ALLIANZ AG, GTZ AND UNDP
PUBLIC PRIVATE PARTNERSHIP
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MICROINSURANCE

DEMAND AND MARKET PROSPECTS

LAO PEOPLE'S DEMOCRATIC REPUBLIC

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ABBREVIATIONS

ADB	Asian Development Bank
AFD	Agence Française de Développement
AGL	Assurances Générales du Laos
APB	Agriculture Promotion Bank
BTC	Belgian Technical Cooperation
CBHI	Community-based health insurance
CCSP	A type of credit cooperative
DFID	Department for International Development (U.K.)
FC	Fonds Coopératifs
GDP	Gross domestic product
GTZ	German Technical Assistance (Deutsche Gesellschaft für Technische Zusammenarbeit GmbH (Germany)
HASPM	HIV/AIDS and STI Prevention and Project Management
IFAD	International Fund for Agricultural Development
ILO	International Labour Organization
JICA	Japan International Cooperation Agency
LAK	Lao PDR kip (currency)
LFTU	Lao Federation of Trade Unions
LVCA	Lao Village Credit Associations
LWU	Lao Women's Union
MAF	Mutual Assistance Fund
MBA	Mutual Benefit Association
MFI	Microfinance institution
MFP	Microfinance provider
MoF	Ministry of Finance
MoH	Ministry of Health
MoPH	Ministry of Public Health
NEM	New Economic Mechanism
NGO	Non-governmental organization
QSL	Quaker Service Laos
SCB	State-owned commercial bank
SCN	Save the Children Norway
SME	Small and medium (sized) enterprises
SOE	State-owned enterprises
SSO	Social Security Organization
STI	Sexually transmitted infection
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Non-English words and phrases

Houia	Local informal savings and credit associations

INTRODUCING MICROINSURANCE

A public private partnership using a market-based mechanism to reduce poverty

What happens when a poor family's breadwinner dies, when a child in a disadvantaged household is hospitalized, or the home of a vulnerable family is destroyed by fire or natural disaster? Every serious illness, every accident and every natural disaster threatens the very existence of poor people and usually leads to deeper poverty. That's where "microinsurance" comes in.

Microinsurance is specifically designed for the protection of low-income people, with affordable insurance products to help them cope with and recover from common risks. It is a market-based mechanism that promises to support sustainable livelihoods by empowering people to adapt and withstand stress. Two-thirds of human beings suffering in the most extreme poverty are women. Often living within $1 per day, they are the most vulnerable.

But will microinsurance actually help those living in poverty by contributing to sustainable livelihoods? We believe it can, and we decided to test the hypothesis in the real world. UNDP approached Allianz AG about working together on a market potential study to analyze the demand, acceptability and affordability of microinsurance products. They immediately saw the value of working in this under-explored area. This public private partnership acquired greater strength when GTZ, with considerable experience in the area of social protection and microinsurance, joined the alliance. The partners agreed to analyze demand for microinsurance products in India, Indonesia and Lao People's Democratic Republic (PDR) and jointly selected a team of consultants to prepare country studies.

The studies clearly indicate that access to microinsurance by the poor and disadvantaged population can contribute significantly to the achievement of the Millennium Development Goals, particularly the goals of eradicating extreme poverty and hunger (MDG 1), promoting gender equality and empowering women (MDG 3) and developing a global partnership for development (MDG 8).

Three country studies

The country studies examine and appraise the most urgent social security risks and needs of poor population groups. They highlight the following aspects of microinsurance supply and demand:

- Existing activities to meet the needs for social safety net mechanisms, including informal strategies;
- The role of government policies;
- Capacity development requirements at various levels;
- The need for advocacy and education to help poor populations as well as potential providers to understand the role of microinsurance;
- The need for ongoing efforts to analyze potential customer profiles, reflect on their ability to pay, and suggest possible products to suit the target groups;
- Possibilities for countries to learn from each other's experiences.

In **India**, the study finds that this country currently has the most dynamic microinsurance sector in the world. Liberalization of the economy and the insurance sector has created new opportunities for insurance to reach the vast majority of the poor, including those working in the informal sector. Even so, market penetration is largely driven by supply, not demand. Microinsurance in India has valuable lessons for rest of the world, particularly in the regulation of the industry. Certain aspects, such as the quota system need further and closer analysis. The quota system, for example, may be viewed in terms of its costs and benefits: is it an onerous obligation for insurers that creates a barrier to innovation and demand-based products? Or, is it an avenue that may lead to the creation of a microinsurance market that meets the needs of the poor and disadvantaged?

In **Indonesia**, demand is strong for insurance to cover the risks that people are least prepared for and have insufficient means to manage. Such risks include serious illness, poor harvest, death in the family and social obligations. Education of children is a priority, and the potential microinsurance policy holders would like to ensure that an unforeseen shock or stress does not deprive their children. The number of insurers in Indonesia is significant, yet few have explored the low-income market. Consequently there is a critical need for capacity development, primarily in the areas of agent training and market education. This could expand opportunities and lead to market-based tools to assist the poor in securing their lives.

In **Lao PDR**, the country study finds that the social security system is nascent (and practically absent for the informal economy) and microfinance institutions are conspicuously inadequate. The analysis confirms a commitment by the Government in several relevant areas: support for reforms, support for pensions and a social security fund for public employees, support for compulsory social protection for the private sector, and support for a community-based health scheme for people working in the informal sector. The study concludes that the potential for commercial microinsurance is in the future at least a few years away. Meanwhile, for microinsurance to become viable, the Government will need to strengthen the financial infrastructure, develop capacity for potential insurance providers and build knowledge of microinsurance mechanism and products among potential policy holders.

Microinsurance is a low-price, high-volume business and its success and market sustainability is dependent on keeping the transaction costs down. Hardly any satisfactory state-run programme of insurance benefits is now available for poor population groups, people working in the informal sector and other disadvantaged individuals—and private-sector programmes are even rarer. A number of constraints make microinsurance look unattractive, including a lack of political will, scarcity of public funds and absence of a viable business model. The costs of marketing and processing appear to be too high and, in view of the extremely low purchasing power of the consumer base, it cannot be easily apportioned to the target group. Such constraints make microinsurance unattractive at the cursory level. Market analysis suggests that progress can be made particularly when public and private sector work together in generating demand-based and innovative products.

Future steps

Where do we go from here? Building on the recommendations of the studies, pilot activities in India and in Indonesia are being implemented by Allianz AG supported by GTZ on behalf of the

German Federal Ministry for Economic Cooperation and Development (BMZ). While it would be critical to address the need to build capacity in nongovernmental organizations (NGOs), trade unions and microfinance institutions, the outcome of pilot activities will point to specific issues to be addressed. Local structures of civil society can help their members gain access to microinsurance and reduce the transaction costs of processing. Market education and skills training are needed on at least two fronts: improving the efficiency of partner-agent distribution methods, and sensitizing potential intermediaries and customers. A clear strategy for communicating with potential customers that conveys information and knowledge of the products is essential to success. It will also be important to work with governments to strengthen institutions and create an enabling environment. Such an environment is enhanced by transparent and participative consultation process. It ensures that the delivery process for microinsurance services is efficient with minimal transaction costs. It is in these areas that UNDP and GTZ will bring their experience and expertise to bear in making the microinsurance pilots successful.

We anticipate that access to insurance by poor people and entrepreneurs in the informal sector will attract private sector investments, assist in the development of the domestic private sector and lead to the alleviation of poverty. Increasingly, a social protection mechanism such as microinsurance appears to be a prerequisite in national poverty reduction strategies. Despite obvious need, however, it has not been possible for national governments to meet this obligation due to budgetary constraints. A possible solution would be to leverage government strategies with market-based social protection systems. The strategy would benefit significantly from south-south learning and sharing of knowledge, policies and practices.

The provision of microinsurance products and services is an obvious candidate for public private partnerships, as demonstrated in our three country studies. We are hopeful that with the interest shown by visionary private sector partners like Allianz AG it will be possible for forward-thinking bilateral donors such as the German Federal Ministry for Economic Cooperation and Development (BMZ) and GTZ and multilateral organizations such as UNDP with its broad reach and anti-poverty mission to catalyze access to microinsurance by the poor and disadvantaged.

We look forward to hearing from you about the market analysis presented in our three country studies. Indeed, your comments, feedback and ideas for innovative partnerships will be a welcome contribution to the global effort to achieve the Millennium Development Goals.

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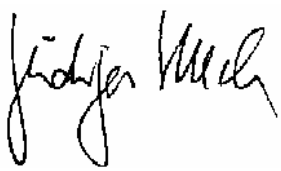

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EXECUTIVE SUMMARY

The Lao People's Democratic Republic (Lao PDR) is a landlocked, mountainous country in South-East Asia, with an estimated population of 6.2 million. Ranked 135 (out of 177) on the Human Development Index (2002), it is one of the least developed countries in Asia. It is a young country, with 55 percent of the population below the age of 20 and only 17 percent above the age of 40. It is also predominantly rural, with 83 percent of the population living in rural areas. Subsistence agriculture accounts for half of gross domestic product (GDP) and provides 80 percent of total employment.

Allianz AG, GTZ and UNDP joined together in a public private partnership to identify the potential for microinsurance in Lao PDR, and selected a team of three consultants to prepare a country study. Microinsurance is commonly defined as insurance products that are specially designed for the low-income market in terms of coverage, delivery channels and premium collection methods.

The **purpose of the research** was to understand and estimate the demand for microinsurance in the country, as well as the potential supply of microinsurance in terms of risk takers (regulated insurers, the Government and others) and various delivery channels. The resulting information should lead to an understanding of the current potential (if any), options available for undertaking pilot initiatives, and what action would be required to meet the demand for microinsurance products and services. In the long term, the research and implementation of the findings should relate to the development of sustainable livelihoods through the availability and access to microinsurance by the poor and disadvantaged people and workers in the informal sector. It should also lead to the exploration of the use of microinsurance as a safety net mechanism to reduce livelihood vulnerability of low-income populations.

The team spent about four weeks in two areas of the country. They studied the demand for microinsurance (demand research) through focus group discussions and key person interviews. Supply and potential were assessed through discussions with donors, government officials and others. They conducted most visits in the capital, Vientiane, with some demand research carried out in Louangphrabang.

Demand research identified several potential gaps in the risk-management strategies used by low-income households. The **three primary risks** were identified as follows:

(1) Inpatient health care: Although the demand was somewhat weak, there was evidence of a need for cover to manage the high expenses of inpatient health care, especially in the case of long-term illness. Such risks can render many households insolvent.

(2) Loss of livestock: Currently, the main form of risk management is self-insurance. People use savings, borrowings, or other means to pay the costs of the risks they face. Monetization is rather limited, especially in the rural areas, so households maintain savings in the form of livestock (as well as gold). This helps them hedge against inflation and generate a healthy

return. This system leads to the second most important risk of the people interviewed for this study–livestock illness and death.

(3) Death of a breadwinner. People identified this as the next most significant risk. This type of loss dramatically reduces the household income as well as long-term income-generating potential. Assistance for both the funeral costs and the ongoing adjustment might be appropriate for microinsurance.

In looking at the financial sector, a microfinance provider (MFP) network is conspicuously absent in Lao PDR. In most countries, it is helpful to have a reasonably well-established MFP network that develops and implements microinsurance. In Lao PDR, the largest MFP has only 1,500 clients. As an alternative, many institutions (donors and development organizations) work with the Lao Women's Union (LWU) and its network to distribute their products. Given the LWU's lack of interest in and capacity to manage commercial microinsurance, this may not be appropriate for the development of commercial microinsurance in the Lao PDR.

Major efforts are being made to improve the financial sector, as well as the microfinancial sector (at least in terms of credit and savings) through technical as sistance, legislative assistance and capacity-building. New microfinance legislation is likely in the near future, and this supports MFPs acting as agents for insurers.

The **Social Security System** is still nascent, although the Government fully supports the current reforms and the extension of its own schemes. Attempts to link up the Government's three different schemes (viz., a pension and social security fund for public employees; a compulsory system for enterprises with 10 or more employees; and a community-based health insurance or CBHI scheme that is supposed to cover people working in the informal sector – all described at 3.2 below) are currently limited to applying comparable procedures of membership administration and purchaser–provider relationships.[1] Furthermore, even users covered under the existing statutory schemes complain about the low reimbursement rate and the slow claims settlements.

Gaps in social security are significant. Because of substantial fiscal constraints, poor people are still not exempted from out-of-pocket health-care payments, although their exemption was established in Decree No. 52 of 1995. There are no social security schemes of any significance for the informal economy, nor does any formal framework address overall poli cy issues of social protection for all sections of the population. Moreover, the rural population is largely unaware of the few protection measures and risk management methods available to them, other than relying on family and village networks that are not sufficient to cope with major risks. The possibility of introducing a Health Equity Fund linked to community-based health insurance (CBHI), which is being pilot-tested in a modified form in Nambak, could contribute to providing health care to poor people. Microinsurance will be a critical component in successful social security.

Research examined **the potential for commercial microinsurance**. Conditions are not yet adequate to support commercial microinsurance, according to most people interviewed.

[1] Hohmann, J., unpublished paper on the linkages of social security schemes in the Lao PDR, Vientiane 2005.

However, over time three options might be possible for generating commercial microinsurance to help fill needs not currently met by government programmes :

- Insurers might work with the CBHI apparatus to help them with reserves and reinsurance. Taking on a reinsurer's role[2]–not just financially but also in terms of skills inputs–could help the CBHIs grow and expand faster while providing more secure protection for their members.
- A mutual benefit association might be developed on a very large scale that would be managed by commercial insurers but owned by the membership.
- An insurer could work with partner organizations which are not in the insurance business to develop a network of intermediaries that would actively work with the low-income market to act as agents selling the microinsurance policies of the insurer.

The option of integrating a commercial insurer into the CBHI programme probably holds the greatest potential. CBHIs can help the insurer move carefully into the low-income market, and the commercial insurer can provide the skills and options that are so often limited or missing in community-based organizations. The inputs of the commercial insurer are important for the long-term success of the community-based organizations. Such an integration of insurer and community-based organization can provide for more rapid expansion in a safe and professional manner. Additionally, it is possible to maintain the ownership of the CBHI that is so important to the CBHI promoters, while using the insurer both as reinsurer and for the outsourcing that the basic structure of the CBHI might not be able to manage. This is a potential win-win-win for members, the CBHI as an entity and the insurer.

Over time, a network developed through a partnership between an insurance company and an existing organization in the field could grow and strengthen to a point that may allow for commercial access to large numbers of low-income people. For now, however, it is important that these potential partner organizations grow to reach significant volumes and strengthen their core business activities. Donors are working on this strengthening, and when these have reached sufficient volumes and quality, potential products could include: a life-linked endowment policy, a health-care cover, and then livestock insurance.

The potential for microinsurance in the Lao PDR is in the future. Currently, the financial systems are nascent, and microfinance is still weak in terms of best practices. The infrastructure of intermediaries is not available, and much capacity-building is necessary. Finally, the demand remains rather weak. It is not likely that commercial microinsurance would be profitable at this time. Virtually every official visited in the country considered microinsurance as premature in this market. The time for microinsurance will come when the financial systems are stronger and there are healthy intermediate organizations with relatively large client bases and control over their portfolios. Such a level of preparedness is likely to be at least a year or more in the future. The one area that offers significant potential at this time is linkage of a commercial insurer with the CBHI efforts.

[2] Reinsurance: A contract by which an insurer is insured wholly or in part against the risk he or she has incurred in insuring somebody else. A large reinsurance company can help protect smaller insurance companies against their own risks. Described as "insurance of insurance companies", reinsurance serves to spread the risk so that no single entity finds itself faced with a financial burden beyond its ability to pay.

CHAPTER I. BACKGROUND

The purpose of the research was to understand the demand for microinsurance in the Lao PDR, as well as the potential supply of microinsurance in terms of risk takers (regulated insurers, the Government and others) and various delivery channels. This information should lead to an understanding of the options available for undertaking pilot initiatives.

Our research identified the needs and demands of the low-income market in the Lao PDR. This included substantial qualitative research among the members of the country's largest non-governmental MFP (microfinance provider). Details of the demand research methodology, and the organization through which clients were identified, are included in appendix 2.

The supply-side research was conducted through the extensive use of key person interviews. The team met with influential informants of government, civil society and the private sector. A list of meetings with the names of those met is included in appendix 5.

1.1 Country analysis

The Lao PDR is a landlocked, mountainous country in South-East Asia, with a population estimated at 6.2 million. Ranked 135 (out of 177) on the Human Development Index (2002), it is one of the least developed countries in Asia. It is a young country, with 55 percent of the population below the age of 20 and only 17 percent above the age of 40. It is also predominantly rural. The country's population is 78.4 percent non-urban.[3] Subsistence agriculture accounts for half of gross domestic product (GDP) and provides 80 percent of total employment.

