SECOND EDITION

Building Security for the Poor

Potential and Prospects for Microinsurance in India



Human Development Report Unit
UNDP Regional Centre for Asia-Pacific
Colombo Office

BUILDING SECURITY FOR THE POOR:

POTENTIAL AND PROSPECTS FOR MICROINSURANCE IN INDIA

Published for the
United Nations
Development Programme

Human Development Report Unit
UNDP Regional Centre for Asia-Pacific
Colombo Office

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The study was led by Anuradha Rajivan, head of the Human Development Report Unit at the Regional Centre in Colombo, under UNDP's Regional Bureau for Asia and the Pacific.* It is based on her previous work on microinsurance as part of linking rural women to commercial financial services in India, which was presented at UNDP's sub-regional workshop in New Delhi on 'Unleashing Entrepreneurship in South Asia' in November 2004. Feedback from the workshop motivated further work during 2005 - 2006. Field research and intensive consultations among providers of insurance, potential clients and intermediary agencies was carried out through BASIX, an organization with considerable experience in the sector. Inputs also were provided by Weather Risk, an organization specializing in launching and popularizing weather insurance products within India, and N. Jeyaseelan, a commercial bank officer from the Indian Bank who were also part of the team of consultants for the study. BASIX prepared the technical background paper for this work. BDP's work on the subject was simultaneously undertaken for India, Lao PDR and Indonesia, which validated many findings and provided the motivation for going into much greater specificity for India. Kalpana Choudhary provided critical inputs in bringing the divergent pieces of work and people together and facilitating two stakeholder workshops. Ranjani Murthy and Lene Hansen reviewed an earlier version of the study. Their feedback helped to bring the work to completion. Omar Siddique provided excellent backstopping and research support. Editorial support was provided by Sadia Mian and Sonia Gomez.

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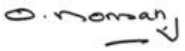
PREFACE TO THE SECOND EDITION

Building Security for the Poor continues to be in demand. It was germinal in contributing to thinking at the policy and operational levels, triggered discussion among insurers looking for market prospects, and motivated further exploration into growth of the sector to benefit the poor. Ongoing demand for the publication, even after the first stock of copies was exhausted, provides the immediate motivation for this second edition. A broader motivation is to continue to engage with policy makers, insurers and other stakeholders in Asia-Pacific and beyond, to focus on using insurance for addressing ex ante risks and shocks among poor households. Poverty reduction is not just about income generation. Equally, it is also about protecting incomes in the hands of the poor. Under the broader area of inclusive financial services, microinsurance is a relatively new area, in contrast with microcredit. Using insurance for managing ex ante risks and shocks among poor households is receiving increasing attention. How can insurance be adapted to cover the circumstances faced by the poor while simultaneously ensuring commercial viability for the insurers? What are the market prospects and complementary support needed to catalyse incipient demand and develop this latent market? It is hoped that the growing interest in these questions within and outside Asia will benefit from this second edition.

When the UNDP Regional Centre for Asia Pacific, Colombo Office supported the research and investigations that went into the first edition of this publication, little was it realized that the book would be a sellout. It has been extensively quoted in the 2008 Report of the Committee on Financial Inclusion set up by the Government of India headed by C.Rangarajan, formerly Chair of the Economic Advisory Council to the Prime Minister. The publication has thus influenced policy at the highest level. The work was presented at Sudan's first national consultative forum on microfinance hosted by the Central Bank of Sudan and contributed to discussions at ADB's regional consultations on the development of the microinsurance sector. It has also become a sales publication at the UN Book store in New York.

Anuradha Rajivan, who led the original work, took the lead in this update as well. She was very competently supported by Niranjan Sarangi who undertook a verification and update of the data. Rohini Kohli supported the production. Without their expertise and dedication it would have been hard to bring out this edition in so short a time.



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CONTENTS

BOXES

TABLES

CHARTS

ANNEXES

ABBREVIATIONS

AFMIN	-	African Microfinance Network
AIC	-	Agricultural Insurance Company of India Limited
AIDS	-	Acquired Immune Deficiency Syndrome
AIG	-	American International Group
AKHS	-	Aga Khan Health Service
AMIN	-	Asian Microinsurance Network
ASSEFA	-	Association of Sarva Seva Farms
BASIX	-	Bhartiya Samruddhi Investments and Consulting Services Limited
BoP	-	Bottom of the socio-economic pyramid
CARE	-	Cooperative for Assistance and Relief Everywhere
CASHE	-	Credit and Savings for Household Enterprises
CBO	-	Community Based Organization
CETREREDA	-	Centre for Rural Education, Research and Development Association
CGAP	-	Consultative Group to Assist the Poor
CPMU	-	Central Project Management Unit
CRIG	-	Community Rural Insurance Group
CSR	-	Council for Social Reconstruction
DATA	-	Development Association for Training and Technology Appropriation
DFID	-	Department for International Development (UK)
DHAN	-	Development of Humane Action
ECCP	-	Economic Cross Cultural Program
FDCF	-	Financial Deepening Challenge Fund
FICCI	-	Federation of Indian Champers of Commerce and Industry
FINCA	-	Foundation for International Community Assistance
FIR	-	First Information Report
GDI	-	Gender Related Development Index
GDP	-	Gross Domestic Product
GIC	-	General Insurance Corporation Limited
GSM	-	Global System for Mobile Communication
HDFC	-	Housing Development Finance Corporation
HDI	-	Human Development Index
HDR	-	Human Development Report
HFF	-	Healing Fields Foundation
HIV	-	Human Immunodeficiency Syndrome
HIVOS	-	Humanist Institute for Development Cooperation
IBA	-	Indian Banks Association
ICICI	-	Industrial Credit Investment Corporation of India limited
IDAS	-	Insurance Distribution and Administration System
IFAD	-	International Fund for Agricultural Development
IFFCO	-	Indian Farmers Fertilizer Cooperative Limited
IIRM	-	Institute of Insurance and Risk Management

