuarial input** – this is essential if the products pricing is to be sustainable. The input of a qualified actuary with experience of crop derivatives is an essential step.
- c. **Historical data set** – reliable historical data on the index to be used is an essential for any index to be established. If the index is to be weather (normally rainfall) then a minimum of 30 years of data is required. The alternative to using weather as the index is to use "gate price" which is the price the farmer receives for his crop.
- d. **APEX farming body** – such as the "small-hold farmers union" or its equivalent. The APEX body is essential in negotiating and communicating with the farmers as well as providing useful inputs

such as being the vehicle for distribution of seed and other farming input for which the farmers take out their loans.

- e. **Local project management** – the complexity of the product and the number of stakeholders (lender, insurer, farmers union, clients, farming supplier, government agency, etc) requires able project management skills in order to ensure that the product is sold to the farmers in the narrow window prior to the planting season starting.

Effective crop insurance: the case of Malawi

Opportunity International was contracted in 2005 by the World Bank's Commodity Risk Management Group (CRMG) to project-manage its first African micro-weather index based insurance in Malawi. Research findings revealed that most farmers could not get agricultural funding from local banks but the same banks were willing to lend if the weather risk could be reduced. The World Bank saw this as an opportunity to use weather index insurance to promote agricultural lending.

The pilot test which Opportunity project-managed had NASFAM (National Smallholders Farmers Association of Malawi) as the APEX organization, Opportunity International Bank of Malawi (OIBM) and Malawi Rural Finance Company (MRFC) as the financiers, Insurance Association of Malawi as the insurers. A total of 892 farmers who belong to NASFAM were provided with loans for high yield certified groundnut seeds. Each farmer received 32 kg which is enough for a one acre piece of land. The cost of seed was paid for by Opportunity international Bank of Malawi for those farmers in Lilongwe and Chitedze, and by Malawi Rural Finance Company for those farmers in Kasungu and Nkhotakota regions of Malawi.

The sum insured, which is about \$50 per farmer, includes the cost of seed, interest and insurance premium. If there is a drought as defined by an

agreed index which is measured at a specified weather station, the insurers will make a partial or full payout to the bank. This will reduce the loan amount due from each farmer. In cases of good rains, the farmers will be required to sell all their produce to NASFAM. NASFAM will first pay the bank its dues before paying the farmer.

Since this insurance makes payouts based on rainfall figures recorded at a weather station, it is important to ensure that farmers are as close as possible to the respective weather station. Consultations with farmers and agricultural extension services revealed that farmers within 20-30 km of the station would experience the same rainfall patterns. Thus the pilot only insured people who are within 20km of the station. This is done to reduce basis risk. It is important to note that because of basis risk, this weather index insurance is meant to make payout in cases of catastrophic weather conditions, which are likely to affect a large geographical area.