An estimated 39 percent of the population is poor.[4] In 2001 prices, households considered poor are those with cash or in-kind income of less than LAK82,000[5] per person per month. This number is somewhat higher in urban households, at LAK100,000 per person per month.[6] The prevalence of poverty is higher in rural areas at 41 percent, while in urban areas only 27 percent of the population is poor. Poverty shows a wide disparity ranging from 12.2 percent in Vientiane Municipality up to 74.6 percent in the Northern Region (Huaphanh District).[7]

In addition to a rural/urban split, poverty is also differentiated **by region**, with the northern region the poorest in the country: 53 percent poor and accounting for 45 percent of all poor households in country. This is also where human development indicators are the lowest. The Vientiane Municipality is the wealthiest region of the country, followed by the central and then the southern regions.

[3] 2005 estimate http://globalis.gvu.unu.edu/indicator_detail.cfm?IndicatorID=30&Country=LA 23 August 2005.
[4] Based on the 1997/98 overall poverty line, defined as the cost of acquiring 2,100 calories per day plus 20 percent for non-food essentials. This was estimated to be LAK15,218 per person per month at 1997 prices. Lao PDR – National Growth and Poverty Eradication Strategy (NGPES), p. 22. June 2004.
[5] The exchange rate in 2001 was LAK8954.58 to $1. Source: CIA, World Fact Book, www.cia.gov.
[6] Lao PDR–National Growth and Poverty Eradication Strategy (NGPES), p. 30. June 2004. (Available on IMF website.)
[7] 'National Human Development Report Lao PDR 2001 –Advancing Rural Development'.

The Louangphrabang Province, one of the research sites, is located in the north of the country. It is 49 percent poor.

Poverty in the Lao PDR is differentiated **by agricultural or topographic zone**. The country is made up of at least two distinct zones based on topography and production systems. The lowland areas along the Mekong River and its tributaries produce the bulk of the nation's food supply. The rolling hills and mid-level mountains are characterized by shifting or swidden cultivation. Subsistence farming is the norm in this zone. Poverty is higher and is increasing in these mid-level areas as competition for arable land increases.

The topographic zones are also distinguished **by ethnic group**. Generally speaking, the Lao Loum, the predominant group in the country (68 percent of the population) tend to live in the lowlands or rice lands. The Lao Theung (22 percent) live on the mountain slopes. The Lao Soung (9 percent) are made up of various sub-ethnic groups, including the Hmong, and traditionally live in the high mountains. The poorest groups are the minority ethnic groups, most of whom practice swidden cultivation. The minority groups have significantly lower human development indicators than the Lao Loum group, with poverty and illiteracy rates highest for the Lao Soung peoples.

Poverty in the Lao PDR is characterized by a lack of infrastructure, with the poor having less access to all-weather roads, electricity, piped water and basic health services, among other things. Only 38 percent of the poor have access to all-weather roads. On average, the poor are 13 km from a road, making it difficult to transport products to market. Women tend to be poorer than men, and women have lower literacy rates.

1.2 Macroeconomic snapshot of the Lao PDR

The Lao PDR is a relatively small country in terms of population, landmass and overall economic power. Financial, health status and educational indicators are provided in Table 1.

Table 1. Key Indicators: Lao PDR

Category	Value
GDP PPP ($ billions)	9 (2002) (World Development Report, 2004)
Population (millions)	6.2 (July 2005 estimate) (U.S. Central Intelligence Agency)
Population density per km^2	24 (2002) (World Development Report, 2004)
Percentage urban population	21.6% (2005 estimate)
GDP/capita ($)	310 (2002) (World Development Report, 2004)
GDP growth rate	6.5% (2004 estimate) (*Asian Development Outlook*, 2005)
Inflation	10.6%, (2004 estimate) (*Asian Development Outlook,* 2005)
Exchange rate (current, LAK per $1)[8]	10,652

[8]This exchange rate will be used in all calculations of current figures in this report: http://oanda.com/ 1 July 2005.

Category	Value
PPP GDP per capita ($)	1,610 (2002) (World Development Report, 2004)
Infant mortality (per 1,000 live births)	Total: 85.22 deaths/1,000 live births Female: 75.04 deaths/1,000 live births Male: 95.01 deaths/1,000 live births (2005 estimate) (U.S. Central Intelligence Agency)
Under-five mortality (per 1,000)	100 (2002) (World Development Report, 2004)
Maternal mortality (per 100,000 live births)	650 (1995) (World Development Report, 2004)
Access to an improved water source (% of population)	37% (2002) (*World Development Report*, 2004) Note this water source is not necessarily safe, simply "improved"
Health expenditure as % of GDP (public/private/total)	1.3%/3.1%/4.4% (2000) (*World Development Report*, 2004)
Health expenditure per capita ($)	$11 (2000) (World Development Report, 2004)
Doctors per 100,000 people	0.2 (1995-2000 estimate, *World Development Report*, 2004)
Literacy rate	66.4%, a 2002 estimate (U.S. Central Intelligence Agency)

The country's financial markets are segmented into a non-monetized rural subsistence economy, an under-monetized microeconomy of mostly informal microenterprises, and a small formal sector of government agencies and larger enterprises.

CHAPTER II. EXISTING BANKING AND MICROFINANCE STRUCTURE

2.1 The banking sector

One way in which people prepare for unexpected events or risks is through saving; however they also need access to credit. Credit and savings are generally the first line of defence for low-income households. They are also the basic financial products of banks and microfinance providers. Not always undertaken through banks, credit and savings may take on a more informal form in practice. Thus, access to banks, MFPs, and informal savings and credit mechanisms are discussed in this section, providing a context for insurance.

The Lao banking system had total assets of approximately $400 million in 2000, which is less than 25 percent of GDP. In the first phase of reforms in the late 1990s, the country moved away from its mono-bank system, separating central banking from commercial banking and permitting joint venture and foreign banks to operate in the country. State-owned commercial banks (SCBs) had to be restructured and rehabilitated. Since then, SCBs have accumulated significant non-performing loans. During the 2000s, financial activity has focused on restructuring banks, improving regulation and supervision, supporting rural microfinance and opening up the banking system.[9]

The banking system comprises three state-owned banks, a policy bank, three joint-venture banks, six branches of foreign banks and one representative office. There are no domestic private banks.[10] Among the state-owned banks is the Agriculture Promotion Bank (APB).

Recent progress has been made in banking reform. In a 2004 assessment, the Asian Development Bank reported:

> Some progress was also made in reforming the banking sector…with the Cabinet approving a proposal to lower entry barriers and improve market access for foreign and private banks. An external audit and review for 2003 of the two dominant state-owned commercial banks – Banque pour le Commerce Extérieur Lao and Lao Development Bank – indicates that non-performing asset ratios remain at high levels. The quality of new lending has improved, however, as a result of enhanced credit policy and capacity-building efforts by international banking advisers.[11]

Six government-owned banks dominate the rural banking sector. Only the APB is relevant to this study, however, as the APB alone is authorized to collect rural savings. The APB was established in 1993 as the prime agricultural lender with a nationwide operation and five regional

[9] World Bank Office in Vientiane. 'Lao PDR Economic Monitor'. November 2004 (covering May through November 2004).
[10] Ibid.
[11] *Asian Development Outlook,* 2005. http://www.adb.org/Documents/Books/ADO/2005/lao.asp 25 August 2005.

banks, which grew out of departments of the former State Bank in 1990 and 1991. The APB delivery structure comprises 16 branches and 90 sub-branches reaching a total of 18 provinces and 133 districts. The five regional banks add another 12 branches. The APB is the largest provider of microfinance, though its main customers are prosperous farmers. They do not reach the small and poor farmers.

Officials at the APB acknowledged that their interest rate structure is inverted. Average deposit rates actually **exceed** lending rates, yielding a **negative** return. Under such conditions, banks refrain from mobilizing savings and restrict their lending. Instead, they continue to depend on government and donor funds. For deregulation to be fully effective, the volume of subsidized credit programmes needs to be drastically curtailed.

Saving

Only a few people were identified as saving money in a bank. This may reflect the fact that price inflation in the country has been high for a number of years, and thus maintaining savings in a non-monetized form may be a better alternative. It could also reflect the fact that opening a bank account is costly, and it is not possible to receive all of one's money when one closes the account.[12] Those who had savings in a bank reported only small amounts in the range of $10 to $100. Most respondents said that they could not save although they keep some cash at home for daily household and business expenses. These savings are also used to fund unexpected expenses. Generally, the amount of cash reported kept at home is greater than the amounts estimated to be in bank accounts.

Low-income people save in a variety of ways. Livestock purchases, particularly cows and buffaloes, are the preferred method for saving. Gardens in which teak trees are grown as a long-term investment strategy are popular in the Louangphrabang area. Teak trees can be harvested starting at 15 years old. At that age, a tree is worth $15. The largest teak trees are worth $100 each. Respondents also reported buying and selling gold jewellery, depending on their financial situation.

2.2 The microfinance sector

Very commonly, when low-income people are moving into the financial sector, they do so first through credit and savings products, and then they move to protect the resulting assets and financial status through insurance. Typically, a strong and vibrant microfinance sector bodes well for the market for microinsurance. Likewise, when microfinance is limited, the possibility of microinsurance products and services is at best in its infancy. For this reason, microfinance is a good proxy for the potential, at least in the short term, for microinsurance.

Microfinance refers principally to the extension of small loans to entrepreneurs too poor to qualify for traditional bank loans. In developing countries especially, microcredit enables very poor people to engage in self-employment projects that generate income. Frequently, the markets for microfinance and for microinsurance are similar. In some cases, microinsurance also may be appropriate for markets that are somewhat better off. This pertains to households at the margin

[12] Reported by Fonds Coopératifs.

and above the poverty line that are currently beyond the need for conventional microfinance. In this group, a risk event could easily push the household back into poverty.

In Lao PDR, the microfinance provider sector is rather weak and in need of significant capacity-building and growth. A number of efforts are underway to aid in improving household financial conditions. The Asian Development Bank (ADB) and others are developing and improving the volume and capacity of MFPs, including through credit and savings products. A capacity-building plan is being developed to help MFPs utilize best practices.

As part of the capacity-building effort, the central Bank of Lao PDR, with assistance from the ADB, has been working to develop a microfinance legislative framework. Such legislation could potentially create problems for microinsurance in that it might restrict MFPs from performing necessary microinsurance activities. The draft microfinance law has favourably provided appropriate flexibility to allow MFPs the option to work with insurers in insurance activities.

The 'Final Draft of the Microfinance Regulation for the Lao PDR' [13] notes the following about insurance in relation to MFPs:

> Article 4: Scope of Activities of Microfinance Institutions
> Microfinance Institutions shall be entitled to: provide financial services, including sale of insurance as an insurance agent, payment services and money transfer services;
> Deposit-Taking Microfinance Institutions and Registered Microfinance Institutions shall not: provide insurance services as a broker;

The ability to have MFPs legally act as insurance agents will be important in building large networks of potential microinsurance policyholders.

The ADB's Brett Coleman writes: "The microfinance regulation was issued in June 2005. However, post-issuance, the Prime Minister's Office has raised objections to the regulation's allowing foreign investment in MFIs". [14] It appears that the regulation will need to be adjusted to exclude foreign investment, and then reissued. The ownership of the MFIs has little impact on potential relationships between MFIs and insurers. " After [final] issuance of the regulations, a pilot microinsurance project would be welcome," Coleman suggests.[15]

The weakness of the country's microfinance sector is seen in the predominantly informal nature of Lao savings. The Lao tend to be risk-averse and savings-oriented. Historically, women are in charge of the family purse and of savings. According to a 1996 rural microfinance survey by UNDP and the United Nations Capital Development Fund (UNCDF), 91 percent of households hold financial savings, mostly in cash, averaging $87. [16] Ninety-one percent also hold non-financial savings amounting to $565, of which 82 percent was held in livestock and 18 percent in gold and silver.

[13] Copy received from Brett Coleman, Microfinance Specialist, Asian Development Bank on 20.6.2005.
[14] E-mail correspondence between Brett Coleman and the author, dated 16 March 2006.
[15] E-mail correspondence between Brett Coleman (ADB) and the author, dated 20 June 2005.
[16] Garson. J., 'Microfinance and Anti-Poverty Strategies: A donor perspective', New York: UNDP/UNCDF, 1996.

The UNDP/UNCDF survey revealed that credit is not an important source of financing for microenterprises. Thirty percent had loans outstanding, averaging LAK200,000, more than half of this from family members. Only about 5 percent had a loan from formal or informal institutional sources. Almost 75 percent reported finance as a major start-up problem. Among the problems of established enterprises, marketing ranked first.

2.3 Some microfinance providers

Fonds Coopératifs
This is understood to be the largest private (i.e., non-government) microfinance programme in Lao PDR. It may well be the only best practice programme in the country. The members of FC CCSPs (CCSPs are a type of credit union) come from the 30 percent of rural households that produce a surplus, which can be marketed, and the 60 percent of urban households that are involved in family-based or micro enterprises.[17] Together, these rural and urban groups account for 31 percent of the population or 1.9 million people. At this time, the CCSPs that make up FC are reaching 1,500 members. FC has 12 CCSPs across the country, with the Louangphrabang CCSP being the most northern cooperative.[18]

Lao Women's Union
The LWU is an official mass organization of the Communist Party focused on women, with a membership of 650,000. It is considered to be the best-organized development organization in the country, with the widest delivery network, reaching out to virtually all provinces and districts. The LWU has a unique delivery structure, extending from national, provincial and district levels, with thousands of staff members and volunteers in the villages.

All donor-funded women's projects are handled by the LWU, which closely cooperates with the various line ministries. Since 1989, it has addressed the needs of poor women, implementing activities in the areas of education and training, health, childcare, legal rights information, income-generating activities and, more recently, improved access to credit. The process is shown below.

In close cooperation with donors, government agencies, and international nongovernmental organizations (NGOs), the LWU has been instrumental in establishing most of the 1,650 existing Lao Village Credit Associations (LVCA).[19] These associations are started in target villages selected by local government at provincial and district levels in cooperation with a donor. Joint ownership of the LVCAs lies with the village, the Government, and the donor. They are managed by a village committee and supervised by local government committees together with the donor agency. In most cases, the microfinance activities are in the form of a revolving fund attached to some other overriding concern such as health, education and training, or raising livestock. Each programme falls under the supervision of the respective ministry in charge.

[17] Statistics provided by FC. May 2005.
[18] According to statistics provided by FC, an estimated 70 percent of rural households are subsistence farmers who are not integrated into the market. More detailed information on FC and its CCSPs can be found in appendix 2.
[19] Seibel, H.D. and C.R. Kunkel, 'Microfinance in Laos: A Case for Women's Banking?' University of Cologne, Development Research Centre, 1999.

So far, LVCAs have served as revolving funds channels for a variety of programme purposes; they have not functioned as financial intermediaries. The LWU has helped to deliver credit. It has not helped women mobilize savings or build viable financial institutions at the local level.

Women organized in the LWU dominate the semiformal financial sector in the country, and the LWU seems to be the only organization with the potential of spreading a network of autonomous local financial institutions all over the country. The LWU itself is not anything like a financial institution, however. It lacks the required technical competence and financial management skills. While supporting projects, it utilizes the expertise available in the line ministries at the provincial and district levels. A massive capacity-building input would be required to enable the LWU to approach this task effectively.

Informal Systems

Except for the LVCAs, local MFPs are in their infancy stage (unlike the MFP 'industries' in other South-East Asian countries). The place of MFPs is largely taken either by LVCAs or by small local networks of reciprocal relationships and mutual obligations among relatives, friends and neighbours. Some examples of these include:

Piggy bank: A microfinance-in-kind institution

Most microfinance institutions promoted by NGOs are revolving funds , and most of the loans are in kind. The Quaker Service Laos (QSL), has been working in the Lao PDR since 1973. Since 1993, it has focused on small-scale irrigation and community development projects, providing revolving funds for rice mills, rice banks, buffalo banks, pig banks and chicken banks. The villagers start by setting up a group of some 20 participants. Every member receives a loan valued at LAK66,000 to purchase a pig. The loan period is two years, including a grace period of one year. The interest rate is 8 percent per annum. Repayment during the second year is in quarterly instalments. Peer pressure ensures that a new loan is contingent upon full repayment of the old loan. If a member encounters a repayment problem, s/he brings it before the group, which then tries to find an acceptable solution (usually by granting an extension).

Rotating and non-rotating savings and credit associations

Local versions of savings and credit associations are known as *Houia*. The rotation is daily, weekly or monthly, with membership varying depending on the frequency of the payments.

More than half of the people interviewed in this project (9 out of 17) reported participating in a *Houia*, or a local savings and credit group. Participants in a *Houia* make contributions periodically as agreed with the payout rotating.