ILO	-	International Labour Organization
IMD	-	Indian Meteorological Department
IMF	-	International Monetary Fund
IMRB	-	Indian Market Research Bureau
IRDA	-	Insurance Regulatory and Development Authority
IRDP	-	Integrated Rural Development Programme
JBY	-	Janashree Bima Yojana
KKVS	-	Kadamalaikundu Kalanjia Vattara Sangam
KSSSY	-	Krishi Shramik Samajik Suraksha
LIC	-	Life Insurance Corporation of India limited
MHIU	-	Micro Health Insurance Unit
MID	-	Microinsurance Department
MIDC	-	Microinsurance Development Committee
MIS	-	Management Information System
NABARD	-	National Bank for Agriculture and Rural Development
NCAER	-	National Council of Applied Economic Research
NCB	-	National Commercial Bank
NEERA	-	Network for Education and Empowerment of Rural Artisans
NGO	-	Non Government Organization
NIACL	-	New India Assurance Company Limited
NREGP	-	National Rural Employment Guarantee Programme
NSSO	-	National Sample Survey Organization
P&GS	-	Pension and Group Schemes
PMRY	-	Prime Minister's Rozgar Yojana
PWDS	-	Palmyrah Workers Development Society
RBI	-	Reserve Bank of India
RCC	-	Regional Centre in Colombo (UNDP)
REGP	-	Rural Employment Guarantee Programme
RFID	-	Radio Frequency Identification Device
RRB	-	Regional Rural Bank
SBI	-	State Bank of India
SGRY	-	Sampoorna Grameen Rozgar Yojana
SGSY	-	Swarnajayanthi Gram Swarozgar Yojana
SHG	-	Self Help Group
SJSRY	-	Swarna Jayanthi Sahahari Rozgar Yojana
SNFL	-	Sarvodaya Nano Finance Limited
STEP	-	Strategies and Tools Against Social Exclusion and Poverty
TCIP	-	Turkish Catastrophe Insurance Pool
TNCDW		Tamil Nadu Corporation for Development of Women Ltd.
TPA	-	Third Party Administrator
TUW SKOK	-	Mutual Insurance Company of Cooperative Savings and Credit Unions
UHI	-	Universal Health Insurance
UMASS	-	Utkal Mahila Swayam Sahayak Samabaya Limited
UNDP	-	United Nations Development Programme
USAID	-	United States Agency for International Development

EXECUTIVE SUMMARY

Moving towards poverty reduction requires not just the generation of growing and sustainable income streams among the poor but also protecting these incomes through effective risk management. In contrast with income generation schemes, risk management among the poor has received much less attention, especially for those in rural areas and for women. Microinsurance is an important constituent of a broader overall poverty reduction strategy. The first Millennium Development Goal aims to eradicate extreme poverty and hunger, while Goal three aims at gender equality and the empowerment of women: microinsurance contributes to both.

Insurance is an ex ante risk management tool through which individuals and businesses hedge potential financial losses in exchange for fixed premium payments. Microinsurance is a set of market based insurance products and processes designed to address both-life and non-life risks faced by people at the bottom of the socioeconomic pyramid (BoP). These products are priced at rates affordable for the intended clients, while being financially viable for sustainability of operations. In contrast with the well established insurance industry in developed countries, it is in a state of infancy in most developing countries, including those in Asia and the Pacific. For the BoP population, there are both supply and demand side bottlenecks, resulting in a 'missing' market. This study seeks answers to the question of how insurance services for the rural poor can straddle two seemingly contradictory objectives – the social bottom line and the financial bottom line.

The timing for this study is strategic - there is a renewed policy interest in energizing the rural insurance market in India at the national-level. The November 2005 regulations by the Insurance Regulatory and Development Authority (IRDA) are seen as highly favourable for growth of this sector, even though some limitations are recognised. Insurance companies are looking to expand their businesses. The microinsurance industry is in a similar state of development as micro-credit was a decade ago.

A well developed insurance sector has both micro implications for households and macroimplications for the economy as a whole. At the household level, insurance serves as a tool for addressing ex ante risks as opposed to coping with a disaster after an unfortunate event has occurred. At the macro level, insurance provides long term funds that can be used for infrastructure development. While the utility of insurance for the poor is evident, market based insurance may not be immediately applicable for all categories of the BoP population. Its potential is likely to be greater for those with income streams and assets to protect, at least in the early days of market development. Conservatively estimated, the potential market size for microinsurance (life and non life) in India ranges between INR 62, 304.70 to 84,267.55 million (US$ 1,298.01 to 1,755.57 million), which is only expected to grow as microinsurance is better understood. In the case of life, the potential is estimated to be between INR15,393 to 20,141 million (US$ 320.69 to 419.60 million); in the case of non-life, between INR 46,911.70 to 64,126.55 million (US$ 977.33 to 1312.05 million). The non-life estimation is limited to four types of coverage – milch animals, livestock, health and crop insurance. The population used for this estimation is 40-50 percent of those

earning less than US$ 1 a day and 50-70 percent of those earning between US$ 1–2 a day. This is expected to increase as demand grows and a wider range of risks are recognized as insurable.