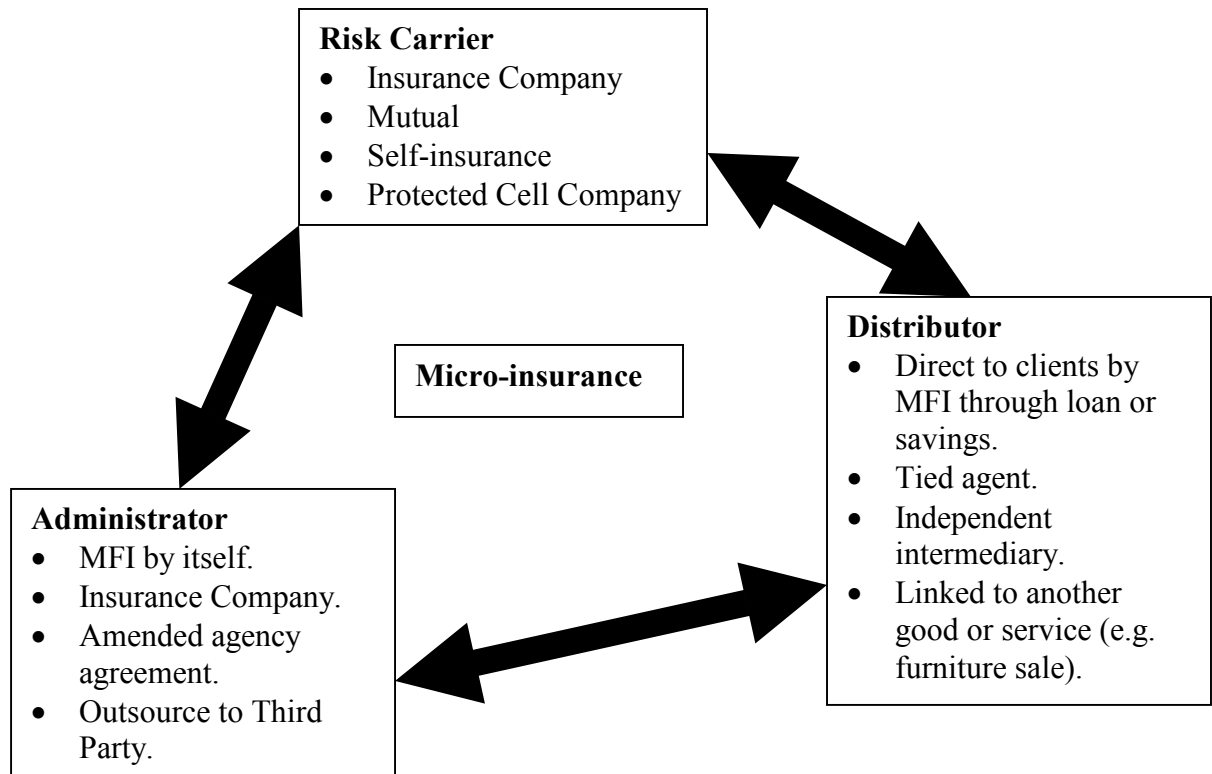
These contracts cover the crop's growing season, which is about 120 days. They are divided into three phases each mirroring the crop's growth stage i.e. vegetative growth, flowering and pod formation, pod filling and maturity. Each of these phases has different rainfall requirements and if the amount received is lower than required for the crop's survival, a payout is triggered.

EFFECTIVE ORGANISATIONAL STRUCTURES

The two most frequently used models employed in micro-insurance are the mutual model and the “partner-agent” model. Under the mutual model a single organisation is responsible for the design and distribution of a product to its own client base; the mutual itself carries the risk associated with the product. In contrast the “partner-agent” model uses a licensed insurance company to carry the risk and provide input on the product design and the “partner”, normally a Microfinance Institution (MFI), provides access to the clients.

A significant amount of material has been written about the relative benefits of these two approaches and it is not our desire to contribute to the debate about which method is most suitable. It is our experience that there is normally more than sufficient supply of underwriting capacity for classes such as life, property and casualty from formal insurance companies. There is an under-supply of healthcare insurance globally and the mutual model provides a risk carrying mechanism for making these products available in many countries.

The point is that in most countries there exist suitable carriers of risk whether insurance company or mutual, yet still the poor have limited access to suitable products. The challenge is to shift from only considering the risk carrier to considering all parties that are required to provide the poor with access to insurance. By breaking down the supply chain into three definable segments, *viz.* risk carrier, administrator and distributor, we are able to consider the possible alternatives and to expand upon the possibilities away from simply a view of the partner-agent or mutual model as providing the only options for micro-insurance.



1. Options for Risk Carriers

The most commonly used risk carriers are insurance companies and mutuals, but there are alternatives to these two well-documented options.

Risk carrier option: Self-insurance

Perhaps the most commonly considered alternative is self-insuring where the organisation (e.g. MFI) establishes the product features and pricing, collects the premiums into a fund and pays claims from the internal fund. This is not considered to be an advisable solution for a number of reasons.

- a. **Lack of expertise:** The majority of organisations serving the poor do not have easy access to insurance expertise required to calculate premiums or reserves—a complex business requiring actuaries. This lack of expertise is further exacerbated when these

organisations try and purchase reinsurance to reduce their potential downside in the event of adverse attritional or natural catastrophe linked losses.

- b. **Leads to a poorly designed product:** The result of an organisation self-insuring is often a poorly priced product that either provides poor value for money to clients or loses money for the organisation selling it; normally an MFI. Those organisations that do manage to calculate a rate that generates a profit are often unable to avoid the temptation of raiding the fund at the end of the financial year. The result is that no reserve is built up for “incurred but not reported” (IBNR) losses or to cover potential future losses arising from catastrophes such as natural disasters or disease epidemics or for a worsening trend of losses such as those generated by the spread of HIV / AIDS.