The daily *Houia* tended to have larger groups with 150 to 170 members. The daily contributions were LAK10,000 to LAK100,000 with the payments being collected by a collector. These *Houia* are organized within large markets. In both of the examples of daily *Houia*, interest charged on the payout is 20 percent and the decision about whose turn it is to take the payout is made by the leader of the group, based on who has the most need for funds.

The monthly *Houia* are organized in various ways. Membership of the respondents' groups ranged from 34 to 70 members, with an average of 42 members. The interest rates varied from

20 percent to 50 percent. Contributions varied from LAK100,000 to LAK300,000. The process for deciding whose turn it was to take the payout changed from group to group. Many groups use an auction system where the highest interest rate will win the pot. In other groups, individuals must declare why they want the money, and the group agrees together who should get the payout.

After they receive the payout, they must contribute the original contribution amount plus an interest amount. At the end of the agreed period for the *Houia*, the proceeds, basic payments plus interest paid, are distributed to the members. Because of the interest rate for borrowing, many people prefer to wait to take their turn at the end. For them, the *Houia* is like an interest-bearing savings account. For those who take their turn at the beginning, the *Houia* is more like taking an interest-bearing loan.

Many people participate in the *Houia* in order to save up for large purchases. Some interviewees reported that they would use their turn to pay off their loan to CCSP. Others reported that they would fix their house. Participation in a *Houia* is a risk reduction strategy because a household can receive the payout out of turn in case of an emergency.

Micro-businesswomen's informal, self-help banks

In the urban microeconomy, women have been the financial innovators in recent years, setting up rotating and non-rotating savings and credit associations that could be called micro-businesswomen's informal, self-help banks.

Most currency exchange shops, which until 1994 belonged to the non-formal financial sector, are owned and run by women. As an additional business, they lend to women entrepreneurs at real market rates of interest, ranging from 5 percent to 20 percent per month.

2.4 Donors in microfinance

Several microfinance projects supported by multi- and bilateral donors[20] and international NGOs are currently implemented. More than 13 projects of international NGOs operate through LVCAs. Multi- and bilateral donors provide the funds to the Government, which subsequently releases them through local governments to the villages.

Until recently, the emphasis was on credit, rarely on savings. This has changed. General loan terms and target beneficiaries (e.g., individuals, groups or communities) are determined through an assessment by the donor agency and local government staff. The village committee makes the final decision on loan terms and appraisal requirements of the expectant borrowers. Most loans are in the range of approximately $10 to $100 and are often used for the purchase of livestock or looms. Most interest rates range from 0 percent to 30 percent per annum with an average of around 10 percent, roughly equivalent to the preferential rates of the state commercial banks.

[20] It is estimated that about 80 percent of this amount was provided by the World Food Programme to establish rice banks. Source: Seibel, H.D. and C.R. Kunkel, Cologne 1999.

Although the situation is improving, experiences are mixed[21] and there is still little awareness of sound microfinance principles such as mobilizing one's own resources, covering of costs from the margin, ensuring timely repayment and building a viable institution. The two training institutions—the training college of the central Bank of Lao PDR and the National University of Laos —do not cater to this market. Because of the lack of effective training facilities, international NGOs and donor agencies carry out their own capacity-building. Experience reveals, however, that a number of microfinance activities came to a halt after the completion of the donor support. Indeed, it is important to recognize that there is no independent NGO structure in the Lao PDR, and that the Government has tight control over such organizations.

[21]UNDP terminated a microfinance project and the IFAD project is challenged with low disbursement rates through the LWU, and about 50 percent defaulted loans.

CHAPTER III. THE INSURANCE AND MICROINSURANCE SECTOR

3.1 The insurance sector

The insurance business in the country appears limited given the low population, limited banking structures, strong government control, and the presence of only one insurer. Although there is the potential for new insurers to enter this market, insurance legislation is old and should be brought up to date to allow for a freer approach to a more profitable business in terms of investment limits and premium setting.

The Lao PDR passed an insurance law based on the French model in 1990. The next year saw the opening of the insurer, Assurances Générales du Laos (AGL), as a joint venture insurance company. At that time, 80 percent of shares were held by Assurances Générales de France (AGF) with the Government of the Lao PDR holding the balance. Subsequently the Government increased its share to 49 percent. In 1998, Allianz AG took a controlling interest in AGF, providing beneficial access to logistics, and support from Allianz AG Asia-Pacific in Singapore. The company **AGL** was given an official three-year monopoly. However, despite market liberalization, no new insurance investor has come forward as yet, and this specific market situation has existed at least until the time of writing (July 2005). The country's only regulated insurer is AGL.

Currently the Government does not have an insurance commissioner, although it is expected that soon the Ministry of Finance will emplace a specialized officer for the insurance industry. Until then, the Ministry of Finance State Assets Department and its officers have been the controlling body for AGL.

Premiums and investments are controlled by the Government, which only allows investment in local time deposits. Even in such a limited market, however, AGL has experienced encouraging results, with gross premiums growing from $3.9 million in 2000 to $8.9 million in 2005. The significant majority of these premiums are in non-life business.

3.2 Insurance and the government

Overview to 1995

The Lao Social Security System was introduced in 1986 by the Government for public employees, including civil servants, the military, the police and their relatives. It has developed significantly since the middle of the last decade.

Articles 20 and 26 of the new Constitution of 1991 stipulated governmental responsibility for the provision of medical services. The same legislation granted social protection to war invalids, as well as the families of those who died in the service of the country, and to civil servants. These groups were entitled to the right to work, as well as medical care and assistance in the case

of incapacity for work, invalidity, old age and several other cases that are determined by law. For further detail see below under the heading "Overview today: 2) Public employees."

A new Labour Law (1994) established social protection for the private sector as well as the state-owned enterprises (SOE), which until then had been covered under the public-sector scheme. Furthermore, the civil service and the armed forces were covered by the legislation. Labour Law articles 50 to 53 stipulated the employers' responsibility for the social welfare of the workers, including health care. Enforcement of the law was a problem as it depended largely on employers' willingness, preparedness, and ability to fund the workers' social security benefits.

According to the 1995 Census, the labour force numbered approximately 2.2 million. Of that number, public- and private-sector employment was about 333,000, of whom approximately 70,000 were engaged in the public sector, 80,000 in the military/police, and 183,000 in the private sector. Due to lack of data, the 1995 Census gives figures only for the urban population (54.5 percent formal sector, 41.9 percent informal sector, and 3.7 percent small farmers/fishermen).[22] Thus, based on these figures, it can be estimated that only about 15 percent of the labour force was covered by the statutory social security schemes mentioned above.[23] This assumes limited formal employment in the rural areas.

Overview today

The three primary forms of social security today are those for the private sector (see SSO below), for public employees, and for the rural population through community-based health insurance (CBHI).

1) Private sector: the SSO

In 1999, a mandatory system was developed in response to the lack of coverage. It was established by Decree No. 207/PM[24] (based on articles 48 and 52–54 of the Labour Law), which came into effect in July 2000. The Social Security Organization (SSO) responsible for its implementation became operational in 2001. Despite all this progress, at that point social security reached only 30 percent of the defined target population[25] of the formal economy.

Decree No. 207/PM provides for the main social security risks designated by the International Labour Organization (ILO) and entrusts the SSO with responsibility to operate the scheme (since 2001). The Board is legally and financially independent from the Government and consists of representatives from the Government, employers, and employees. The focus of the scheme is the personnel of private companies and their dependents,[26] including SOE, with equal to or more than 10 workers, including their branches with fewer than 10 staff members. In addition, the

[22] Adam, E., M. von Hauff, and M. John (eds.), *Social Protection in Southeast & East Asia*, Friedrich Ebert Stiftung, Singapore 2002.

[23] Those employed divided by the total labour force. (333k/2,200k = 15 percent).

[24] On 23 December 1999 the Prime Minister's Office signed Decree No. 207/PM on Social Security System for Enterprise Employees. The social security scheme was declared a compulsory and state-guaranteed insurance. Its purpose was described as 'to ensure welfare rights and benefits for employees, with the objective of improving living conditions and contributing to the socio-economic development of the country'.

[25] Hohmann, J., unpublished paper on the linkages of social security schemes in the Lao People's Democratic Republic, Vientiane 2005.

[26] Spouses and children up to 18 years are covered as family members without any additional contribution.

Decree allows voluntary subscription of small enterprises. Once the voluntary membership is accepted it becomes compulsory and permanent. Furthermore, individuals can also join the scheme, while paying the employer's and employee's contribution.

Despite the stipulation of a mandatory membership, the compliance of employers subscribing their employees to SSO is still very low.[27] At present, employees of 181 enterprises are enrolled and there are about 23,000 paying members and 48,000 beneficiaries.[28] According to a recently presented actuarial review of SSO, this represents only 31.4 percent of those legally covered by the scheme.[29] All those insured are located in the Vientiane area. After over four years of operations, it is just beginning to move outside of Vientiane.

In addition to health insurance, the SSO social security scheme is a broad scheme covering several short-term and long-term benefits. The short term covers include: illness; income compensation in case of temporary loss of working capacity; work-related injury or illness; maternity; and funeral grants. Long-term benefits cover: retirement pension; survivors' benefits to protect dependents of deceased employees; and invalid benefits in case of permanent loss of working capacity.

Benefits of medical care under SSO are currently offered at four public hospitals in Vientiane. They are provided without additional user fees.[30] The health-care package is fairly comprehensive, with only very few treatments excluded.[31] The hospitals are presently paid on a capitation basis (in 2004, LAK60,000).[32]

By Decree No. 207/PM, the total contribution is 9.5 percent of a person's wages, with employees contributing 4.5 percent, and employers obliged to pay 5 percent. An assessable income ceiling limiting access has been set at LAK1,000,000. This ceiling has not yet been adjusted to changes in the national income level.[33]

[27] The private insurance company Assurances Générales du Laos (AGL), part of Allianz AG Group, is offering a comparable health insurance product for the same target group and a real competitor to the mandatory scheme.

[28] Cited in Hohmann, J. (2005): Female members represent around 66 percent of all primary members. In consequence, the coverage in employment sectors with high female workforce, such as the garment industry, is comparably higher than in typically male-dominated employment industries (construction, transport). Figures provided by Mr. Davone, Computer Division, SSO.

[29] Actuarial Review of the Social Security Fund of the Lao People's Democratic Republic, ILO, Vientiane 2005 (unpublished).

[30] Through Decree No. 52, introduced by the Government in 1995 for specific services in government health-care institutions. User fees are levied for patient registration and ancillary services but not for consultations by professional health workers. By decree, monks, students, and indigents have been exempted from paying user fees. The rules have been crudely implemented, however, especially for the poor.

[31] Excluded are inpatient services beyond 60 days of hospitalization within one year, chemotherapy, open heart surgery, organ transplant, artificial insemination, sex interchange, haemodialysis, aesthetical surgery, (non-work-related) motor vehicle accidents, and diseases covered by the Government.

[32] The amount has constantly changed in the past, due to the changed numbers of dependants and because the hospitals claimed that the per capita amounts were not covering their treatment costs.

[33] Currently, 20 percent of male members and 6 percent of female members earn above the ceiling. See ILO (2005).

2) Public employees

Additionally, a pilot scheme for civil servants is being started with technical assistance from ILO. The premiums collected per member are much less than those for the SSO. This will require the Government to make up the difference between the civil service scheme and the SSO scheme for the private sector. The results of such a programme remain to be seen. [34]

Box 1. The Public Sector Social Security Scheme

The Public Sector Social Security Scheme, covering around 875,000 people in 2003,[35] is funded by a 6 percent contribution of employees based on their basic salaries and a government subsidy to pay the non-covered expenditures. The scheme offers cover for pensions, widow/widowerhood, maternity, and disability, as well as medical care in the case of illness or work injury. The contributory amount is currently mainly used for the payment of pensions, while reimbursement for health-care expenditure depends on the fund's net balance. A reimbursement scheme, based on a fee-for-service system with a threshold for reimbursement, covers health insurance. The employee contribution of 6 percent of earnings is used to meet the short-term costs of the medical scheme. It is not based on actuarial calculations and thus is not sustainable.

Currently major reforms are on the way to enable broader protection for health care. These developments take the experiences of the social security schemes of the formal sector and the CBHI into consideration.

Government employees, including schoolteachers, policemen, and soldiers, as well as office workers, are covered by state-provided life and medical insurance. Families in which at least one spouse works for the Government have some medical coverage. Six out of the 17 families interviewed had this kind of formal insurance. As mentioned earlier, the client base of FC programmes come from the middle class. Thus, these families are more likely to have a member who is employed by the Government than lower-income groups.

The government medical insurance covers the government employee 100 percent and covers other family members by between 50 percent and 100 percent. Generally, the interviewees report that this insurance covers hospitalization but not outpatient care. The cost of the premium for government insurance was reported variously as LAK2,000 or LAK4,000 per month.

The extensive coverage of government insurance offers insights into possible expectations that might have to be met by private insurers entering this market.

The Ministry of Labour and Social Welfare was established almost 10 years ago and covers primarily disaster relief, reintegration of refugees, and assistance to orphans. Decree No.102/PM

[34] E-mail communication from Dr. Dean Shuey, Officer in Charge, WHO, the Lao People's Democratic Republic, dated 17 March 2006.

[35] The beneficiaries are composed of about 91,000 civil servants, around 100,000 armed forces and police officers, 4,500 contracted employees, and roughly 680,000 dependents. Source: Tangcharoensathein, Viroj et al. (2004a).

of 1993 states that in every classified village,[36] the village chief is responsible for managing social organizations and assistance to the poor, the disabled, the elderly, widows, and orphans. In the event of risks such as death, he may call together the village population to find solutions (usually through contributions) on how to assist the bereaved family. There are a few other subsidized services, however:

- Decree No. 52/PM (1995) exempts monks, students, veterans, and the poor[37] from paying user charges in hospitals. In practice, however, only a few are classified as 'poor'.
- Drug revolving fund: without the provision of the fund, villages' access to medicine would be endangered. The poor are supposed to receive drugs without charge, but according to the World Health Organization (WHO), de facto only 0.3–10 percent are exempted and thus gain access.
- Poverty Alleviation Fund: The Government has defined 72 poor and 47 poorest districts, providing $50,000 to each of the 47 poorest districts.
- The provision of basic medical treatment, pension ($10 per month), and income-generating activities are granted to the poor, veterans, orphans, and the elderly.

3) The rural sector: CBHIs

The lack of social security for the rural population led to the development of community-based health insurance (CBHI) as a third approach to health insurance in 2000. Three pilot regions, the north (Louangphrabang Province), the centre (Vientiane Province), and the south (Champassak Province), are being surveyed to see if this could be an appropriate system for workers in the informal economy–with subsequent expansion of the scheme to 15 districts. This scheme is further described below in section 3.3 as a subsection of the 'Solidarity-based Microinsurance.'

Conclusions on the current situation

The Social Security System is still rudimentary although the Government is fully supporting the current reforms and the extension of the schemes. Attempts to link up the three different schemes are currently limited to applying comparable procedures of membership administration and purchaser–provider relationships.[38] Furthermore, even users covered under the existing statutory schemes complain about the low reimbursement rate and the slow claims settlements. Moreover, very few people are fully informed about the benefits to which they are entitled. Often civil servants, who are granted a lower minimum salary than private-sector workers, are unable to pay for the provided medical services, and hospitals have to absorb the medical costs. This indicates insufficient contributions due to low earnings—although the Government aims at self-financing of both the schemes for the public sector and the private sector.

In addition, due to substantial fiscal constraints, poor people are still not exempted from out-of-pocket payments, as laid down in Decree No. 52 of 1995. No social security schemes of any significance exist for the informal economy, nor is any formal framework in place to address

[36] Definition by the Decree: Any geographical area comprising over 20 houses, or with a population exceeding 100 persons.

[37] Definition of poor, which is certified by the village chief: <16 kg rice/month and <85.000 kip/month. In addition, if people do not have sufficient money for health, education, clothing, and rice and cannot afford to live in a solid house they are considered to be below the poverty line.

[38] Hohmann, J., unpublished paper on the linkages of social security schemes in the Lao People's Democratic Republic, Vientiane 2005.

overall policy issues of social protection for all sections of the population. Moreover, the rural population is largely unaware of the few protection measures and risk management methods available to them, other than relying on the family and village network, which are insufficient to cope with the major risks.

3.3 Microinsurance in the Lao PDR

Microinsurance is commonly defined as insurance products that are specially designed for the low-income market in terms of coverage, delivery channels, and premium collection methods. Even the calculation of premiums and marketing materials and strategies are specially designed for this market. Simply taking a product for the wealthier market and offering it to the low-income market is not generally considered to be microinsurance. In the Lao PDR, the specificity requirements are valid and appropriate in defining microinsurance.

In this paper, the authors discuss products from AGL, which are priced at $2 per month. This does not necessarily reflect their status as microinsurance; it means merely that they have a low premium that low-income people may be able to afford. Some products may be appropriate for this market within the under-$2 range, but microinsurance products are offered with premiums far below $2 in countries where the GDP per capita is well above the $310 in the Lao PDR. Two dollars per month is almost 8 percent of GDP per capita, which is substantial for low-income people. That said, premiums are a factor of institutional efficiency, loss rates, management's ability to implement effective controls, and other components that vary not only between countries, but also between companies.