Ground realities based on primary field investigations in rural areas in three Indian states provide very clear insights. The states of Orissa, Rajasthan and Tamil Nadu were selected as they are quite distinct, allowing us to capture\ considerable variability of circumstance relevant for rural insurance, as well as the different stages of development of this industry. Field investigations were supplemented by two consultative multi-stakeholder workshops covering operational, strategic and policy level issues. All this provides clarity on (a) the differing perspectives of clients, insurers and intermediaries, (b) what works and what does not, and (c) concrete measures that could provide a fillip to the microinsurance sector.

Six key issues pertinent to the growth of the microinsurance industry are analyzed, capturing the concerns of different stakeholders. (1) There are specific reasons for low demand for insurance in spite of intense need. Suppliers have their own concerns which helps to explain why there has been so little effort at market development. Consequently, the rural market is characterized by limited and inappropriate services, inadequate information and capacity gaps. (2) There are challenges in product design, which result in a mismatch between needs and standard products on offer. Reasons for inadequate effort in product development are identified. (3) Pricing, including willingness to pay and the availability of subsidies, influence the market. In the absence of a historical database on claims, premium calculations are based on remote macro aggregates and overcautious margins. Building and sharing claims histories can help in aligning pricing decisions with actuarial calculations, thereby reducing price. (4) Difficulty in distribution, is one of the most cited reasons for absence of rural insurance. The high costs of penetrating rural markets, combined with under utilization of available distribution channels, hinder the growth of rural insurance services. (5) Cumbersome and inappropriate procedures inhibit the development of this sector. (6) Contrasting perspectives of the insured and the insurers, lead to low customization of products and low demand for what is available.

The core issue is the gap in perspectives between the insured and the insurers. For the rural poor, a product should fulfil needs and be affordable. When both these criteria are met, there is a willingness to pay for the service. The poor are specific about their need for insurance to cover high frequency risks, many of which are low impact events. They also need to be able to trust the insurers. One bad experience with an insurer in a small well knit community can have long term adverse effects on client faith in insurance services. For the insurer, many of the needs of the poor do not translate into an insurable proposition due to questionable profitability. Frequently occurring adverse events are difficult to cover, making them a challenge for insurance companies with limited rural infrastructure. In addition to this misalignment of incentives, there is the problem of deliverability. Insurers are yet to identify and effectively use appropriate distribution channels. This mismatch and difficulties in distribution have prevented insurance companies from investing in new product development and providing appropriate services.

Intermediary organizations also have their own set of issues. There are reasons why existing distribution channels have not considered insurance as an add-on service. Insurance burdens the system without, as things stand, sufficient returns. Centralization of services by insurers to keep costs at a minimum

also simplifies meeting audit requirements. But centralization leads to delays in settlement leading to frustration and reduced trust of rural clients.

Several interesting local innovations were identified and documented in the course of the field investigations. These provide ideas to insurers for modification, replication and expansion. The key obstacles that need to be addressed relate to addressing customer satisfaction (demand- supply gaps, appropriate products and pricing), distribution efficiencies for better outreach, and procedural issues for easier renewals and claim settlements. Unleashing the incipient potential for growth of the microinsurance sector needs a longer term perspective, replacing the current preoccupation with immediate profits. Specific recommendations are identified in nine areas, which can be taken up nationally. Of these, the five areas identified for strategic external support to complement national efforts with preliminary cost estimates for a three year-period are:

- Support for innovations in concept design- products, pricing, distribution, processes – facilitating experimentation and exchange
- Support for initiating database building and management
- Support for capacity development for insurers, insured and facilitators
- Support for the development of technological innovations and their use
- Support for policy dialogue

The total cost estimate for external support works out to approximately US$ 1.5 million over a period of three years, or around US$ 0.5 million on average per year for three years. Put together, this could form the ingredients for possible programme development.

Microinsurance, which was poised for a take off in India in 2005, has in fact done so. With heightened interest from different stakeholders, stimulus provided by the November 2005 directives of the IRDA, and better awareness overall, by 2007 the sector witnessed rapid growth and established a growth trajectory closely linked to the overall growth of insurance in the country (IRDA, 2007; Allianz, 2009). However, it is yet to take the shape of a movement, as happened in the case of microcredit.

INTRODUCTION

1
Chapter

1.0 Background and Structure

Rationale for Microinsurance

Moving toward poverty reduction requires not just the generation of growing and sustainable income streams among the poor, but also protecting these incomes through effective risk management - a complementary, twin-track approach. However, in contrast with income generation schemes,[1] risk management among the poor has received much less attention, especially for those in rural areas and even more so for women, who tend to be at the bottom of the economic and social pyramid. The very first Millennium Development Goal aims to eradicate extreme poverty and hunger; microinsurance also contributes to the third Goal of women's empowerment among the rural poor. With low assets and incomes, even small shocks can have disproportionately large, adverse impacts on women's human condition because the capacity of this section of the population to weather risks is limited; a need exists to institutionalize risk management.