- c. **Regulation:** The final reason that organisations should not self-insure is that it is often illegal or if not illegal it falls into a grey area of the law. In order to carry risk in most countries, the organisation must comply with the Insurance Law. With the current trend of Governments to regulate the micro finance sector, those that are self-insuring contrary to the regulation are running ever-increasing levels of institutional risk.

Risk Carrier Option: Protected Cell Company

In cases where a micro-insurance product is not available, the pricing is adverse for the client or the required level of customer service is deemed to be lower than the market expects, then there is an option of establishing a Protected Cell Company (PCC).

A Protected Cell Company (PCC) transacts insurance by using the host’s capital and regulatory status; policies are issued in the name of the

registered host insurance company. A management contract is drawn up between the host insurer and the PCC owner whereby a management fee is paid to the host by the owner in recognition of the cost of capital and as a “rental” for the licence required to transact insurance. The owner of the PCC is entitled to determine the terms and conditions of the insurance products that are provided to clients of the PCC, and can therefore determine the pricing of any product as well as the service standard, for example the speed of claims payment.

The PCC transacts its own products and at the end of the year any profit or loss that is made is the responsibility of the PCC; if the products are incorrectly priced then the owner, in this case an MFI, would end up having to fund a loss from its loan portfolio. In most cases, the insurance company would help the PCC to secure stop-loss reinsurance so as to limit the financial downside of any underwriting loss in a given year.

Whilst the PCC has benefits over the self-insuring option because it is legal and taps into the expertise of a friendly insurance company who may assist in establishing pricing and reinsurance cover, it also shares some of the downsides of self-insuring. The most significant downside being that any underwriting loss experienced over a period must be funded by the owner of the PCC.

In addition to facing the difficulties of purchasing reinsurance and the potential for making a financial loss, the owner of the PCC must have access to insurance expertise on a regular basis in order to manage the PCC and establish suitable rates to charge in relation to the risk. Without this expertise it is unlikely that an insurance company would be willing to consider establishing the PCC and as a result the number of organisations for which establishing a PCC is a viable option is limited.

2. Options for administrators

Typically the work load associated with the administration of insurance products can be broken down into two key stages: firstly there is policy formation where the client must complete an application form and pay a premium and secondly there is a claims process where details of a loss need to be recorded and the benefit paid to the claimant.

Administrator option: Amended agency agreements

The test of an insurance product for a micro entrepreneur is the speed at which claims are paid and whilst efforts are made to educate clients about the involvement of an insurance company it is quite common for clients to blame loan officers when claims are paid slowly. Whilst insurance companies take steps to reduce the waiting times for claims payment, it can often take a number of weeks to process a claim. When this processing time is added to the time that it can take for a client to gather the required claims documentation and for the MFI to conduct its own administration, it can take quite some time from the date of death until the date of claims settlement.

This waiting period has caused client dissatisfaction and a number of MFIs have sought to amend their agency agreements to ensure that the MFI is placed to administer and verify claims as they arise. An example of this is the Christian Enterprise Trust of Zambia (CETZAM) which is a member of the Opportunity International Network. CETZAM pioneered the introduction of funeral insurance by MFIs in Zambia by partnering with NICO Insurance in 2001 to provide the "Ntula Funeral Insurance" product. By May 2002 it was clear from client research conducted by Opportunity International that claims were taking too long to pay and as a result NICO was approached to consider amending the insurance agency agreement.

It was agreed that CETZAM would be empowered to pay claims that it considered to be valid and to offset the claim value from the premiums collected during the calendar month. The documents that supported the

claims were submitted along with the monthly premium report and premium payment and NICO would check the documents to ensure that it agreed with the claims that had been paid. If CETZAM had paid an erroneous claim then NICO would demand repayment of the claim value; to date no claims have been refuted by NICO.

The claims settlement speed reduced from two months to less than two weeks as a result of this agreement. In September 2002 market research was conducted with CETZAM's clients and 81% reported that the Ntula product helped them and their families in a time of stress.