No microinsurance legislation was identified, and there seems no interest in enacting any at this time, as it is a very low priority for the Government. It should be noted that the World Bank's Economic Monitor for the country[39] does not even mention insurance. It is clear that the focus is on banking first.

In a subsistence economy, insurance needs are covered by reciprocal exchange relations and mutual obligations.[40] Based on experience elsewhere, the demand for microinsurance may evolve through several stages:

1. Small resources may be first mobilized through ad hoc contributions in the neighbourhood and allocated based on reciprocity;
2. Regular contributions are made and allocated in fixed amounts with self-help groups and informal institutions. These respond to social obligations and emergencies in a limited way;
3. Informal and formal local microfinance institutions provide access to savings and credit as the need arises;
4. Regular contributions are made through formal institutions;
5. These stages are usually followed by the demand for loan protection through life, health and livestock insurance as part of credit risk management.

[39]World Bank Office in Vientiane. 'Lao PDR Economic Monitor', November 2004 (covering May through November 2004).
[40]Seibel, H.D. and C.R. Kunkel, 1999.

Institutions also may gradually progress from informal and semiformal to formal and would eventually offer all three services: microsavings, microc redit and microinsurance, with linkages between them.

3.3.1 Commercial microinsurance

If further consolidated, formal institutions such as MFPs could partner with a regulated insurance provider.[41] This is being tested on a limited basis, with AGL offerin g a life and disability product through Lux Development and Prodessa, two NGOs. The NGO clients pay a set premium of 1 percent, while the general public's payments are based on the insured's age, starting at 0.4 percent for the same product. General policy holders of age 40 pay 1 percent of the sum assured.

AGL has tested products in 10 villages with their two NGO partners. With these schemes, started in the early to mid-1990s, 829 people are insured. The products, as detailed in Table 2, offer premiums of between $1 and $2 per year. The benefit is a maximum of 100 times the premium. Additionally, the lowest annual premium for an individual health contract is $10, and for third party liability (TPL) on a motorcycle is $2. These might be considered products accessible to this market.

AGL has defined microinsurance products as those with annual premiums of less than or equal to $24 (or an average $2 per month). In the Lao PDR, such a premium is equivalent to about 8 percent of GDP per capita. AGL offers four products in this range: term life, health, worldwide personal accident, and motor third party liability for two - and three-wheeled vehicles. A summary of the most important details of these products is provided below: [42]

Table 2. AGL 'microinsurance' produ cts

	Term life	Health	Personal Accident	Motor TPL
Year started	1994	1993	1992	1991
Target market	Head of family	Employees, all Lao people	Employees, all Lao people	All vehicles in Lao PDR
Who is eligible?	20<Age<64	3<Age<60	16<Age<60	All registered vehicles
Marketed also with NGOs?	Prodessa and Lux Development	NA	NA	NA
Coverage (maximum benefit amount)?	Death only (Flexible)	Hospitalization (Basic plan to $1135)	Options for death ($567), total permanent disability ($756), daily allowance ($0.3) and medical expenses ($47)	Corporeal damages (compulsory plus three options), and material damage (three options from $473 to $1,655)

[41] The Assurances Générales du Laos (AGL), part of Allianz AG Group, is the only private insurance provider in the country. In the area of social protection, it offers a health insurance product for the same target group as the one operated by the SSO for the formal economy.

[42] From an e-mail to the author by Philippe Robineau received on 29 March 2006.

	Term life	Health	Personal Accident	Motor TPL
Annual premium?	1% of sum assured for NGOs. Age based for others starting at $4.2	$10.2 for basic plan	$3.5—$11.7 depending on options and employment class	$1.2–$12 based on number of wheels, ccs, and option chosen.
What is the underwriting process?	Information request: Health certificate. Underwriting is done only at head office (HO).	Information request: Health certificate. Underwriting is done only at head office.	Information request: Business activity, professional class, sum insured. Underwriting is done only at HO.	Information request: Vehicle registration, engine, chassis no., Capacity or weigh or number of seats, usage … Underwriting at HO and agency
How many policyholders at 31/12/2005?	280 policies, 1800 individuals	370 policies, 2000 individuals	400 policies, 3800 individuals	N/A
What marketing materials does AGL provide?	Brochure, poster, Billboard, sketches	Brochure, poster, Billboard, sketches.	Brochure, poster, Billboard, sketches.	Brochure, poster, Billboard, sketches.

These products are priced in a range that may make them accessible to the low-income market. Except for those sold through the NGOs, these are products for the general market in the Lao PDR and are not particularly focused on addressing the demands of the low-income market. The attempt to market term life products through the two NGOs (Prodessa and Lux Development) is an important start, but this has resulted in limited policies even after 12 years. It is clear that AGL has an interest in attracting the low-income market, but it will require improved delivery channels and specialized microinsurance products to be able to generate the volumes that could help it improve the premium to coverage ratios and provide products that might be profitable over time.

Unfortunately, in 2006, the institutional preconditions are not yet conducive to the development of microinsurance programmes that are able to attract large numbers of low-income people. Without this, there is limited potential for profitable commercial microinsurance, and products will remain underutilized.

3.3.2 Solidarity-based microinsurance

Building on the solidarity mechanisms among family members, communities and peer groups, a few voluntary systems have emerged: [43]

(1) **Mutual Assistance Fund (MAF) of LFTU:** In 1993, the Lao Federation of Trade Unions established the MAF to supplement the public-sector social security scheme on a voluntary basis. The standard contribution is LAK1,000 per month. District committees have the flexibility,

[43] Adam,E., M. von Hauff, and M. John (eds.), *Social Protection in Southeast & East Asia*, Friedrich Ebert Stiftung, Singapore 2002.

however, to increase the premium up to LAK6,000 per month. The benefits cover illness and employment injury (up to LAK80,000 for major surgery), maternit y (LAK20,000 per child upon birth), death (depending on the membership, LAK200,000 for less than one year of membership, up to LAK600,000 for more than three years of membership), marriage (LAK20,000), and disaster relief (up to LAK100,000).

(2) **Welfare fund for teachers**: In 1992, a voluntary welfare fund was established in Hai Xai Phong District of Vientiane Municipality aimed at increasing solidarity among teachers. Members contribute LAK2,000 per annum and may receive LAK1,000 per day if hospitalized up to a maximum of 20 days per case and two episodes of hospitalization per year. Members may have access to loans and payments to families in the event of the member's death. As the teachers are covered under the public-sector social security scheme one adv antage of this Fund is access to credit at low interest rates. Participation in this scheme also indicates members' dissatisfaction with the public services and their limited benefit package and reimbursement delays of 6 to 12 months.

(3) **Emergency funds** are established at many workplaces to assist employees confronted with a crisis such as the death of a family member, or expenses for customary celebrations such as marriage, childbirth and village festivities. The existence of the funds is particularly ev ident in garment factories staffed with young women from rural areas. These women seek to maximize savings in preparation for the period of unemployment after the end of their contracts. They also need this protection for lengthy illnesses for which user c harges are taken at urban health-care facilities. As contributions are very low, it can be assumed that protection is quite limited.

(4) **Community-Based Health Insurance (CBHI)**: According to the director of the SSO, more than 80 percent of the population (including workers from the informal economy) is currently *excluded* from the two social security schemes run by the Government. Therefore, the Ministry of Health (MoH), in collaboration with WHO developed a non-profit voluntary CBHI and initially launched three pilot schemes.

The community manages the CBHI. For that purpose a CBHI Management Committee [44] has to be created for each scheme. The CBHI Management Committee functions as the insurer taking over all tasks such as collecting contributions, calculat ing and paying the capitation lump sum to the provider (main and referral hospital), and monitoring the quality and quantity of health-care provision. Furthermore, the Committee has the duty to provide the MoH and the WHO project team with the required sta tistics and information regarding the CBHI scheme.

By March 2006, there were four CBHI schemes that were started with WHO assistance and a fifth scheme using the same methods that is being supported by a Lux Development health project. The four WHO schem es have between 300 and 600 member families each, and the fifth scheme may have as many as 1,000 families. WHO has funds for a Phase II and in this phase, five regional teams will be trained that can facilitate new schemes. Additionally, WHO has funding for the start-up costs of 15 additional schemes.

[44]The Committee consists of 15 representatives fro m insured families, village leaders, delegates from the District Governor Office, and delegates from the health sector.

The capitation[45] sum covers outpatient consultations and all fees to hospitals or physicians including physical rehabilitation and pre- and post-natal services based on mutually agreed contracts that are approved by the Ministry of Health.[46] The whole family is the unit of insured persons. Using a capitation system, CBHI members select health-care providers and negotiate coverage and costs. The insurance risk is effectively held by the health-care providers (the capitation payment is to cover all care procedures agreed for all members). If priced poorly, this has the potential to lead to disincentives to providing care.

The CBHI pilot models have made use of an insurance design, management mechanisms, and evaluation tools, which have already successfully been implemented for the SSO private-sector Social Security System as mentioned in Table 3:[47]

Table 3. CBHI Details

Location and number of members	Premiums and benefits	Remarks
Sisathanak District, Vientiane Municipality (Centre)–2,928 beneficiaries Nambak District, Louangphrabang Province (North)–3,880 beneficiaries since June 2003 Champassak District in Champassak Province (South)–1,569 beneficiaries since February 2004	Contribution according to family size: LAK10,000 per month for single members LAK17,000 per month for 2-4 persons per household LAK21,000 per month for 5-8 persons Up to LAK23,000 per month for more than 8 family members Provider payment is based on capitation and differs among the districts: LAK35,000–LAK58,000 per person per year. No co-payments are applied. Benefits as SSO health benefits: all normal expenses on health care, including medical consultations and exams, diagnostic procedures, cost of treatment and drugs, cost of nursing, administrative costs and room charges. In case of emergency, insured family members may use the medical services of nearby and appropriate hospitals.	Challenges: Limited membership High drop-out rates (31% in Sisathanak) Between 17% and 47% late payment of contributions Tendency to overuse the benefits by members Over-prescription of drugs to reduce counselling time by health workers Larger average-size families in the CBHI scheme (5.6) causing proportionally higher health-care expenses per member in relation to the SSO formal-sector scheme (2.1), as capitation is based on beneficiaries Cost of transport to the referral hospitals causes major financial problems

[45] Capitation is the system of payment for each customer served, rather than by service performed.
[46] Exclusions such as traffic injury, organ transplant, self-inflicted harm, complicated dental care. For further details see 'Draft Regulations for the pilot projects CBHI', Ministry of Public Health (MoPH)/WHO, Vientiane, August 2002.
[47] Ron, A., 'Draft Report: Review of CBHI pilot scheme project', MoH–WHO, Vientiane, August 2004.

The CBHI programme has all of the problems of any voluntary health insurance scheme –late payment by members, adverse selection where high users stay and low users tend to drop out, providers that resist controlling their costs (which is understandable where a capitation and fee-for-service system run in parallel), and health-care inflation. But even given these issues, each of the schemes is actively functioning and self-sustaining without the use of donor money to supplement the insurance scheme. For these programmes, donor money has been used only for the initial training and sensitization, as well as for ongoing supervisory visits from the central team. No donor funds have been used to supplement the insurance schemes themselves. That said, it is important to recognize that the district-based schemes also do not collect reserves (to avoid fund management problems) and they do not have access to reinsurance.

CBHI is a voluntary insurance product, and it requires that there be health services of sufficient quality to encourage people to buy it. It requires that there be sufficient managerial expertise to handle capitation payments to the provider and to collect money and account for it. There must be sufficient cash income in the community so that people can afford to join. These conditions are not met in a lot of districts in the country, particularly the poorest ones.

Recommendation for CBHIs: Equity Funds

Although the experiences in the Lao PDR are promising, the very low-income population cannot enrol or maintain membership in the CBHI schemes. Therefore, it is proposed that collaboration between the MoH and the development partners enable use of planned Equity Funds to serve as the social assistance funds to purchase health insurance cards for the vulnerable populations that cannot regularly pay all or part of the regular contribution. This mechanism is pilot-tested in the CBHI Scheme in Nambak, where the Swiss Red Cross purchases the cards for very poor families.

The use of the Equity Funds would cover the poorest populations through the same prepayment mechanism as contributing families, and thereby facilitate equity in access to health care. Equity Funds could be used in two ways, in conjunction with social health insurance: [48]

- **In communities where less than 25 percent of the population is below the poverty line**: Purchase health insurance cards for the identified poorest families, at the same contribution level as other households enrolled in the CBHI scheme.

- **In communities where around 50 percent of the population is below the poverty line** : Subsidize all households, without prior identification of the poorest, through a uniform subsidy, which will be reduced and replaced by household contributions over a period of five years. Thus, the contribution burden would be shared, with an increasing share for the households over time and as household income increases.

3.3.3 Potential for CBHI integration with commercial insurance

One generally important aspect of the CBHIs is that they are developing a market for health insurance, and a consumer understanding of the principles of insurance. Working directly with low-income communities and groups, these initiatives are educating the market on the value of

[48] Ibid.

health insurance as well as strengthening the ability of health-care providers to offer quality services. It is possible that an insurer could become an important part of this process by providing the expertise and insurance backup that could greatly improve the effectiveness of these initiatives.

In terms of the potential to link these CBHI schemes with a commercial insurer, it is important to recognize that they have been developed, at least to some extent, to mirror the coverage of the nascent government SSO schemes. This was done to provide the potential for CBHI schemes to join the SSO programme once the SSO has expanded and become better represented throughout the country. But such a linkage, even if it happens, is likely to be several years in the future.

Significant potential does exist with the integration of a commercial insurer into the CBHI initiatives. These CBHIs are providing knowledge of insurance among the low-income markets, have worked on developing products that satisfy the needs of their members, yet do not have the skills to maximize the contributions of their members. Even with a capitation system such as is used by the CBHIs, members might want expanded cover to address gaps within the coverage agreements. The CBHIs do not want to hold funds because of the financial management risks involved. Thus, a CBHI could contract with a commercial insurer to offer expanded products such as livestock or breadwinner death cover based on the payment of small additions to the premiums that the members pay. Additionally, the limited medical cover could be enhanced through additional voluntary cover. In addition, health-care providers could work with the insurer to obtain cover for losses within the capitation system.

In these ways, a commercial insurer could help CBHIs to respond more comprehensively to the needs of their members while also assisting with the improved knowledge base and fiscal stability. This could help to bring more people into the CBHI system, provide better risk management options for the low-income members, and do it in a professional and sustainable manner, once the volumes grew.

3.4 Donors in microinsurance

No international agency, with the exception of WHO, ILO and Belgian Technical Cooperation (BTC), supports microinsurance in the Lao PDR. Even those organizations promote only the CBHI schemes in collaboration with the MoH. The Swiss Red Cross linked a small project component to CBHI, providing health cards to enable poor people to have access to the scheme. Discussions took place with the World Bank and the ADB, but they did not materialize into a direct implementation of such insurance schemes. Unanimously, all these organizations considered microinsurance to be premature in the existing conditions.

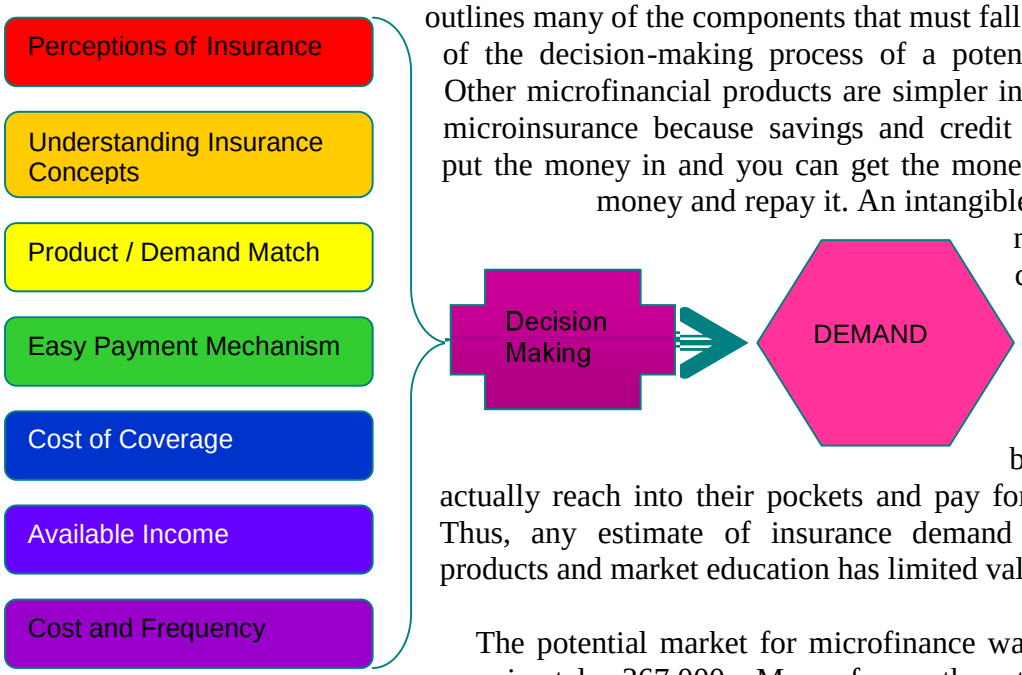
A number of organizations, however, support health projects and microfinance activities. In general, both could offer potential linkages to microinsurance, if the agencies intend to support long-term investments and institutional strengthening at a later stage.