For India, in keeping with its national development goals, risk management among low income populations can contribute to economic and social inclusion, especially for rural households and women, addressing the multidimensionality of poverty. It can complement rural development and employment generation schemes, promoting convergence between income generation and protection. Insurance can minimize the loss of development gains among the rural poor by reducing vulnerabilities faced by the relatively disadvantaged. Where income is dependent on credit-based agricultural operations or rural micro and small enterprises, insurance can provide cover for repayments in times of loss.

Microinsurance is an important component of a broader set of financial services under microfinance – making available financial services for poor households and their enterprises to sustain their livelihoods. Access to financial services enable those at the bottom of the socio-economic pyramid (BoP) to increase and diversify their incomes, build assets, and graduate from daily survival to planning for an improved future. It can contribute to improvements in their quality of life through better nutrition, shelter, health and education, which also enables improvements in productivity. Because microfinance has largely developed outside the formal financial sector, with separate techniques and standards, it tends to face limitations of scale and reliance on subsidized or donor funding - though major exceptions do exist. The size of the currently excluded BoP population is enormous; larger financial institutions could play a very important role in scaling up. Integration of financial services for the poor into the overall financial sector can expand sustainable outreach. Inclusive finance not only means increasingly opening up financial services to the excluded, but also covers the integration of providers of sustainable microfinance into the formal financial sector. This will result in improved access to capital, better protection of savings of the poor, and increased legitimacy and professionalism of the microfi- nance industry, without compromising the social objective.[2]

Establishment circles with faith in the market mechanism also have started supporting it in recent years. This is probably because it is a seen as a market-based instrument that has demonstrated some clear successes in poverty situations, where other market-based approaches have failed.[3] Macroeconomic structural adjustment programmes promoting privatization, trade and currency liberalization, deregulation and fiscal tightening have been

Moving toward poverty reduction requires not just the generation of growing and sustainable income streams among the poor, but also protecting these incomes through effective risk management

The timing for this study is strategic - policy interest has been renewed in energizing the rural insurance market in India

criticized for having contributed to inequality and poverty in any parts of the developing world. Inclusive finance, which includes microinsurance, also can be a safety net for millions of people destabilized in the process of structural adjustment.

Insurance is an ex ante risk management-tool through which individuals and businesses hedge potential financial losses in exchange for fixed premium payments. For the purposes of this study, microinsurance is taken as consisting of a set of market based insurance products and processes designed to address risks faced by people at the bottom of the socio-economic pyramid. These would cover life and non-life risks and be priced at rates affordable for the intended clients, while being financially viable for sustainability of operations. Low price is not the only criteria for microinsurance. Based on the experience of microcredit and microsavings, women are expected to form a very significant part of the client population for microinsurance.

The microinsurance industry is in a similar state of development as microcredit was a decade ago. A key difference between promoting insurance and credit is that clients have to *pay money* upfront rather than *receive money*. They have to be able to trust insurers. Even in developed countries like the United Kingdom , insurance started by being sold door-to-door by a trusted person from the neighbourhood, often to housewives. To what extent can insurance companies provide a useful service to the world's BoP population, without it being seen primarily as a charitable social obligation, and only incidentally, if at all, as business opportunity? Can insurance services for the rural poor straddle two seemingly contradictory objectives – the social bottom line and the financial bottom line? The study attempts to address this question. It proposes concrete steps under specific aspects of microinsurance, including recommendations for insurance companies and government, and also identifies specific areas of external catalytic support.

Can insurance services for the rural poor straddle two seemingly contradictory objectives – the social bottom line and the financial bottom line?

Strategic Timing

The timing for this study is strategic - policy interest has been renewed in energizing the rural insurance market in India at the national level. In November 2005, India's Insurance Regulatory and Development Authority (IRDA) issued regulations seen as highly favourable for growth of the sector, even though some limitations are recognized. These are being studied and discussed closely by insurance companies and intermediaries. Some discussions have informed the present study as well. The team is pleased to be participating in shaping this new industry, catering to the needs of around one quarter of the world population at the bottom of the socio economic pyramid.

The Global Context

In contrast with the well established insurance industry in developed countries, where the legal and economic infrastructure is relatively strong, insurance is in a state of infancy in most developing countries. Insurance services, overall, are almost negligible among the rural poor in developing countries of Asia and the Pacific. Globally, United Kingdom, Netherlands and Ireland are leaders in the industry; Table 1.1 gives an overview of the penetration and density observed worldwide. *Insurance peneration*[4], used to measure the level of risk awareness in the population and significance of insurance in the economy, is seen to be highest in Taiwan, Province of China, United Kingdom, South Africa and Netherlands. Another measure. *insurance density*[5], indicates the maturity of the industry in the economy. Ireland, United Kingdom, Netherlands and Switzerland have the highest insurance density in the world. The situation is quite different in most developing countries of Asia and Africa, where insurance penetration and density are both low. India ranks much better under penetration than density, which is

the general pattern in Asia. People's Republic of China ranks 48th in the world in terms of insurance penetration and 62nd in terms of density. India is below the People's Republic of China in insurance density, with a ranking of 78, but above it in terms of insurance penetration, with a ranking of 30. More developed Asian countries like Japan, Republic of Korea and Singapore rank high on insurance penetration and density scales, whereas poorer developing countries such as Bangladesh, Indonesia, Pakistan, Philippines and Sri Lanka rank low.