Administration Option: Outsourcing

In micro-insurance schemes there are few instances of outsourcing administration. One reason why adding simple insurance products such as credit life constitute such a large part of the global market for micro-insurance is that they are relatively easy and relatively cheap to administrate. Such relatively simple products rarely motivate management to consider the costs and benefits of outsourcing some or all of the administration of the product.

When the product becomes more complex, for example health insurance, then the case for outsourcing needs to be assessed. There are also instances where a single administrator acting on behalf of a number of MFIs or other organisations can reduce the cost of delivering insurance to the poor by centralising processing costs rather than each organisation having to set up their own administrative procedures. Third Party Administrators (TPAs) have played a critical role in providing access at reduced cost to the poor in South Africa.

Health insurance typically involves a relationship with a health service provider. This relationship, among other factors, introduces costs and new administrative burdens, for example ensuring that the health provider is not

defrauding the scheme. Health insurance schemes often outsource part of their administrative operations to a professional third party administrator (TPA). By specialising, TPAs are often able to lower the overall administrative costs and this saving can be passed onto clients.

3. Options for the distribution of products

The large number of clients that currently purchase micro-insurance gain access through the financial organisation with which they have an existing loan or savings account, and the majority of these clients have loans rather than savings accounts. Whilst this approach has significantly reduced the transaction costs associated with providing insurance, it has limitations because clients can only gain access to insurance whilst they either have an active loan or a savings account and clients require access to insurance over different periods than say a loan period.

In principle there are a multitude of options that could be used for the distribution of an insurance product to a low-income household, some of which would include the following:

- Retailers – for example a chain of supermarkets that collect premiums at the checkout.
- Workers Unions & Cooperatives – premiums could be collected from dues paid.
- TV / Direct sales – advertise products directly to the customer.
- Cell phones – using the cell phone infrastructure to gather premium payments.
- Burial societies – use the informal societies to sell a regulated product.
- Worksite marketers – sell products to low-income workers during lunch breaks.

Whilst some of these methodologies may work in countries with higher than average infrastructure and incomes, the reality is that many developing countries do not have the required infrastructure or required levels of client education to implement such methods of distribution. So what alternative forms of distribution have been used in the micro-insurance sector?

Alternative distribution: Micro-insurance agents

A current example of a system of micro agents can be seen in the case study of TATA-AIG in India. In this model, Tata-AIG obtains recommendations of NGOs that have a good relationship with the local community in the area in which it wishes to sell micro-insurance. TATA-AIG develops partnerships with these NGOs. In return for a consulting fee, the NGO provides suggestions on members of the community who could be good agents for micro-insurance policies: the micro-agents. If these are accepted, they are then asked to form into groups of peers. The group, referred to in the TATA-AIG model as a CRIG (Community Rural Insurance Group), operates as a partnership.

TATA-AIG helps the group leader obtain an agent's license which requires an investment in training of the individual. The members of the group all sell policies for their own account, but the leader with the agent's license submits the policies and receives an additional commission for the extra work he or she does. The model relies on direct marketing similar to that used by firms such as Tupperware and Avon.

Besides the group approach of the CRIGs, the micro-agent model is also being done on an individual basis. Like the CRIGs, micro-agents tend to be women who are either office bearers of a Self Help Group (a type of ROSCA) or a voluntary worker of an NGO. After being certified, micro-agents are encouraged to source business from the geographical vicinity of their homes, which may extend to 4 or 5 villages depending on the size of the village.

The NGO can do a variety of tasks in this model including aggregating the premiums and sending them on as a single sum to TATA-AIG, allowing the agents to use their offices to conduct business, playing a role in the training of micro-agents, and helping to distribute benefits. The model thus has some additional positive externalities by providing a new income stream for rural NGOs and micro-agents.

Distribution alternatives: Independent micro-insurance intermediaries

Unlike the micro-insurance agents developed by TATA-AIG in the example above, there is an increasing role for micro-insurance intermediaries that are independent of a single insurance company. An independent intermediary could be a corporate or individual partnership structure working on either a local or global scale partnering with a risk carrier (most likely an insurance company).