The table in appendix 2 lists those projects of multi- and bilateral donor agencies and international NGOs that offer potential for integrating microinsurance into their mission.

3.5 Microinsurance demand

Qualitatively estimating potential demand and market potential for microinsurance

An estimate of the total market potential for microinsurance is difficult because there are so many different components of demand to consider. Figure 1**,** at left, **Components of Demand,** outlines many of the components that must fall into place as part of the decision-making process of a potential policyholder. Other microfinancial products are simpler in this respect than microinsurance because savings and credit are tangible –you put the money in and you can get the money out, or you get money and repay it. An intangible product requires much more consideration and understanding on the part of potential policyholders before they will actually reach into their pockets and pay for microinsurance. Thus, any estimate of insurance demand without specific products and market education has limited value.



The potential market for microfinance was noted above as approximately 367,000. Many fewer than this number will actually be potential microinsurance policyholders (of any product beyond credit life). It may be that best practice microfinance can reach about 25 percent of this number over the next five years: about 92,000 clients. Of those, perhaps one in four would purchase a policy, but not until they are comfortable with the MFP and have generated some surplus income that allows them to pay for microinsurance. Microinsurance will not replace the *Houia*, as these are often primarily social organizations, and so the amount contributed to them is not likely to be diverted to microinsurance. The potential market lies among those who are making more money because of some economic improvement.

Because of the state of microfinance and the general financial sector, it is unlikely that these conditions will be met to an extent that makes product development and implementation worthwhile for another two years. Government officials such as village chiefs do act as opinion leaders and may be able to influence the market education and the distribution channels that will effectively get the insurance products to the low-income clients. The distribution channels, however, will need strengthening by the insurer in conjunction with donors.

Characteristics of likely microinsurance customers

Potential microinsurance customers in the Lao PDR, would most likely come from among the base of current microfinance clients. The microfinance industry in the country is relatively young

and undeveloped. FC, an umbrella network representing 12 CCSPs or credit cooperatives, has at present a total of 1,500 borrowers (referred to as members) throughout the country. This is perhaps the only private and legally registered microfinance institution in the country. Other microfinance programmes are operating as part of multisectoral NGO programmes. The numbers of borrowers reached by these other programmes is unknown.

FC has targeted its programme to the 30 percent of rural households that produce a marketable surplus, and the 60 percent of urban households that are involved in family-based or microenterprises. (An estimated 70 percent of all rural households are headed by subsistence farmers who are not integrated into the market.)[49] Together, these rural and urban target groups account for 35 percent of the country's population or 2.2 million people. In the best case scenario, presuming all potential microfinance members agree to have access to microinsurance policies, the potential market for microinsurance might be as high as 367,000 in the medium term. Even then, the potential market for microinsurance would most likely be significantly less than these households since some of the households in this category will have access to life and medical insurance through a family member who holds a government job. It is unlikely that FC would reach 100 percent of its market target. The existing member base of FC is made up of wealthier rural households and entrepreneurial urban households, who are in the socio-economic centre. They are not rich but they are not living below the poverty line. The first target market for microinsurance would have similar characteristics. (See appendix 5 for information on persons interviewed for this research.)

Major risks of low income groups

The risks faced by low-income groups in the Lao PDR can be categorized as life cycle, business, and environmental types of risks. In the life cycle category, respondents identified serious illness (i.e., illness requiring hospitalization), death of a family member, and children's education as events that require large sums of money. Business risks included a weak business environment (or lack of demand), production risks, livestock disease, and loan repayment. Environmental risks included covariant shocks such as flooding as well as livestock loss due to disease.

(1) **Serious illness**

Illness was the most frequently mentioned risk facing families. Generally, outpatient visits to the doctor have only a moderate financial impact on a family. For the lower-middle-class focus group participants, doctor visits reportedly cost from $12 to $50. The $50 estimate includes transportation, the doctor's fee, and medication in the case of malaria. Some outpatient conditions can, however, have a very significant impact. For example, one family has a daughter who was recently diagnosed with goitre. Her medicine alone costs LAK500,000 per month. This cost will quickly become a burden to her family. If the condition does not improve, the girl will need to have surgery.

Life cycle events such as giving birth can have widely varying impacts on a family's finances, depending on where the birth takes place and the health of the mother. In one village, it was reported that giving birth costs LAK100,000 when the doctor attends the mother in her home. A birth in a hospital can cost from LAK300,000 up to LAK2 million depending on length of stay.

[49] Statistics provided by FC, May 2005.

Generally, hospitalization is considered to be the most expensive risk of all. One informant estimated the average cost of hospitalization for people in his village to be around LAK5 million. Examples of hospitalization costs include:

- Appendix operation with a five-day hospital stay, LAK3 million
- Hospitalization for malaria, LAK2 million.

The worst possible risk that can happen is to have a family member suffer from a long-term illness that requires hospitalization but eventually results in death.

(2) **Livestock disease**

This risk was mentioned frequently in the Louangphrabang region but not in the Vientiane area. This is a widespread risk. With one informant reporting that each family in his village probably loses at least one animal per year to disease, the negative impact of such a loss on household income cannot be overestimated. The cost of livestock losses varies, depending on the number of animal deaths and the type of animal. Pigs cost $40 each, cows $200 each and water buffalo $100 for a small animal and up to $500 for a large one. Disease also affects poultry as well as animals. One family reported losing $200 worth of animals in one year. The animals had been purchased with a microfinance loan so the impact was magnified because it put more stress on the family to find ways to repay the loan.

The impact of livestock disease appears to be more important in the Louangphrabang area, but it is also very significant in remote rural areas where families are more dependent on livestock for their livelihoods. The significance of this risk is heightened by the fact that livestock purchases are the principal and preferred means for Lao families to save for the future.

Loss of livestock has both short- and long-term impacts on a household's economic stability. Livestock disease is a significant risk because livestock purchases are themselves a risk-reducing coping mechanism that families use to save for future emergencies. Therefore, death of livestock increases household vulnerability in the short and long term.

(3) **Weak business environment**

Participants mentioned two dimensions to this risk. The first relates to the seasonality of the tourism sector that affects those living close to Louangphrabang, a major tourist centre. During high season, business is good and everyone is earning a relatively large income. In the low season, incomes plummet. For example, the owners of a small restaurant estimate that their sales are LAK5 million–LAK6 million per month in the high season and only LAK1 million in the low season. Another risk relates to crop seasonality. Farmers who grow vegetables as cash crops find that they can hardly cover their costs due to the low prices at harvest time when supply costs are high, as is the cost of transportation to market.

(4) **Production problems**

Another business risk relates to a range of activities associated with food processing or production. Two important sources of income for several respondents were Lao whiskey and rice noodles production. Respondents reported that if the quality of the rice used in production of either whiskey or noodles is not good, the final product is not good and cannot be sold at the best

price. Whiskey production also requires the correct temperatures to ferment properly. Other production problems include machinery breakdowns. The impact of the risks posed by production problems includes decreased income, high repair costs, and losses due to d own time. The risks related to whiskey production are less severe as the costs of production are low and the margins are usually high when the product is good.

(5) **Death of a close relative**
Funeral costs are another significant life cycle risk. Like the c osts associated with illness, funeral costs are significant in that they are generally unpredictable. Reported funeral costs ranged from LAK2.1 million for a small child to LAK6 million for an elderly woman. In one village, the minimum cost of a funeral is reported to be LAK500,000, although some respondents state that funeral costs can be managed to a certain extent by shortening the number of days over which one takes place. On the other hand, the cost of a funeral somewhat understates the cost of a death in the family. Buddhist tradition calls for holding a memorial service on the anniversary of a death. As can be seen below, the cost of the memorial can be more than the funeral.

This research found that death of a family member was a manageable risk for many families, with the possible exception of the death of a breadwinner . We did not come across examples of families where a breadwinner had died. In the case of the death of a breadwinner, the impact will be much greater than the examples we have pres ented. Most households we interviewed grow some if not all their own rice. The death of a male household head would mean the loss of significant labour power for the family and would impact their food security.

The idiosyncratic risks for which people in the Lao PDR most need assistance are those that bring with them the highest costs. These include: the risks of serious or long -term illness and hospitalization, livestock disease and the death of a breadwinner.

Current risk management strategies applie d by low-income groups
In the Lao PDR, people use a limited range of coping mechanisms. In large part, this reflects a less developed financial services sector.

Risk reduction strategies
In addition to savings, *Houia* and formal insurance (all discussed above), people use several strategies for reducing risk:

- **Reduced expenditures:** One risk reduction strategy is to cut down on household expenditures and reduce consumption in order to prepare for the costs of an upcoming event such as a birth in the family.
- **Income diversification:** One of the most widespread strategies for risk reduction is income diversification. The average number of economic activities per household was 2.8, not including salaried jobs held by household members. Households living in area s affected by the high tourism season switch to, or add, other activities during the low season in order to maintain an adequate income. Some focus on agricultural activities during the low season while others make and sell Lao whiskey.
- **Purchasing inventory:** Some of the respondents who have production -related businesses had a clear preference for purchasing more inputs, such as rice, when they had surplus

funds on hand. This is part of the pattern of preference for saving in hard assets rather than in cash. It makes sense in an environment of rapid price inflation and in an economy where agricultural prices vary from season to season. This strategy saves money and protects the purchaser from the risk of price inflation in the future. Other respondents who are not involved in food processing also purchase rice when they have surplus funds. These respondents use rice purchases as an income-smoothing strategy. They buy rice during the high season, when they have surplus funds and sell the rice when their business activities are low and they need extra cash.

Box 2. Income Diversification as a Risk Management Tool

Income diversification is not only a risk reduction strategy used as a precautionary measure but can also occur as a result of risks already experienced by the household. For example, Mrs. N. reported that almost one third of the pigs that she purchased with her CCSP loan died of disease. In order to make up for this loss and earn income with which to repay her loan, she and her husband decided to start growing vegetables as cash crops on their rice field. In the process, they discovered that raising pigs and growing vegetables are complementary businesses. The vegetables that they are unable to sell in time can be fed to the pigs, and the pig manure can be used to fertilize the vegetable garden. The unfortunate death of her pigs led to a valuable lesson learned for Mrs. N.

Loss management strategies

Other than borrowing, people who have suffered a risk event use several strategies to manage the financial impact of that risk. These include:

- **Gifts:** Households receive gifts from family and from their community in cases of specific risks. In the case of a death in the family, most village members contribute something to the cost of the funeral. Typically, in the villages visited, the village chief requests each household in the village to contribute LAK5,000. This can amount to about LAK1 million but will cover only a fraction of the actual funeral costs. This system varies depending on the village and the actions of the chief. Gifts from relatives might be received in cases of funerals and possibly for large medical expenses.

- **Selling assets:** After using existing income, the second strategy that households most typically use is the sale of assets, particularly livestock and poultry. Livestock and poultry sales are common coping mechanisms. Many households sell animals just to exist through the low season. In major emergencies, households will be forced to sell off larger animals such as buffalo, which can bring as much as $500 each, although frequently these must be sold at a deep discount because of the urgent requirement for cash. A less common strategy is to sell gold jewellery. In extreme cases, people will sell land, such as rice fields or teak wood gardens.

The coping mechanisms used in the country are notable due to the limited use of the kind of high-stress strategies that undermine household coping capacity in the future. Most of the respondents in this study have their own land, and we found little evidence of land being sold to cover emergency expenditures. We found no direct evidence of pawning of land although we

heard that people could borrow against their land title. Pawning of land is not a popular mechanism for raising cash in the Lao PDR, in contrast to Indonesia. This suggests that since households are coping with emergencies without doing long-term damage to their asset base, they may not perceive the need for microinsurance.

At the same time, we found that households have very low levels of cash savings. This is due to a combination of factors, including a reported difficulty in saving and the preference for saving in hard assets. Many households rely on participation in a *Houia* in order to save and to have access to large sums of cash in case of emergencies.

If households could obtain life and medical insurance at the same cost as government employees, many could easily afford the premiums of LAK2,000 to LAK4,000 per month. Many middle class households are spending LAK100,000 to LAK300,000 per month on *Houia*, albeit with the knowledge that they will receive a certain return in the future.

Microinsurance demand: Conclusions

Given the low level of access to microfinance and the fact that current microfinance efforts seem to be reaching the middle class, some of whom have access to formal insurance through a family member with government employment, it appears to be premature to introduce microinsurance products. There is not enough demand to make microinsurance commercially viable at this time. Furthermore, the demand centres are not all in one place but are both rural and urban based and spread throughout the country without effective intermediaries that could distribute the insurance products to them. In the short term, efforts should be made to expand the outreach of microfinance and to include poorer, more vulnerable groups in that outreach. In order to do this, solidarity group lending or other methodologies that do not require collateral should be introduced on a large scale. (FC programmes require collateral and guarantors.) Expansion of microfinance will assist in producing the future market for microinsurance. (as in earlier cases remove conclusion and please included any additional value added in the earlier text).

3.6 Microinsurance prototypes for the Lao PDR market

In considering products and services for the low-income market, it is useful to highlight the most important insurance risks that people noted in the demand study. These were:

- The risks of serious illness including long-term illness and hospitalization;
- Livestock disease;
- Death of a breadwinner.

Hospitalization cover

The demand research showed much interest in hospitalization cover. This is commonly where people have the most financial difficulty and risk. To make this product successful will require much focus on controls, and good relationships with providers. Some prerequisites include:

(1) **Inpatient facilities that will:**

- Offer good quality care;
- Work with low-income people;

- Treat policyholders without charge (reimbursement schemes defeat the purposes of insurance in that the policyholder still has to find the money before receiving care) ;
- Prepare monthly invoices for the insurer;
- Accept payment directly from the insurer on a monthly basis, or hold a depo sit from the insurer which is depleted on mutual agreement to cover care costs ;
- Allow confirmation of admittance and treatments by insurer staff ;
- Provide updated fee schedules;
- Allow the purchase of medication from an unrelated source .

(2) **Policyholders that:**
- Are part of some large group;
- Are somehow vetted for general heath by the large group (it is too expensive to do a medical examination on every person insured, and too much volume to review applications);
- Exhibit appropriate diversification.

(3) **Systems that:**
- Provide an easy and efficient mechanism for paying premiums (this will need to be developed by the insurer or an intermediary);
- An efficient and inexpensive way to vet admissions that is not expensive for the policyholder;
- Possibly cover basic transportation costs.

A product like this, given satisfaction of the above prerequisites, should cover:
- Transportation to the hospital;
- Any inpatient care up to a limit in terms of cost and in terms of longevity of hospitalization. This could be the equival ent of $500 and 14 days;
- A non-private room;
- Medications, diagnostic tests, treatments, and surgery (it might be best to source medications separately since these are usually the most expensive part of treatment, and hospitals have the ability to over-prescribe).

Pricing of the health product requires serious actuarial work. The risk structure of the lives of low-income households is usually significantly different from that of the middle and upper classes, for which there are often some data.

AGL has already been offering a low-cost hospitalization product, and CBHIs have been offering a basic cover similar to that of the SSO. AGL has found a limited market, and CBHIs have no reserves and a limited product. Although CBHI members are price sensitive it c ould be possible to link these two efforts to provide a more secure product that leverages both the CBHI ability to attract the low-income market and the commercial insurer's skills and reserves. A product like this could be developed by the CBHIs and eith er directly insured, or more appropriately, reinsured by the insurance company's partner.

Life of a breadwinner

Covering the life of a breadwinner is often the 'easiest' insurance to offer when starting, but the demand appears limited, and no appropriate distribution channel seems to be available yet. When the time comes to start, possibly after 24–36 months, a simple life product tied to a 10-year savings might be appropriate. It will be helpful for people to see some accumulation of savings to help offset the intangible nature of insurance, but this needs to be very simple.

Livestock insurance

Livestock insurance is also complicated and usually not done profitably. A product like this requires much attention to controls. Success would require at least:

- Offering the cover to groups of farmers (at least 10 people) who understand that in case of fraud among any members all cover will be terminated;
- Cover no more than 75 percent of the livestock replacement value;
- Have a veterinarian check all new livestock covered;
- Have a veterinarian determine cause of death;
- If marketable, sell the livestock in front of all group members;
- Confirm appropriate vaccinations.