Table 1.1

Global Insurance Industry: Density and Penetration

	Insurance Penetration	Penetration Rank (out of 88)	Insurance Density	Density rank (out of 88)
Global Average	**7.5**		**607.7**	
Global Leaders				
Denmark	8.9	12	5103.1	5
France	10.3	9	4147.6	6
Hong Kong, China (SAR)	11.8	6	3373.2	13
Ireland	11.6	7	7171.4	1
Korea, Republic of	11.8	5	2384.0	21
Netherlands	13.4	4	6262.9	3
South Africa	15.3	3	878.5	31
Switzerland	10.3	8	5740.7	4
Taiwan, Province of China	15.7	1	2628.0	19
United Kingdom	15.7	2	7113.7	2
Asia				
Bangladesh	0.7	84	2.9	88
China	2.9	48	69.6	69
India	4.7	30	46.6	77
Indonesia	1.6	69	30	79
Pakistan	0.7	83	6.5	86
Philippines	1.5	73	23.9	81
Sri Lanka	1.5	70	24.9	80
Singapore	7.6	18	2776.0	17
Japan	9.6	10	3319.9	14
Africa				
Algeria	0.5	88	21	82
Nigeria	0.6	85	5.5	87
Middle East				
Arab Republic of Egypt	0.9	81	14.4	84
Israel	5.5	27	1278.5	29
Hashemite Kingdom of Jordan	2.6	53	68.6	71
Lebanon	3.4	40	185.7	53
United Arab Emirates	1.9	64	811.6	34

Source : Sigma Report 3/2008, Swiss Re.

Both supply and demand side bottlenecks exist in extending insurance services to the rural poor, resulting in a missing market

The Missing Market for Inclusive Insurance

For rural households to pay for insurance, theyneed dependable, useful, transparent and affordable solutions to effectively deal with risks and shocks they face. For such solutions to be sustainable, they have to be commercially viable as well. Both supply and demand side bottlenecks exist in extending insurance services to the rural poor, resulting in a missing market. A mismatch exists between the standard products and services available in the market and what can be of use to the target population.

On the supply side, the standard set of products offered by insurance companies is largely designed for the relatively better off, predominantly urban male clientele, with a few products aimed at female customers. Insurance-companies have limited understanding of the needs and priorities of the rural poor. Another challenge is finding effective delivery mechanisms for better outreach. Rural households are more dispersed and have a lower population density than metros and other urban areas. Road infrastructure linking rural areas tends to be poor. This adds to costs, both, managerial and financial. Like inclusive credit, inclusive insurance is expected to be a 'low ticket' business, requiring volumes for viability.

A welldeveloped insurance sector has both micro level implications for households and macro implications for the economy as a whole

On the demand side, the poor have not ought formal insurance services to a great extent. While the rural poor face very specific and varied risks and shocks, they have tended to depend upon less formal coping mechanisms. Insurance is not well understood and the knowledge of its potential as a risk management tool is not widely prevalent. Pricing of existing insurance products has been a deterrent. Moreover, the products have been unsuitable. Complicated procedures also have contributed to alack of demand, in spite of need.

In combination, these and other bottlenecks discussed below have constrained the development of more inclusive insurance services. Though ambitious in stated intent, most poverty reduction programmes have limited reach and only partially support the poor, addressing risk incidentally, if at all. The most vulnerable rural populations - in particular, women - are largely excluded from the insurance market.

Micro and Macro Benefits

A well-developed insurance sector has both micro level implications for households and macro implications for the economy as a whole. At the household level, insurance serves as a tool for addressing ex ante risks instead of coping with a disaster after an unfortunate event has occurred. Insurance can provide part or full cover for both unanticipated events - natural disasters, illness and death - as well as expected events such as drought, or vital events like marriage or childbirth, when households in India can face destabilizing lump-sum expenses. It can serve as an alternative and a supplement to more informal, traditional support mechanisms.

At the macro level, insurance provides long-term funds that can be used for infrastructure development while strengthening risk-taking abilities of people. In India the life insurance sector has contributed INR 6,041,798 million (US$ 125,871 million) as funds available for investment, as of March 2007 cumulatively; non-life insurance investment amounts to INR 503,828 million (US$ 10,496 million) in the same period[7]. These funds have been invested in government and market securities, social and infrastructure sectors benefiting the national economy. The current numbers may well be insignificant if the untapped potential of the insurance industry is taken into account. Table 1.2 presents an estimate of the extent of exclusion in the sector, providing a basis to estimate the potential size of this missing market.

Table 1.2
Population Excluded from Insurance in South Asian Countries

Countries	Excluded (Percent)	Population (Million)
India	90	950
Bangladesh	93	134
Pakistan	97	147
Nepal	95	23

Source : Mare Socquetl, 2005. ILO / STEP, Microinsurance Workshop, October, Hyderabad.