Whilst the intermediary could be an agent on behalf of a single insurance company or a broker and work for multiple insurers it is most likely that the intermediary would seek to service large groups of clients. The most suitable client groupings are being served by entities that have an existing financial structure, such as MFIs, rural banks and Sacco's. However, groupings such as cooperatives, unions and even religious groups can also be targeted. The benefits that the intermediary brings are as follows:

1. **Product Development:** existing models such as the "partner-agent" or mutual models places the product design in the hands of the risk carrier which is not optimum. An intermediary that can understand the needs of clients, operational reality of the MFI and the needs of the insurance company should be able to design a product that is more suitable for all parties.
2. **Transaction cost:** it is not cost efficient for an individual MFI to develop its own MIS for transacting insurance business. An

intermediary that benefits from a wider client base and global reach can fund such an overhead. Investment in systems reduces transaction cost as does operating efficiencies brought about by serving a much larger client base than a single MFI can reach.

- 3. Administration:** an intermediary is well placed to handle administration relating to claims processing as well as reporting to the insurance company in relation to who is covered and what premiums are due.
- 4. Additional channels of sale:** without systems, MFIs are often unable to offer insurance products to their clients outside of the loan. An intermediary brings the capability to track clients and record who has paid premiums even when a loan is not in force.
- 5. Staff training:** an intermediary is well placed to provide organisations' staff with training in the product and the basics of insurance. This increases financial literacy and ultimately client satisfaction.

Opportunity International has established such an intermediary and in November 2005 the "Micro Insurance Agency" was incorporated. Its first subsidiary was opened in Uganda in January 2006. Its initial product range has been targeted at the microfinance institutions and is based around a package of credit life, funeral, disability and property coverage. There are plans to introduce healthcare products to the products sold to microfinance clients later in 2006. The Micro Insurance Agency plans to open subsidiaries in Ghana, South Africa and the Philippines by the end of 2006.

In addition to targeting microfinance clients, the Micro Insurance Agency plans to sell products to other client groups served by unions, cooperatives and religious groups. In order to reduce transaction costs, Opportunity International has invested in its computer software (Automated Insurance Management System) which is used off-line with the main server being located in the US.

RECOMMENDATIONS ON ORGANISATIONAL STRUCTURES

The intention of this section is not to be prescriptive; these are not the only alternatives to the mutual, cooperative or “partner-agent” model. Rather the intention is to provoke the reader into considering the provision of insurance to the poor as not necessarily being so rigidly restricted to the existing channels that are used of the loan and the loan officer.

If the industry is to reach its full potential then clearly it will need to move beyond just the existing borrowers or savers. There is demand from a much larger segment and from those that are currently not served by a loan. In order to reach these clients we will need to find new ways of grouping them together or ways to reduce the current transactions costs to enable us to sell products to individuals.

Conclusions: Key issues facing the industry

Having learnt lessons in relation to product design and meeting clients needs and having considered the best ways to provide the poor access to insurance, what are the issues that the industry must face in the coming years?

1. Why are the poor not buying?

Swiss Re in its SIGMA publication states that developing countries such as the US spend in excess of 10% of their GDP on insurance premiums. In contrast a country like Bangladesh spends less than 0.5% of its GDP on insurance. Why aren't the poor buying insurance? Whilst simplistic, it seems that the major reason must be a combination of the following:

a. Perhaps the poor do not need or want insurance?

There are plenty of client demand studies that are now available, but when Opportunity International started its insurance project in 2001 with its partner in Zambia the Christian Enterprise Trust of Zambia (CETZAM) there was little industry wide material. However, Opportunity knew that clients had identified that the product they most wanted CETZAM to develop was funeral insurance, perhaps no surprise in a country with a life expectancy below 35 years old.

Market research with CETZAM clients demonstrated that 40% of clients experienced a death in their extended family each year and that the cost of these funerals was equivalent to between three to six months of a family's disposable income. Against this frequency and severity is perhaps no surprise that 87% of CETZAM's clients said that the Ntula funeral product was a benefit to them.

Four years on, Opportunity is servicing over 570,000 active policyholders and 2,700,000 lives – clearly there is a demand.

b. Perhaps insurance companies do not want to provide products for the poor?