Clearly, this product will be labour intensive and somewhat expensive: identifying and developing the farmers' group, veterinarian visits, and the potential for moral hazard and fraud looms large. Profitability is likely to be elusive.

Concluding advice for potential commercial microinsurance providers

Any insurance products will start especially slowly in the Lao PDR, and will take time to succeed even when people have seen the results. Because of the difficulty in managing the health and livestock policies, it is probably best to offer the life insurance product linked to an endowment first, even though this was not the first preference of the market.

An insurer in the Lao PDR would be advised to start in this market with cover for the breadwinner(s) in the low-income households. This will help the insurer to better understand the market, and to start to collect some actual mortality and possibly morbidity data [50] that will help in more adequately computing premiums. This should be considered as a pilot test where the market is tested for actual interest in insurance, the distribution channel is tested for efficiencies and capacity, and the systems, preferably computerized systems, are also tested. Once (1) the volume of policyholders reaches a sizeable risk pool, possibly 20,000 in the Lao PDR, (2) the three areas of market, people, and systems are all stable, and (3) the capacity and quality of hospitals are assessed, then a hospitalization scheme could be tested, followed by a livestock policy, after the hospitalization and life products are stable.

[50] The term **morbidity rate** can refer either to the incidence rate or to the prevalence rate of a disease. Compare with **mortality rate**, the number of people dying from a particular disease during a given time interval, divided by the total number of people in the population.

CHAPTER IV. PROBLEMS, OBSTACLES, AND OPPORTUNITIES

4.1 Prerequisites for the adoption of microinsurance in the Lao PDR

The low-income financial products market in the Lao PDR is at a nascent stage of development. In order for commercial microinsurance to work, people should already have access to monetized savings and credit so that they understand the basic formal financial products. This makes the introduction of microinsurance more acceptable.

Many people are already receiving government insurance, and others participate in *Houia* that might be a form of insurance. Additionally, the Government CBHIs have shown that most people at least are not averse to microinsurance.

In making microinsurance efficient it is best if it can be sold to groups of policyholders. This dramatically reduces the costs of delivery. It was reported that Lao people do not like to be in large groups. Additionally, apart from the LWU, there are few organizations with effective outreach to large numbers of people.

4.2 Institutional barriers to the integration of microinsurance and risk management

The country's financial sector is still very new, with many efforts under way to improve the banking industry. This industry is very small and is dominated by SOEs that are still digging out from serious non-performing asset problems. This is not the time to burden them with a new product line.

The LWU is the key mass organization for getting new ideas into the whole market around the country. This organization is working with several donors and others to implement various products and projects. Its capacity for promoting and selling microinsurance appeared limited, and thus it would need significant capacity-building to be able to implement such a programme.

There may be a philosophy difference between the LWU and a commercial insurer that would make this relationship difficult. It is not likely that the LWU would be an appropriate partner for commercial microinsurance.

The insurance market remains very small also, with one regulated insurance company enjoying monopoly status. Although this company has provided an alternative package to employers, its market remains predominantly among the wealthier members of Lao society. The company has noted an interest in moving downmarket to develop products for low-income people, and indeed has tested basic life and disability products.

In order for AGL and future insurance companies to reach the low-income market effectively and efficiently, it is probably necessary to do so through one or more intermediaries. These

intermediaries would already be managing financial transactions with a large membership so that their cost of delivery would be minimal, and both they and their clients would be accustomed to the mechanisms of financial transactions. At present, there is not an appropriate int ermediary to deliver significant volumes of commercial microinsurance.

The lack of MFPs to work with in marketing microinsurance is an important constraint, not only because of the lack of intermediaries, but also because MFPs are important in helping to develop monetized savings as well as maintaining financial networks. Such entities represent an important step towards complete microfinance provision, which will include microinsurance.

There are two potential training facilities, the training college of the Bank of Lao PDR and the University. Neither of these has the capacity (or the will) to develop and implement microinsurance courses. It is likely that AGL would need to train its own staff as well as those from any potential intermediary that might be developed through the ongoing work of the ADB and others.

4.3 Potential partners for microinsurance provision

We identified and met with several potential partners that share a common vision required for successful implementation of microinsurance - GTZ, ILO, Concern Worldwide, World Concern, Belgian Technical Cooperation, the APB, and the AFD. Though their current work is supporting non-insurance microfinance and other projects, they could be a direction for the future. The AFD is subsequently planning to support the health sector, and this may include health microinsurance. All indicated in one way or another that it is early for microinsurance in the Lao PDR given the very basic financial structures in terms of physical infrastructure, regulation and supervision, and most important, the human capacity of both potential implementers and the market.

CHAPTER V. THE NEXT STEPS

5.1 Distribution systems

Distribution through existing entities is not likely to be effective at this time given that the potential distributors either think it is too early for microinsurance, or do not have the capacity to sell commercial microinsurance. It might be reasonable to begin discussions with potential distributors so that they know of the potential for microinsurance once the market is ready, and because potential distributors will have a better understanding of when the market is ready. Of the organizations visited, it would be advisable to meet with Concern Worldwide and Belgian Technical Assistance; they appear to have the best objective knowledge of microfinance and the low-income market in the country. It would also be important to follow the activities of the ADB, which is working on a major project for enhancement of microfinance.

It is possible for an insurer to create a distribution system on its own, as did Delta Life Insurance in Bangladesh. This model has proven profitable, although the delivery channel is about 10–12 percent of premiums more expensive than other insurers using a partnership model with intermediaries. Unless low-income people are used for distribution, it is very difficult for an insurer to have effective agents in these markets. There are two key reasons for this: (1) low-income and especially rural people do not trust outsiders, and this makes sales especially difficult for an intangible product; (2) agents have very little incentive to work with the low-income market especially if customers are not combined into large groups because the commission on microinsurance premiums is much less attractive than that on premiums for middle- and upper-income clients.

Tata-AIG (part of American International Group) in India is testing a system of training village women as sales agents for their villages. The success of this model is yet to be seen, and India has a dramatically different financial landscape from the Lao PDR.

5.2 Marketing considerations

Marketing microinsurance will require trusted media, and significant education of both the sales force and the market itself. It is important to recognize this as 'educating' and not just 'informing'. Educating will ensure that people who purchase the insurance actually understand what they are buying and how it helps them. This creates a better policyholder, and will significantly increase the potential for renewals.

AGL has been involved in social responsibility programmes that aim to develop insurance awareness in general and road safety in particular. This programme is advertised through 13 posters and leaflets that explain, using drawings, the basic benefits of insurance (motor, health, fire, term life) and how to avoid road accidents. The fact that AGL has already embarked on such a programme to generate widespread awareness of insurance within the Lao PDR offers an important first step, which can be further refined to address more specific needs and concerns of the low-income market.

Common mistakes in marketing centre on misunderstandings of the low-income market: for example, posters filled with text that is difficult to read, or television advertising when most of the people aimed at do not have a television set. It is critical that any marketing efforts be vetted by focus groups of likely policyholders. This will save much money, time, and confusion. It will be necessary to develop picture-based posters and brochures. Brochures are important because people need something tangible that reflects the product. People will not get individual policies (which are too expensive to produce and distribute), so they need something tangible to satisfy the physical evidence aspect of the '8 Ps' of marketing.[51] There should also be something small given to people that tells them what to do to make a claim, and what is covered. This needs to be simple, and in other countries has been done on the front and back of a business card.

The simplicity of the information provided reflects the policy components, which must also be easy to understand. There should be few exceptions or limitations, and the cover should be very clear. This is necessary in marketing to the low-income market, and will be especially important in the Lao PDR.

5.3 Capacity improvement

When considering operational capacity one must understand the model to be followed in order to understand the capacity needs. Thus, we look at three potential models.

(1) **CBHI**. In CBHI programmes, the risk pool is severely limited by the population of the community or group, as well as the capacity of a local person to manage the insurance transactions. They generally have limited reserves, and no access to reinsurance. Unless there is going to be significant coordination of these groups, risk pooling among all the groups, and 'reinsurance' from the Government or a donor agency, these will prove difficult to sustain. If there were a coordinating body for the CBHI, and premiums were combined to create a larger pool, this could prove an appropriate entry point for a commercial insurer. The insurer could then absorb the premiums and shift the risk from the community to a regulated insurer. This would link people into a broader and (presumably) more stable system offering access to additional products. This would probably be an improvement for local groups.

To make this happen there would need to be:

- A mechanism to consolidate the premiums and track the policyholders. Such systems would have to be developed by the insurer in close contact with the coordinating body and could include mobile electronic options;
- Health-care facilities within relatively easy access of policyholders. These facilities would need to be willing to compile activity and invoice the insurer on a monthly basis;
- Controls developed to manage the provider–policyholder transactions. This is commonly a place where there are significant moral hazards and outright fraud.

[51] The '8 Ps' are: Product (design)–specific features, terms, etc.; Price–interest rates, transaction cost, etc.; Place–distribution, accessibility, etc; Promotion–advertising, PR, etc; Positioning–in target customer's mind; Physical Evidence–the physical appearance of the product/service; People–the human interactions as the product/service is delivered; and Process–how the product/service is delivered: the steps.

(2) **MBA**. A second model for the Lao PDR might be that of the Mutual Benefit Association (MBA). In this case, a large group of people, possibly the consolidated CBHIs, could generate the initial capital from their members to start a member-owned insurance provider. In many ways, this model is little different from starting a greenfield insurance company (that is, a regular insurance company in an untouched market), except that people with little knowledge of insurance would be on the board. This structure would require:

- A legal structure for this type of insurer;
- At least two professional insurers to manage the MBA;
- Training on all levels, including the board;
- Implementation of computerized systems;
- Facilities;
- All that was required of the CBHI consolidation model above.

(3) **Partnership with intermediaries.** The third option would be the partnership model that has been presented throughout this paper. This model has a regulated commercial insurer working with intermediaries so that the risk is borne by the insurer, and the marketing is done by organizations that work directly with the low-income market. The capacity of the current insurer is unknown because our team was denied appointments to meet with relevant people during the visit. The intermediaries need significant capacity-building in terms of offering best-practice microfinancial products. Some progress is being made in intermediary capacity-building but it will take time before insurance can be introduced.

A potentially successful intervention in the country could be a hybrid of the community-based and partnership models. Linking a commercial insurer with CBHI efforts could generate a synergy that allows each partner to do what it does best. The insurer provides options that allow the CBHI to expand the options for its members, while the CBHI continues to be the owned organization of its members. The members make their product decisions, negotiate with the insurer for products beyond their basic capacity, and sell these products to their members. Ownership and decision-making remain intact for the CBHI, and the insurer (within commercial reason) responds to those demands while obtaining a larger market.

5.4 Other resources required

There will be a large and continuing need for the development and stability of potential microinsurance intermediaries. In addition, capacity-building of these future intermediaries will require a sustainable training and capacity-building infrastructure. As we have seen in many other countries, getting microfinance to a stable stage is a long and arduous task, requiring much technical assistance.

In general, people with insurance expertise will need to be developed in terms of the micro-market. Because there is only one insurer in the country under study, however, it is likely that these professionals would have to be 'poached' from that insurer.

5.5 Legal structure

If an MBA is to be developed there is a need for:

- Specialized legislation that allows for such a membership body outside the control of government or the ruling party. A good example can be found in the Philippines.
- The development of a supervisory body and guidelines for supervision to provide legal oversight in its mission to protect the consumers. This would more likely be additional training for the two people in the Ministry of Finance who supervise the current insurance company.

Implementation of the insurer–intermediary model is mostly covered by current insurance legislation. It will be important to have a provision for institutional agents, so that every intermediary's field staff need not be licensed as agents.

New microfinance legislation is currently being worked on with the ADB. It will be important that MFPs covered by this legislation should be legally able to act as agents and accept some form of remuneration.

5.6 Financial structure

Because integrating a commercial insurer into the CBHI system will take significant input of time and skills, and because it is unlikely that such an intervention would be profitable for at least a few years, it will be necessary for donor intervention to support the integration initiative. It is critical that such inputs be limited to a reasonable time period, however, and that whatever structure is developed for the implementation of this suggestion be done with efficiencies in mind. The market that is served by the CBHIs is a price-sensitive market. Systems must be developed that result in extremely low operational costs with very low margins that require high volumes for profitability.

CHAPTER VI. CONCLUSION

The Lao PDR is a country with 6.2 million people, and a continued relatively strong central authority. The *macro*financial activities are in a nascent stage, as are the *micro*financial. There are efforts under way to improve these structures, their supervision, legislation a nd capacity. The insurance 'industry' is comprised of one insurance company. The major banks and a minority share of the insurance company are owned by the State.

Demand research among potential microinsurance clients showed a need for hospitalization and livestock cover, as well as that for the death of a breadwinner. The demand was weak to moderate. Possibly this demand contention is supported by the low level of uptake of these products offered by AGL, although the issue holding back AGL is more likely related to product design and delivery channels.

The infrastructure for microinsurance is extremely weak. Potential intermediaries are very limited in both number and capacity, and in most cases where there are such intermediaries , they are still working with the low-income market using non-best-practice methodologies.

A commercial insurer will almost certainly need to develop an infrastructure of non -insurer intermediaries to reach this market. AGL has, since its beginning, developed an agency model that includes an insurance agent in each province. These agents could be working with organizations with large numbers of potential policyholders. This may improve distribution but access to the organizations and their members is still an issue to be addres sed. That infrastructure is practically nonexistent. Coupling this lack with a weak-to-moderate demand, it is clear that it is too early for profitable commercial microinsurance in the country. It may be appropriate to begin developing the microinsurance p roducts and processes with subsidies from government (as a support for social security), or from donors to support initial research and development and first- and second-year operational deficits.

Donors and development organizations should continue to observe and document lessons from the experience with the CBHIs and the development of the microfinance market. In particular, they should look closely at organizational structure, capacity and best-practice operations. The successful implementation of the MFP legislation is also important. Success in these areas will provide evidence of the preparedness for microinsurance, and should energize the effort to develop microinsurance products. It is likely to take at least two more years to develop the potential for profitable professional microinsurance.

With the initial aid of donors, however, in order to improve the potential for microinsurance, an insurer might begin to work with the CBHI apparatus with the objective of integrating itself into the CBHI system. The CBHI system helps to address some of the issues of trust that make voluntary sales of commercial insurance difficult. The professionalism an insurer brings to a CBHI has the potential to provide a different layer of trust. CBHIs currently have no reserves and no reinsurance. An insurer link could help to limit the potential that CBHIs will suffer significant losses. Additionally, though low-income people especially do trust in their local institutions, they frequently end up in difficulties because of corruption and mismanagement,

both of which a commercial insurer could help to improve. Linking CBHIs and commercial insurers thus could have the outcome of mutual strengthening leading to greater outreach. This represents a strong potential strategy for expanding microinsurance throughout the country.

During the intervening time, it is appropriate for the Government and/or donors to work with the insurance 'industry' to prepare legislation facilitating microinsurance as well as working with those involved in capacity-building of MFPs and potential policyholders to develop a more receptive market, and marketing and servicing capacity. Any potential microinsurer should also consider inputs to the current process of developing legislation for microfinance.

The Government should be putting mechanisms in place to assist in the provision of social security to the low-income masses. This effort should include interactions with the insurance 'sector' to consider the distribution of activities in terms of social security. This should lead to a more efficient implementation of private/social insurance that would best serve the citizens of the Lao PDR.

APPENDICES

Appendix I: Methodology and Respondent Statistics

Methodology

The researchers carried out individual in-depth interviews with 18 respondents over the course of the week of 31 May to 2 June 2005. Two interview tools were used to explore risks and coping strategies, and loan and savings use over time. Additionally, one key informant interview was conducted. The interviews took place with members of the FC network of credit cooperatives (CCSPs). Fourteen interviews were conducted with members of the CCSP in Louangphrabang and four interviews were conducted with members or employees of the CCSP in Hong Ngu a, in Naxaythong District. Seventy-two percent of households and 76 percent of villages in Louangphrabang province are considered poor. The districts within Louangphrabang in which we conducted our research are not categorized as poor, however. Nor is the Naxaythong district adjacent to Vientiane..

Fonds Coopératifs and CCSPs

The members of FC CCSPs come from the 30 percent of rural households that produce a surplus, which can be marketed, and the 60 percent of urban households that are involved in family-based or microenterprises. (An estimated 70 percent of rural households are subsistence farmers who are not integrated into the market.)[52] Together these rural and urban target groups account for 35 percent of the population or 1.9 million people. At this time, the CCSPs that make up FC are reaching 1,500 members. To the best of our knowledge, this is the largest private (i.e., non-government) microfinance programme in the country. It may well be the only best-practice programme in the country. Currently, FC has 12 CCSPs across the country, with the Louangphrabang CCSP being the most northern cooperative.