Potential Clients for Microinsurance

While the focus of this study is pro-poor risk cover for rural populations, insurance as an instrument may not be immediately suitable for all categories of the rural poor. For example, the ultra poor, the destitute, the old and infirm, children, and others who do not have current productive potential, may require other complementary support. Just as microcredit is not a panacea to address poverty in its many dimensions, [8] microinsurance should not be seen as the only or even the best instrument for all poorpersons. It is obviously beneficial for those with income streams and/or assets to protect. The importance of protecting existing assets increases the less the households have – the bene- fits being inversely proportional to the person's economic status. While insurance can be vastly beneficial for the ultra poor, elderly and infirm, insurance mechanisms, in the form of planned savings to hedge against adverse circumstances, whether expected or unexpected, need to be in place before these situations arise. It appears that the potential utility of microinsurance may be even broader than that of microcredit, being closer to the potential market for micro-savings, balanced by affordability considerations in the early stages. Some 52.4 percent of India's population of 1.08 billion earns less than US$ 2 a day (PPP terms), of which one-third is estimated to earn less than US$ 1 a day.[9] Microinsurance can be an important constituent of a broader overall poverty reduction strategy to protect incomes and minimize loss of development gains among the low income populations.

Quantitative estimation of the microinsurance market is a difficult proposition. The potential size of the market depends upon a number of factors including:

- Realizing the need for insurance
- Awareness about the products
- Supply of suitable products
- Affordability of price
- Reliability of service by insurers and inter mediaries
- Trustworthiness of insurance companies and agents
- Period of collection of premium
- Availability of finance for payment of the premium
- Social, cultural and environmental barriers

Insurance as an instrument may not be immediately suitable for all categories of the rural poor

These factors are dynamic, and therefore change over time. However, an attempt has been made to move toward a quantification of potential demand (see Annex 1). Conservatively estimated, the potential market size for microinsurance (life and non life) in India ranges between INR 62,304.70 to 84,267.55 million (US$ 1,298.01 to 1,755.57 million), which is only expected to grow as microinsurance is better understood. In the case of life, the potential is estimated to be between INR 15,393 to 20,141 million (US$ 320.69 to 419.60 million); in the case of non-life, between INR 46,911.70 to 64,126.55 million (US$ 977.33 to 1,312.05 million). The non-life estimation is limited to four types of coverage – milch animals, livestock, health and crop insurance. The population used for this estimation is 40-50 percent of those earning less than US$1 a day and 50-70 percent of those earning between US$ 1 – 2 a

day. This is expected to increase as microinsurance is better understood, demand grows, and a wider range of risks are recognized as insurable and appropriate supply responses.

Genesis

This study builds on previous work by the team leader on issues in managing rural financial services in India and advisory work in other countries. This work with commercial banks, intermediaries, potential beneficiaries and insurance companies suggested that although supply and demand side bottlenecks were persistent, with some initial catalytic support, it would be possible - and mutually beneficial - to galvanize the insurance sector through a strategic public-private partnership for providing inclusive insurance services.[10] Discussions and feedback from the New Delhi sub-regional workshop on "Unleashing Entrepreneurship in South Asia" indicated much wider interest in exploring ways of promoting rural insurance for the BoP population. As a direct follow-up, the UNDP Regional Bureau for Asia and the Pacific provided financial support for this work.

Structure

The Study is divided into six chapters. Chapter 1 contains the background, the aims and scope, research methodology and limitations of the study. Chapter 2 presents the national context - the evolution of the insurance industry in India, development of microinsurance and macro factors in the country that influence growth of microinsurance, leading up to the recent regulatory developments. Chapter 3 analyzes the risks faced by the rural poor, including how low income populations cope with risks; categorization of risks by frequency and impact; how risks are perceived and prioritized by the target population; and the range of risks faced. Chapter 4 analyzes recent secondary sources in the sector, presenting what the literature says. It identifies six key issues relevant for catalyzing the market for microinsurance – demand and supply, product design, pricing, distribution and outreach, procedures and regulation. Chapter 5 presents an analysis of findings from the field work based on direct interactions with current and potential clients, insurers and intermediaries, combined with feedback from the two multi-stakeholder workshops among insurers, intermediaries (MFIs, NGOs), regulators and bankers. In combination, these help in understanding ground realities with respect to key issues. It also presents concrete examples from the field that capture specific problems and local innovations. The concluding Chapter 6 identifies the way forward to catalyze the incipient market for microinsurance, based on both secondary sources and insights from the field. It contains specific recommendations regarding product design, pricing, strategies for distribution and improving the claims process, which can build better customer satisfaction and make insurance viable. It also proposes building and managing a common database, based on local information, to help sharpen actuarial calculations so prices are better aligned with risks, rather than relying on remote macro figures for determining pricing. An important suggestion is to support innovations to provide a space for experimenting with new ideas in this emerging industry and benchmarking products that cover common risks. Specific recommendations for service suppliers and Government, including the IRDA, are proposed. The chapter concludes with a proposal with rough cost estimates for developing a project to provide catalytic support to the incipient market for microinsurance.

1.1 Aims of the Study

The ultimate objective is to address poverty by meeting the risk management needs of the rural poor, currently outside the cover of insurance. Risk management complements control over assets and generation of income among the

rural poor. In order to propose ways in which insurance services can become more inclusive - useful and affordable to clients, while being financially viable for insurance providers - this study aims to:

- Explore the evolution of insurance as a whole in India and, in particular, the development of microinsurance, identifying supply side factors that come in the way of growth of this section of the insurance industry.

- Examine different risks faced by the rural poor in India, their current coping mechanisms, categorization and prioritization of risks by the client population. This is expected to help in identifying factors that inhibit demand.