Certainly there is sufficient capacity for life and property coverage from existing regulated insurance companies and it has been the experience of Opportunity International in the ten countries implemented so far that insurance companies are interested in providing products to the low-income market. It often takes some negotiation and technical knowledge to convince an insurance company to amend its products, terms and conditions to meet the needs of the poor; but this is an effort worth making. The main challenge has been to simplify products to streamline administration and hence reduce transaction costs.

In the key area of healthcare it is clear that there remains an undersupply of cover in many developing countries from regulated insurance companies. It is into this vacuum that the mutuals have developed most successfully acting as the main provider to the poor.

c. Distribution - a missing link?

If one accepts that the poor want to have access to a range of suitable products and that there are risk carriers willing to provide coverage that meets these needs then one key reason why so few people in developing countries have insurance is that there is no way to bridge the gap between the buyer and the seller. Of course, client education is also a key factor; but like in all markets there are always “early adopters” who recognise a product as the solution to a problem and education comes from both formal as well as informal (e.g. word of mouth).

It would seem that the next challenge facing the industry is to work out how to best expand outreach beyond the microfinance borrowers and savers and to meet the needs of the wider market.

2. Client education

The majority of micro-insurance is sold as part of a loan package and this means that there is little motivation on the part of the loan officer to “sell” the insurance to the client. The insurance is presented as part of the loan and often the client does not even know they have insurance; they certainly do not understand all the terms and conditions.

This lack of understanding not only leads to a low claims ratio, but it also leads to a low level of client satisfaction concerning insurance and the MFI in general as the client believes that they are being ripped-off. Even in

instances where the insurance performs as intended the client experiences dissatisfaction as they did not really know what to expect.

It is common to hear a client complain to a loan officer that they “paid their premium last loan and no one died, so why can’t they have their premiums back”. Without training it is hard (or impossible) for the loan officer to answer such a question because they often do not purchase insurance themselves. Once the loan officer understands that the “premiums of the many have paid for the losses of the few” then she is better positioned to answer clients’ valid questions.

Investing in client and staff education is therefore critical as this will enable staff to better explain to clients how insurance and more specifically the products being sold actually work. This in turn will lead to higher levels of client satisfaction with the product.

3. Health insurance suppliers

As noted earlier in this paper, experience has shown that there is more than sufficient life, property and casualty underwriting supply. However, in many countries there is a lack of insurance companies that are willing to provide medical or health insurance.

There is significant client demand for access to health insurance and whilst the challenges of providing sustainable health insurance are significant, there is a significant market available. The challenge will be to convince a large insurance company with the potential for global reach to enter this market.

4. Crop insurance suppliers

Similarly to health insurance, there is currently a lack of supply in relation to crop insurance; but here the situation is worse as there is no history of

mutual societies or cooperatives providing cover in the absence of insurance companies.

If microfinance is to really reach the majority of the world's poor then a mechanism for reducing the climatic risk associated with lending to rural smallholders must be found. Innovative projects such as that conducted in Malawi under the umbrella of the World Bank provide evidence that it is a possible but significant resource in terms of money and more importantly qualified people are required if these successes are to be scaled up and replicated.

5. Transaction costs

There is clearly demand from a wider segment of the poor for insurance than currently exists for credit alone; yet to date our only mechanism for reaching the poor is via the MFI. Even those clients that currently have a loan have no access to insurance in-between loans. The models that we are currently using restrict us to dealing with large groupings of clients; the transaction costs are too high and margins too low to consider selling insurance directly to the public.

In order to broaden access to the mass market the industry will have to find new ways to distribute insurance which involve lower transaction costs. This will inevitably require technology to play an increasing role in the distribution channel; most likely cell phone technology.

6. Challenging the existing models

The dominance of the "partner-agent" model and the mutual society in the delivery of micro-insurance to the poor will limit the potential outreach. The involvement of the MFI has been essential in refining products, systems and an understanding of the client. They will remain a major conduit for the

insurance industry, but we must start to look past the MFI to reach clients both above and below their target borrowing market as well as those that are in the same segment but are yet to receive a loan.

Insurance distribution is not restrained by a lack of capital. Micro lenders can only expand as quickly as they can accumulate a loan portfolio. The same restriction does not apply in insurance as there is a huge capital resource available from the existing insurance industry and the missing link in providing insurance to the poor is a distribution network for which the cost of establishing the infrastructure to serve 100 or 1,000,000 clients remains constant.