CCSPs offer their members loans ranging from $100 to $1,000 with loan terms up to 1 year. Repayment is usually interest only with balloon payments of pri ncipal at the end of the term. The interest rate is 36 percent per year. Sixty percent of the members are women.

Characteristics of sample group

Seven men and 11 women were interviewed, reflecting the gender distribution of members of CCSPs. Nine interviews were conducted in Louangphrabang district and five in the Xieng Ngeun districts in the region of the Louangphrabang CCSP. Four interviews were conducted in the Naxaythong district, about 35 km outside of Vientiane.

Household Composition	
	Average
Total Number of People in Household	6.2
No. aged 17 and above	3.4

[52] Statistics provided by FC. May 2005.

No. aged 16 and less	2.2
No. of Children 6-16 in school	1.8
No. engaged in economic activities	2.7

Age of Respondents	
Average Age	41.5
Youngest Respondent	23
Oldest Respondent	60

Education Level of Respondents	
	N=17
None	1
Some Elementary School	4
Completed Elementary School	1
Completed Junior High School	5
Completed High School	6

Gender and Marital Status of Respondents	
	N=17
Married	15
Single	1
Widowed	1
Male	6
Female	11

Gender of Primary Income Earner	
	N=16
Male	8
Female	1
Both (husband and wife work together)	7

Household Economic Status	
Average Annual Household Income	LAK23.6 million
Average Number of Economic Activities per Household (not including salaried employment)	2.8
Number of households with at least one person in a salaried employment	9
Respondents owning own house	16

Access to Financial Services	
Average Amount of Current Loan from CCSP	4.8 million kip

No. of Respondents with Savings Account in Bank	3
No. of Respondents participating in *Houia*	9
No. of Respondents with access to formal Insurance	6

Economic Activities of Respondents
Cattle keeping for others
Cattle raising
Corn growing
Fish trading
Handicrafts selling
Handicrafts/Weaving production
Ice making
Whiskey production
Noodle production
Pig raising
Poultry raising
Restaurant
Rice growing
Small shop
Teak wood growing
Vegetable farming
Watch repair shop

Appendix II: Donor Involvement in Microinsurance in Lao PDR

Name of organization	Project
ILO	**Development of Social Security** in collaboration with the Ministry of Labour and Social Welfare. The comprehensive support covers the following activities, among others: Setting up of a tripartite steering committee attached to ILO/UNDP project; Support to the CBHI scheme jointly with WHO. Project Capacity-building for Labour Law Implementation
UNDP	To reach the poorest people in the Lao PDR, UNDP has been focusing its rural development activities on several poor districts, including Sekong, Huaphanh, and Xiengkhoang. Projects cover a wide range of sectors, such as income-generating activities, and the provision of health. **Macroeconomics of Poverty Reduction**, initiated by the UNDP Bureau for Asia and the Pacific. The regional programme has several objectives: Discussions on integrating poverty reduction objectives into national economic policy-making and general socio-economic development strategies; Policy options and institutional means to foster more pro-poor stabilization, economic restructuring, and growth. In order to achieve these objectives, the programme supports activities such as access to assets, productive inputs, technology and employment, and the ability of low-income households to save and invest as well as access to health and a decent standard of living.
WHO	WHO supports projects in health financing, health system organization, and regulation. In this context WHO, jointly with the Ministry of Health, implements the **Development of Social Safety Net through Community Based Health Insurance** projects in the Lao PDR and Viet Nam. The CBHI is piloted in three districts in the Lao PDR as a trial of an innovative scheme of health-care financing.
ADB	The ADB has taken a leading role in improving the landscape for microfinance. This has included: Promotion of the Agriculture Promotion Bank Support to CBHI Assistance in developing the microfinance legal structure
World Bank	Several poverty reduction projects such as the **Poverty reduction Fund** and the **First Poverty Reduction Support Credit** are provided with strong emphasis on macroeconomic development. The **Financial Management Capacity-Building Credit Project** aims to provide a comprehensive framework for capacity-building activities to improve the financial management in the Lao PDR and to provide a credit for specific technical assistance and training activities within such framework Designing and implementing individual restructuring plans for state-owned commercial banks; Assessing, developing, and supporting the legal and institutional framework for resolving non-performing loans; Strengthening the capacity of the Bank of Lao PDR to supervise SCBs and the capacity of the Government to monitor and support Bank restructuring plans; Developing rural and microfinance.

Name of organization	Project
European Union	In the area of rural poverty reduction, the European Union has targeted especially the north of the country with significant minority populations. NGOs play an important role and collaborate closely with the European Commission, carrying out projects in health, humanitarian assistance, and food security. Other main areas of support: Reinforcement of the health-care system through the provision of basic equipment and drugs; Capacity-building through training of local staff in technical issues as well as the management of the health system; Increased access to health care by improving physical structures in remote areas and the provision of mobile medical teams; Strengthening of the public health-care system's capacity to provide access to effective and affordable sexually transmitted infections (STI) services Establishment of support mechanisms for the planning and monitoring of a National Care and Prevention Programme.
International Fund for Agricultural Development (IFAD)	The Xieng Khouang Agricultural Development Project Phase II aims at increasing household food and income security, improving nutrition for the poor, and increasing the availability of alternatives to opium poppy cultivation. These objectives will be achieved by: e.g., Encouraging agricultural development, including irrigation, crop and livestock production; Providing income-diversification opportunities through savings and credit; Community-based savings and credit groups. The Oudomxai Community Initiatives Support Project aims at: Improving the capability of the poor and their organizations to make efficient use of their natural resources and the services available for their own social and economic development; Providing rural financial services to support investment in on- and off-farm income-generating activities; Support the implementation of the National Poverty Reduction Programme, including support for the LWU to mainstream gender issues in all project activities.
EC/UNFPA	The European Commission funds the United Nations Population Fund (UNFPA), which launched the EC/UNFPA **Reproductive Health Initiative** in collaboration with NGOs. The project aims to create sustainable mechanisms through which reproductive health demands of vulnerable groups and deprived populations could be met.
Belgian Technical Cooperation (BTC)	The following projects are directly linked to health insurance: Development of Social Security; Financial and managerial strengthening of the Social Security Organization including social health insurance; Support to the health-sector reform in the provinces in Vientiane and Savannakhet with the focus on reforming the health system and controlling malaria; Education, agriculture, infrastructure, and health care are covered in a project for integrated rural development in the province of Savannakhet.

Name of organization	Project
JICA	The following projects could have a relevance for health microinsurance: Propagation of public health: Efficient management system of medicine and health care; Improvement of medical technology: improvement of medical services of core hospitals, as well as educating medical personnel; Local Development Programme: Community development, programmes for the elderly, disabled, and childcare, etc.; Improvement of health and hygiene with the Ministry of Health. Conference ASIA-PACIFIC Elderly, International Cooperation towards Ageing People in the Lao PDR, ASEAN–Japan High Level Meeting, Yokohama, Japan, 30.08–02.09-2004 Help-Age International–Concerning Ageing, Health and Welfare.
GTZ	The **Integrated Rural Development Programme** in Luang Namtha: The variety of components include: Improvement of agricultural production and increased access to financial services (e.g., setting up of village banks); Strengthening of the basic health network, including preventive and curative care.
International NGOs Swiss Red Cross	The Swiss Red Cross focuses on **mother and child health care** in rural areas through preventive care and awareness building, immunization, family planning, and development of village pharmacies. Moreover, they provide health cards for the poor that give access to the community-based health insurance scheme (**CBHI)** of the Ministry of Labour and Social Welfare.
Save the Children Norway (SCN)	**Child Labour** in the Provinces Borikhamsxay and Pakkading: Building awareness on issues related to children and working to reduce the incidence of economic exploitation of children.
CARE International/Lao	**HIV/AIDS and STI Prevention** and Project Management (HASPM): The HASPM project aims at reducing HIV/AIDS and STI incidence in Louangphrabang, and the vulnerability to HIV and STIs. Health care and social development are components of CARE's support.
Action Contra la Faim (ACF), CONCERN World-wide, German Agro Action (DWHH/ GAA), Quaker Service (QSL)	Microfinance and economic development
Australian Red Cross (ARL), Comité de Coopération avec le Laos (CCL), Christian Reformed World Relief Committee (CRWRC), Handicap International (Belgium and Action Nord Sud), World Vision (WVL)	Health care

Appendix III: Terms of Reference

Microinsurance: Demand and Market Prospects: India, Indonesia, and the Lao People's Democratic Republic

1. Introduction

Allianz AG[53] has expressed interest in being a partner with UNDP and GTZ in market research to estimate the demand for microinsurance interventions in three major Asian markets (India, Indonesia, and the Lao People's Democratic Republic). This represents a mutually beneficial opportunity for UNDP and Allianz AG. For UNDP, it would create access to microinsurance to meet the demand, so far unsatisfied, to reduce the vulnerability of over 3 billion people, and it has the potential to assist in achieving the MDGs. For Allianz AG, it would provide a leadership niche in this growing industry. Microinsurance also constitutes a new market opportunity for Allianz AG. In partnership with UNDP, Allianz AG could make an important contribution to the development of the nascent microinsurance markets. A consumer base of practically half of the global population presents a significant market with a lucrative potential for the insurance industry. Given the added threat of human-induced climate change, the insurance industry can proactively assist in reducing the vulnerability of poor people in developing countries to weather-related natural disasters.

The underlying premise of this proposed partnership is that the delivery of microinsurance will benefit poor and low-income groups, establish local entrepreneurs, and strengthen livelihoods. This will be driven by the creation of safety mechanisms for managing risks, and shocks and stresses including natural hazards. The hypothesis is that access to insurance by entrepreneurs in the developing countries will draw private-sector investments and promote national development priorities.

2. Background

Currently over 1 billion people–two thirds of them women–live in extreme poverty on less than $1 a day without access to most of the social services basic to a decent quality of human life. This figure rises to nearly 3 billion, if a standard of $2 is used.[54] The success of the strategy to reduce the proportion of people living in poverty is contingent upon generating income-providing activities, augmenting access to resources necessary for livelihoods, building assets, and assisting the poor and the disadvantaged populations to manage risks.

Vulnerability to risks from stresses and shocks including illnesses, injuries, property loss, and premature death are everyday realities for the poor. Additionally, it is the poor people occupying marginal, dangerous, and less desirable locations to live and eke out livelihoods, who are hardest hit by natural disasters. In 2000, leaders of 189 nations agreed on eight Millennium Development Goals including their commitment to reduce the proportion of people living in abject poverty by 50 percent by 2015. Simultaneously, in the face of economic globalization, it has become necessary to think

[53] Allianz is one of the leading global services providers in insurance, banking and asset management. Allianz is working in more than 70 countries, and it is one of the five leading asset managers in the world. Allianz has demonstrated strong commitment to the broader goals of sustainable development.
[54] OECD. 2001. DAC guidelines on Poverty Reduction. Paris.

innovatively in order to reduce the vulnerability of poor people to shocks and stresses through provision of safety net mechanisms to manage risks.

Micro and small enterprises employ a significant portion of the labour force in developing countries, albeit in 'survivalist' employment and in the informal economy. The informal economy provides employment for the majority of people, particularly women, in the developing world. Besides providing low incomes, the informal economy does not provide any formal means to manage risk.

Many of the micro and small enterprises operate outside the legal system, and this also contributes to their low productivity. These enterprises lack access to financing and long-term capital, which is the basis for providing sustainability to all entrepreneurial activities. Additionally, the institutions that finance such enterprises are themselves prone to the risks of the borrowers, a fact that can constrain their going to scale. For instance, microfinance providers (MFPs) allow low-income entrepreneurs to borrow money and are therefore vulnerable to the same risk as their clients. In the event of a risk event striking borrowers or a family member, their ability to repay the loan is in serious jeopardy. While MFPs use several options [55] to protect themselves from the risk of non-payment, none of them is perfect.

Micro and small enterprises can be engines of growth, if they are developed to generate income and wages for their clients and support their transition out of poverty [56]. In addition, since reducing vulnerability is about risk management, risk management should be an intrinsic component of sustainable livelihoods. Microinsurance [57], though relatively new, provides such an option to the 'working' poor people. Microinsurance aims to provide protection to low-income people against specific risks and hazards in exchange for premium payments proportionate to the likelihood and costs of the risks involved.[58] At the same time, there is a need to explore safety net and insurance mechanisms that would, in particular allow poor people to alleviate the economic impact of natural disasters.

Informal mechanisms such as savings and other traditional risk management structures [59] have proven to be too costly and therefore unsustainable as long-term coping strategies [60]. While the private and formal sectors appear to be the most suitable to provide microinsurance products –as they can design and offer sustainable and long-term risk reduction strategies that are also profitable –this role is yet to be explored comprehensively both as a business model and as an intervention for social protection. It is equally important to understand how microinsurance relates to government policies and the role of the Government and the public sector in terms of creating an enabling environment, laying the foundation for its efficient implementation through developing capacity, strengthening institutions and infrastructure, and disseminating information for the development of microinsurance opportunities as safety net mechanisms.

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[55] Expect the group to repay; Try to claim from the estate; Write off the loan as a bad debt; Self-insure; Partner with an insurance company.

[56] Sievers, Martin and Paul Vandenberg. 2004. Synergies through Linkages: Who Benefits from Linking Finance and Business Development Services? SEED Working Paper No. 64. ILO. Geneva.

[57] Access to insurance reduces the vulnerability of households and increases their ability to take advantage of opportunities. Moreover, by reducing the impact of household losses that could exacerbate their poverty situation, insurance enhances the stability and profitability of households.

[58] Cohen, Monique and Jennefer Sebstad. 2003. Reducing Vulnerability: The Demand for Microinsurance. Microsave-Africa. Nairobi.

[59] Targeted savings and consumption loans including Rotating Savings and Credit Societies and savings clubs can help the poor to cope with day-to-day events, but as risks increase in magnitude and uncertainty, losses increase and simple savings and loan activities are unable to manage those losses. Brown, Warren (2000): Why MFPs are providing insurance to low income people? Dhaka.

[60] Kawas, Celina and Marla Gitterman. 2000. Roundtable on Microinsurance Services in the Informal Economy: The Role of Microfinance Institutions. The Ford Foundation. New York.

Microinsurance to manage risks for population with low incomes and low insured values has limited precedent. Although MFPs have demonstrated interest in participating in the microinsurance industry [61] as in fact many of the existing products have been defined for the clients of an MFP, it is critical that the finances and management of the insurance business are separated from the MFP's savings and credit activities. Part of the reason lies in the fact that the microinsurance product could have high transaction costs and the difficulties in controlling moral hazard and adverse selection. While households understand microfinance very well, their limited understanding of insurance that could lead to a bias against insurers. Microfinance providers may also be challenged by the need to achieve scale, and skills requirements for actuarial analysis, investment opportunities, and regulation.

MFPs have employed different strategies for providing insurance to their clients. For instance, institutions like SEWA or ASA in India, [62] in collaboration with national public insurance companies and private insurance providers such as Bajaj Allianz AG and GTZ, have provided integrated insurance schemes covering sickness, death, widowhood, maternity, and loss of flood, fire, and riots to its clients. MFPs in Uganda, in partnership with American International Group (AIG) have offered a group personal accident and credit life and disability policy in Uganda since 1997. The premium is bundled with the cost of auxiliary financial services into the MFPs' interest rates, or as a separate fee. Gaining from its experience in Uganda, FINCA International has offered the same AIG product in Malawi, the United Republic of Tanzania, and Zambia. A private insurance company, Delta Life Insurance, provides a combination of life and endowment microinsurance products, called Gono -Grameen Bima. CARD Bank in the Philippines, through its Mutual Benefits Association (MBA) has been offering life insurance policies with long-term savings. Canadian Cooperative Association (CCA) China has recently started a small pilot health programme consisting of an integrated health insurance appr oach for its clients. The programme is being supported by funds from the Canadian Government as well as client membership fees.

The lessons learned from the limited number of ongoing activities clearly emphasize that microinsurance is a highly technical operation, and that it is vital to better understand the market potential and efficient delivery of microinsurance services. Apparently none of the initial microinsurance ventures were preceded by any form of market potential study that looked at the deman d and acceptability of the product, development costs, cost of premiums or their affordability based on a sustainable business model. Furthermore, none of the products launched until now were followed up, or included the education of clients, insurance service providers and other stakeholders, or disseminated relevant information on a broader basis. This is part of the reason why the client turnover rate in some of these initiatives has been large, and many of them have failed to show even a modicum of the potential profits microinsurance is potentially capable of. There is indeed a lot to understand prior to introducing microinsurance as a viable market initiative to help poor people cope with income erosion to reduce their vulnerability while providing a new business opportunity to forward-looking insurance companies.

Microinsurance is a nascent market. If microinsurance can be delivered in a cost -effective manner through MFPs and other civil society organizations, the significant numbers of their client s who are in need of insurance services per se represent a profitable segment for the insurance industry. Previous attempts to launch microinsurance products have quickly revealed some key factors for success in implementation:

[61] Response to demand from clients, reducing household risk, protecting the institu tion, and an additional business opportunity.