- Study what the literature says, identifying key issues relevant for the development of this industry, both, on the demand and supply sides.

- Understand ground realities through direct interactions with a variety of stakeholders – current and potential clients, intermediaries and insurers – to explore the realistic market potential for microinsurance in India. This exploration is expected to identify problems and potential solutions for product design, pricing, distribution for better outreach, and ways of addressing procedural challenges.

- Draw conclusions for the way forward, with specific recommendations on each key issue, identifying possible roles of different players for a public-private partnership, including areas of external support to galvanize microinsurance.

- Facilitate cross-fertilization of ideas and exchange of experiences across states in India and across countries where microinsurance work is on going or where there is interest.

Given the size and diversity of individual states in India, each the size of countries, it is expected that the study will be of wider relevance to other developing countries in similar circumstances.

1.2 Scope of the Study

In pursuit of the aims, this study investigates:

a. India's Insurance Industry

How has the industry as a whole evolved over time, and who have been the target clients for insurance services? With a history of nationalization, how has economic liberalization, the entry of private companies and increased competition affected the potential for microinsurance? What are the implications of recent regulatory developments as policies have started to refocus on the needs of the poor?

b. Risk Assessment Among the Target Population

As a starting point for entry into this market, two questions addressed are: What are the nature and magnitude of risks facing the rural poor? How does the target population, at present, prioritize these risks and cope with them? Understanding this helps in assessing the incipient demand and existing competition.

c. Demand and Supply

The rural insurance market is characterized by many and different risks that are not covered or inadequately covered. While the need for risk management exits, demand continues to be latent. Assessing this demand vis-à-vis present coverage of insurance services helps in understanding the scale of this potential market, relevant for both the private and public sector insurers.

d. Product Design

There is no reason to expect that risks faced by rural clients will automatically be similar to urban ones (commonalities may, however, be expected in urbanized rural areas in proximity to urban centres). Standard insurance products normally offered to urban clients need to be re-examined, taking into account the specific and varied needs of the new clientele. Existing products and their features are examined to understand the gaps that need to be addressed in product design to suit the needs of low income, rural clients.

e. Pricing

From a client's perspective, the products, apart from being suitable, also have to be affordable. Hence, estimating willingness to pay for services is critical. On the other hand, for the insurance industry pricing has to be commercially viable. An attempt is made to find ways to bridge the gap between the two perspectives.

f. Distribution and Outreach

Distribution of microinsurance services for better outreach is a challenge for insurance companies interested in expanding to this target market. This is perceived by suppliers as perhaps one of the biggest constraints to growth of the industry. Possible distribution channels that could be effective are explored.

g. Procedural Bottlenecks

Standard procedures that work for urban clients may not be suitable for remotely located and less educated rural clients. How can procedures be simplified to suit the new environment? An attempt is made to address this issue.

These questions are investigated from the perspectives of the clients and insurers. The investigations lead to concrete suggestions for the growth of the microinsurance segment of the industry. The study proposes recommendations for insurance companies, intermediaries, policy makers and international agencies that can catalyze the expansion of the insurance industry to increasingly cover those currently excluded. This provides ideas for possible programming.

The following section (1.3) presents the research methodology for this study. Those readers interested in proceeding with the rest of the study can directly move to Chapter 2.

1.3 Research Methodology

The study employed a mix of three methodologies: (a) secondary research based mainly on a review of the literature and secondary data search, both from India and outside; (b) primary research based on field investigations in three states in India, each the population of some nations; and (c) two multi-stakeholder workshops, the first on operational aspects and the second on strategic and policy issues. Previous direct and diverse ground level experience of team members in addressing rural finance broadly, and rural insurance in particular, helped in providing a starting point to frame the questions that later evolved as the study progressed.

a. Secondary Research

This included a survey of recent material on concepts, issues, and successful and failed initiatives on microinsurance in India and outside, with a data search. Together with insights from experience of the team members, the survey helped in developing a framework for the study and short-listing key issues that hampered the development of microinsurance for further analysis. The literature survey also helped in structuring the primary field investigations.

b. Primary Research

This included field investigations in three selected states of India - Orissa, Rajasthan and Tamil Nadu - covering different geographic regions. These states also capture differences in stages of microfinance development in the country, with Tamil Nadu being relatively advanced. The investigations were in the form of focussed group discussions among the target-population, complemented by in-depth interviews among selected stakeholders.

India is an enormous country (population 1.08 billion; area 3,287,263 sq. km),[11] with varied geography and socio economic and cultural diversity. The three states were selected to capture the variation in geographic, economic and socio cultural conditions relevant for microinsurance within the limitations of time and budget. Orissa, in the east, is one of the poorer states in the country, with poor social conditions, and prone to floods and droughts. Rajasthan is in an arid region in north-western India, with low rainfall and low agricultural output,