[62] India is leading insurance industry expansion into emerging Asian markets. Both India and China are opening their enormous markets to overseas companies, which will create market expansion opportunities for t he insurance sector.

- Products should be launched after a careful market study including qualitative consumer surveys;
- Products should be designed in close consultation with the stakeholders;
- Information and knowledge of the products must be clearly communicated to and shared with the potential customers;
- Claims must be settled as quickly as possible;
- The transaction costs of delivery must be clearly understood, appropriately allocated, and minimized;
- The product provider must have considerable knowledge and experience of the actuarial side of insurance provision;
- Products must be launched sequentially starting with simple products (life/funeral, catastrophe insurance) and then moving into more sophisticated products such as health.

Hence there is a need to initiate market potential studies in a limited number of countries. It is also recommended that the outcome of the studies be implemented through timely, pilot, 'learning by doing', microinsurance initiatives that are based on sound business models and practices premised on well-defined market and comprehensive market analysis. It is hoped that the success of such smaller pilot initiatives would allow microinsurance initiatives to be taken to scale and achieve wider acceptance and validation. The pilot initiatives will also assist in delineating and creating an enabling environment, and putting it in place to ensure that the process is efficient and transparent with minimal transaction costs. In addition, the lessons learned from the pilots will provide a valuable estimate of the extent and nature of capacity development at the human, institutional, and system-wide levels that is required for local governments, civil society, and the private sector to make microinsurance a viable business.

The countries of interest would include India, Indonesia, and the Lao People's Democratic Republic. While India has a large number of existing microinsurance activities, Indonesia has an active microfinance and microenterprise system and intends to expand social security systems to the informal economy. In the Lao People's Democratic Republic, one of the group of the least developed countries, demand is high, and the Government already supports social health insurance. Additionally, in India the government policy directs the insurance industry to spend a certain amount of resources to improve the quality of life for poor people.

3. Objectives of the study

It is in the above context that the UNDP–Allianz AG–GTZ joint market research and exploration of microinsurance interventions in selected countries is being formulated. The first step is to review the existing experiences through a desk study and then undertake market-based studies in a limited number of countries to acquire a better knowledge and understanding of the potential for microinsurance and efficient delivery of demand-based products. It is hoped that the study would provide an evidence-based theory of change to make microinsurance a sustainable alternative for providing safety net mechanisms for poor and disadvantaged communities.

3.1 Overall long-term objectives

To substantiate linkages between microfinance, development of entrepreneurs and sustainable livelihoods through the availability and access to microinsurance by the workers in the informal sector.
Explore the use of microinsurance as a safety net mechanism to reduce vulnerability of livelihoods of the poor including impacts of climate-induced natural disasters.

Goals of this activity

- To estimate the demand for microinsurance in three countries of Asia.
- To estimate the potential supply of microinsurance in terms of risk takers (regulated insurers, governments, and others) and various delivery channels. This estimation will include a discussion of transaction costs for delivery of microinsurance services.
- To explore the option of undertaking pilot initiatives through the development of a basic process outline inclusive of estimated costs.
- To foster dialogue and cooperation between the insurance industry, governments, and civil society, and enhance North-South and South-South partnerships.

3.2 Benefits of UNDP–Allianz AG–GTZ collaboration

A joint study on microinsurance will benefit from the unique capabilities of the three partners. By virtue of extensive country offices and projects that work closely with developing countries' governments, the private sector, and civil society, UNDP and GTZ provide an in-depth understanding of national policies, institutions and capacities, an excellent ability to convene diverse stakeholders, and make available experiences from several microinsurance projects. Allianz AG, as a leader in the insurance market, brings the knowledge of insurance market structures and product design to the partnership.

4. Activities needed to generate outputs

The market study will explore options for engaging the insurance in dustry in providing microinsurance as a safety net mechanism for the developing countries by assisting in risk management and strengthening the development of local entrepreneurs and other poor and low-income groups within the overall framework of sustainable livelihoods and Millennium Development Goals (MDGs).

A team of three international consultants will complete the activity (one of the consultants heading the team). These consultants, knowledgeable about microfinance and microinsurance initiatives globally, will receive country-specific technical information from national insurance experts. This activity would also include discussions with other microinsurance providers in the country such as ICICI Lombard. These inputs will include desk activities such as briefings on the state of the market in the target country, as well as acquisition and provision of secondary data relating to the insurance industry, including: Insurance laws and regulations; insurance commission annual reports; microinsurance activities; and available studies on the sector especially those that relate to the low-income market. In-country experts will also provide access to any relevant documents and/or studies including those conducted by Allianz AG in the target countries, as well as assist in obtaining entry for interviews by the consultants as appropriate. The assistance of the insurer in the advisory capacity will be limited, in order to ensure the objectivity of the results and recommendations and broader viability of the market intelligence activities.

Further inputs are expected from UNDP, GTZ, and other organizations, if required. The studies will be conducted in teams of two with additional contribution by the national Allianz AG insurance experts to prepare a business plan for undertaking potential pilot projects in at least two countries jointly selected by the organizations who will fund the future projects (details are elaborated under para. 5).

In particular, the experts will analyse the lessons learned from prominent past and ongoing microinsurance activities globally, and prepare a comprehensive report for each of the three selected countries covering the issues addressed in the Terms of Reference provided below. The experts will ensure that the paper is cohesive, clear, forward-looking and uses out-of-the-box thinking to identify pathways for the implementation of policy and microinsurance incentives that promote cost-effective adoption of risk management strategies and have practical recommendations that can be implemented at the field level.

The paper will cover the following:

I. Landscape review

The research should glean critical lessons for enabling policy environment, barriers, and incentives for marketing microinsurance as a business product by engaging the insurance industry in partnership with the national governments, and capacity development demand for implementing microinsurance initiatives at the ground level. It should cover:

- Literature review and analysis.
- Relevant institutional and legislative frameworks.
- Available knowledge sources and networks including current providers of microinsurance at the ground level as well as the insurance companies that underwrite the microinsurance;
- Assess the most important risks and the vulnerability of poor and low-income groups and analyse the current risk management strategies applied by them.
- Analyse the options of risk management strategies available in the selected countries and identify the gaps of risk management tools (including linkages of microinsurance with national social security programmes).
- Identify successful microinsurance initiatives and evaluate the possibility for, and potential impediments to, their replicability;
- Identify market barriers to the adoption, use and sustainability of cost-effective microinsurance and risk reduction measures;
- Identify cultural and social barriers that hinder the widespread adoption and use of microinsurance and risk reduction measures;
- Identify institutional barriers (regulatory, governmental, development banking, legislative) to the integration of microinsurance and risk management and elaborate on relevant reforms supporting social security in the informal economy, if any;
- Identify demand centres of microinsurance as well as the areas for which microinsurance is most desired.
- Examine the role of microinsurance for reducing the vulnerability of low-income groups and on the development of local entrepreneurs.

II. Role of governmental, civil society, disaster community

- Identify and evaluate government policies and strategies in place for providing an enabling environment for microinsurance at the state/community levels, and highlight important lessons; include funding sources, business prospects, etc.;
- Identify community initiatives including microfinance-led initiatives to provide microinsurance to local clients. Highlight important lessons; include funding sources.
- Define capacity development needs (human, institutional and system-wide) for implementing successful microinsurance initiatives.

III. Insurance/reinsurance industry: Market opportunities

- Identify insurance industry market strategies (including products of interest) and ongoing initiatives to provide microinsurance and reducing vulnerability, and increasing physical and economic resilience (risk management, risk pooling, incentives, funds). Note vision, funding sources.
- Assess the insurance products in the context of other risk management tools for poor and low-income groups (state-supported programmes and informal systems such as savings and credit products).

- Identify partners (in the selected countries) who share a common vision and the desire to learn and implement the new product segment of microinsurance.
- Qualitatively estimate potential demand and market potential for microinsurance (in three countries) including clients' comprehension of the concept of insurance, understanding of risks, and willingness and ability to pay according to different social and economic groups.
- Provide present viable business propositions and recommendations for design and deliv ery of microinsurance products; broadly estimate the transaction costs including consideration of the capacities and institutional capabilities of microfinance and local development banks to deliver insurance benefits.
- Identify development banking and comm ercial banking initiatives to provide microfinance and/or safety net mechanisms for the governments or communities to increase physical and economic resilience.

IV. Bilateral, multilateral, and other donor communities

- Identify donor communities and thei r interest in microinsurance;
- Identify risk pooling limitations and opportunities.

V. Action plan: Undertaking pilot interventions

- Synthesize critical lessons learned from previous initiatives undertaken to determine both the key factors for success, and the barriers, and operational and institutional impediments, to the implementation of microinsurance strategies for risk management, risk transfer and risk reduction.
- Identify creative and innovative pathways for advancing the implementation of policy and insurance incentives that promote cost-effective adoption of risk management strategies.
- Identify areas in which funding support may be necessary, including linkage of microinsurance with development of local entrepreneurs.
- Identify capacity developme nt needs.
-

Planning meeting

In order to ensure that all parties are clear on the objectives, approach, and expected outputs, it is necessary to have all parties meet to plan this activity. Because of cost constraints, this meeting should take place as a teleconference with parties from Allianz AG, GTZ, and UNDP, as well as the core consulting team, Michael J. McCord, Monique Cohen, and Gaby Ramm. This meeting should take place before the first field visit.

Output

An output in the general form of a business plan will be provided for each country, following the basic outline below:

Executive summary

Includes a synopsis of the national strategic business plan that summarizes the highlights of the plan.

Vision/mission

Provides a snapshot of the present stage of microinsurance in the country, plus a picture of where the industry is going given Allianz AG/UNDP/GTZ intervention as suggested in the plan. Included will be summary of the goals, objectives, and requirements on how to get there.

Microinsurance overview

This section provides basic information about microinsurance in the country, including issues of: regulation, competition, social protection programmes, other government, private, civil society, and donor

initiatives and plans that make up the structure of microinsurance and insurance in the country. This section will also include a discussion of key international lessons learned.

Demand analysis

In this section we will define the microinsurance market in the country, the general characteristics of the target market, assessment of current risks impacting the market, how the market currently manages these, and where there might be potential demand opportunities in terms of products and services. This section will also include consideration of the benefits of microinsurance over those of currently utilized risk management strategies. Finally, it will include a discussion of market risks to product introduction. Some specific information will include:

- Existing risks experienced by low-income populations,
- How poor people prioritize risk,
- The strategies they use to mitigate risks ahead of time and to cope with shocks after they occur,
- Significant differences in coping behaviour by gender.

Annex 1 provides a detailed explanation of the methodology for conduc ting the demand analysis.

Product/Service strategy

A detailed review of formal- and informal-sector microinsurance initiatives will identify:

- potential partnerships
- products
- interested MFPs, insurers, and others
- delivery channels
- transactional processes between the different organizations (agents and insurers)
- general potential product opportunities with a product development strategy
- additional research required
- potential relationship structure issues between different institutional partners
- capacity development requirements
- output indicators
- risks to the product(s) including governmental, regulatory, legislative, supervisory, environmental, cultural, and others.

Marketing/Market education plan

This section will discuss the marketing requirements of insur ers, delivery channels, and the potential market. Some suggested areas of market education would be addressed based on lessons from the demand analysis. Delivery strategies will be addressed.

Financial plan

This section will include:

- a basic draft outline of the costs of testing and implementation.
- a discussion of potential profitability
- an estimate of additional donor/investor inputs required.

Support documents

This section includes a variety of additional documents to substantiate the plan.

6. Duration and costs

Country	Final product due on or before:
India	30 April 2005
Indonesia	31 August 2005
Lao PDR	31 August 2005

7. Qualifications and experience

The candidates should have an advanced degree in a field related to finance, insurance wit h an emphasis on microinsurance and microfinance and international development, and 10 –12 years of professional experience in implementing such initiatives at the field level. Experience in dealing with issues of insurance, safety net mechanisms, or risk m anagement at the level of government, civil society, communities, or the private sector is highly desirable.

S/he should have a good understanding and experience in the area of poverty alleviation, sustainable development, development of entrepreneurs and building partnerships between diverse stakeholders. The consultant should have a good knowledge base of MDGs and be well experienced in the role of insurance in reducing vulnerability and strengthening sustainable livelihoods. Excellent writing skills in English are necessary. The candidate should be able to function effectively in an international, multicultural environment. S/he must be fluent in both spoken and written English. Knowledge of other UN official languages is an asset.

Annex 1: Methodologies to be applied in demand research

Methodology:
Microfinance Opportunities will use the qualitative research methods it has developed and used in other microinsurance market research studies. These include focus group discussions (FGD), participatory rapid appraisals (PRA), and individual in-depth interviews.

1. Focus group discussions and participatory rapid appraisals

A variety of qualitative tools and techniques will be implemented including focus group discussions that address low-income populations' risks and risk management strategies, PRA tools including the life cycle, time series of crisis, seasonality of income, expenditures, savings and credit, and seasonality of risks. These will be used to investigate:

A. Risk and risk management strate gies

- Range of risks and the effectiveness of the coping strategies (indigenous/informal group insurance mechanisms, formal insurance and other instruments) used to address them.
- Ranking of key risk in terms of the financial stress and lump sum cash needs t o cope with them.
- Changes in risks, their impact, and coping mechanisms over time.
- Changes in cash flow, financial needs and prevalence of shocks in the course of the year.
- Identification of vulnerability of and coping mechanisms used by different income g roups.
- Client use of financial services, including credit, savings and insurance to manage risk both before and after the event.

B. Client satisfaction with existing insurance schemes for poor households
FGDs will be held with members, ex-members, and non-members of existing insurance schemes for poor households in order to learn about the level of satisfaction with and understanding of these products.

Individual interviews
In-depth interviews will be held with key informants who are members of indige nous, informal, group-based insurance schemes or who are policyholders with existing insurance schemes. Individual interviews will also be used to explore the demand side issues related to affordability. This will generate information for the purposes of learning more about:

Indigenous/informal insurance schemes and the importance and use of savings and loans to manage risk
Interviews will be held with key informants to ascertain the use of indigenous insurance schemes and the use of savings and loan produ cts to manage risk.

Information related to the demand for microinsurance products
The AIMS/SEEP loan use tool will be used to investigate the use of savings and loans by microfinance clients to cope with key risks. These interviews will identify clients' pre-existing financial obligations in order to determine their willingness and ability to pay for microinsurance.

Appendix IV: List of Meetings

Name	Position	Company	Email	Web Site	Phone
Woitellier, Etienne	Directeur	Agence Française de Développement	afdvientiane@groupe-afd.org	www.afd.fr	+856-21-243 295
Sayaphet, Phanthaboun	Deputy Director	Agricultural Promotion Bank	phansayaphet@yahoo.com		+856-21-212 024
Coleman, Brett	Microfinance Specialist	Asian Development Bank	bcoleman@adb.org	www.adb.org	+632-632-5561
Cyhn, Jin	Economist–Governance, Finance and Trade Division; Mekong Department	Asian Development Bank	jcyhn@adb.org	www.adb.org	+632-632-5441
Phomkong, Phongsavanh	Consultant	Assignments for World Bank, etc.	pphong2000@yahoo.com		+856-21-413 240
Hohmann, Juergen	Health Economist, Social Security Specialist	Belgium Technical Cooperation	Juergen.hohmann@attglobal.net		+856-20-561-500-4
Bagchi, Palash	Assistant Country Director	Concern Worldwide	acdlaos@laotel.com		+856-21-213-578
Svengsuksa, Sisaliao, Dr.	President	Fonds Coopératifs	fcsisaliao@etlao.com		+856-21-261-825
Genrich, Rolf	Programme Director	GTZ–Human Resource Development for Market	rolf.genrich@gtz.de	www.gtz.de	+856-21-217 554
Matzdorf, Manfred	Senior Adviser	GTZ–Private Sector Development and SME Promotion	manfred.matzdorf@gtz.de	www.gtz.de	+856-21- 217 554
Kallabinski, Jens	Programme Coordinator	GTZ–Rural Development in Mountainous Areas of Northern Lao PDR	jens.kallabinski@gtz.de	www.gtz.de	+856-21-414 563
Howell, Fiona	Chief Technical Advisor	ILO	ilossp@etllao.com		+856-21-242 074

Name	Position	Company	Email	Web Site	Phone
Sophimmavong, Khamtanh	Head of International Relation Division	Lao Federation of Trade Unions	Khamtanh_s@hotmail.com		+856-21-212 754
Latmany, Chantheum	Executive Member Committee, Chief of Cabinet	Lao Women's Union			+856-21-911 438
Manivong, Khamphet		Ministry of Health			
Vorsaran, Somnuk	Director General	Social Security Organization	somnv02@yahoo.co.uk		+856-21-241 280
Shuey, Dr. Dean A.	Officer in Charge	WHO	Shueyd@lao.wpro.who.int		+856-21-413 413