Table 1.3

Macro Indicators for the Selected States and All India

Indicators	Orissa	Rajasthan	Tamil Nadu	All India
Total population	37 million	56 million	62 million	1.08 billion
Comparable countries, in terms of population	Poland- 38.6 million Spain – 42.6 million	Italy – 58 million United Kingdom - 59.5 million	France – 60.3 million	People's Republic of China – 1.3 billion
Geographic location	East India	North West India	South India	South Asia
Location risks	Cyclones, floods and droughts	Droughts	Droughts	Most types
Percent rural	85	78	56	71.5
Poverty percentage (2004-05)	46.4	22.1	22.5	27.5
Popular rural occupations	Agriculture, fisheries	Agriculture, tourism	Agriculture, dairying	Most types
Average household size	4.8	6.1	4.3	5.3
Per capita income (2006-07)	INR 20,240	INR 20,492	INR 32,733	INR 29,642
Female: male ratio	972	922	987	933
Infant mortality rate	97	87	43	62
Female literacy (%)	51	44.3	64.6	47.8
Main local language	Oriya	Hindi	Tamil	Several
Organizations with insurance experience	Parivartan, BASIX	Urmul	Kalvikendra, Dhan Foundation Gandhigram Trust	-
Organizations with limited insurance experience	Utkal Mahila Swayam Sahayak Samabaya (UMASS)	Sewa Mandir	Sarvodaya Nano Finance Ltd (SNFL)	-

Sources: www.census.tn.nic.in; www.tn.gov.in; Census of India 2001, Government of India; UNDP, 2006a; Government of India, Central Statistical Organisation [http://mospi.gov.in/]; Government of India, Poverty Estimates for 2004-05 [http://planningcommission.nic.in/].

characterized by poor social indicators, especially those related to women. Tamil Nadu, in the south, is relatively developed, where rural areas are largely dry and face challenges of uncertain rainfall. The states capture various agro-climatic regions in a country where rural households face different forms of risks. Individual states also have considerable intra-state variation.

Table 1.3 presents basic macro indicators for the three states. Given the comparability in size of these states to some countries around the world (Pakistan's 154.8 million population and 778,720 sq. km size; Bangladesh's 139.2 million population and 133,910 sq. km size; Malaysia's 24.9 million population and 328,550 sq. km size; and Vietnam's 83.1 million population and 325,360 sq. km size), one can expect the experience at state level to be of relevance elsewhere.

Focused group discussions (FGDs) among current and potential clients were carried out in two locations in each state. The FGDs were based on a pre-designed survey instrument (Annex 2) that provided qualitative information to help assess client perspectives on the bottlenecks confronting microinsurance and the potential market. The FGDs provided a rapid assessment of users' perspectives on risks and insurance needs to assess demand, product design, willingness to pay (with implications for product pricing) and delivery mechanisms. The FGDs were structured to account for differences in rural clients with insurance cover and those without or limited prior insurance experience. Most FGDs were conducted among those with insurance cover to understand their current challenges, such as suitability of product design and delivery mechanisms, which were limiting the growth of this new industry. Including those without or with limited insurance experience ensured that the study captured risks faced by the potential target market and gauged unmet demand for microinsurance services. In addition, in-depth, semi-structured interviews with selected stakeholders in the three states supplemented the FGDs. These covered staff of life and non-life insurance companies, MFIs, NGOs and Government regulatory agencies, thus capturing the different perspectives of suppliers, intermediaries and regulators. Tables 1.4 and 1.5 present the coverage of groups and institutions in the three states.

Table 1.4

Coverage of FGDs in the Selected States

State	Extent of prior insurance experience among the groups and their facilitating organizations	
	With prior experience	Without or limited experience
Orissa	Parivartan, Kalahandi district: 2 FGDs BASIX, Ganjam district: 2 FGDs	UMASS, Ganjam district 2 FGDs
Rajasthan	Sewa Mandir, Udaipur: 3 FGDs	URMUL, Bikaner district: 2 FGDs
Tamilnadu	Kalvikendra, Vilupuram district: 5 FGDs Gandhigram Trust, Dindigul district: 2 FGDs Dhan Foundation, Theni district: 1 FGD	SNFL, Madurai district, 1 FGD
Total FGDs	**15 FGDs**	**5 FGDs**

Interviews with insurance companies were structured to understand the operational and policy issues on the supply side. Interviews with intermediaries – NGOs and other community organizations - were undertaken to understand grass roots perspectives on demand for, and distribution of, insurance services to the target market. These organizations are uniquely positioned to bridge the gap between demand and supply. Staff of Government agencies provided regulator and policy perspectives. These interviews resulted in first hand knowledge of existing microinsurance products, distribution challenges, limitations in product design and bottlenecks at the operational level, as well as future prospects for insurance companies.

c. Two multi-stakeholder consultative workshops

The workshops provided important inputs – one, at an operational level, and two, at a more strategic and policy level. They provided space to present the findings of the field investigations to experts and practitioners for feedback and discussions. The categories of stakeholders who contributed to the consultations were:

* Insurance companies (life and general insurance), for understanding operational and policy issues

* Bankers, to get their perspectives regarding their entry into and exit from the insurance sector and their plans for diversification into insurance, especially into the new microinsurance market

* NGOs, MFIs and CBOs, to understand grassroots perspectives and assess the support required in distribution and outreach of microinsurance services

* Rural insurance experts, to uncover issues on rural insurance and to obtain views on the scope and strategies for scaling-up to better serve the untapped market

Table 1.5

Institutions Visited

Type of Institution	Name of Institution
Intermediaries	PWDS, DATA, CSR, Sangamam Women SHGs Federation, Tiruchendur, Kadamalai Kalanjia Vattara Sangam, Healing Field Foundation, Parivartan, BASIX, UMASS, URMUL, Kalvikendra, SNFL, Gandhigram Trust, Dhan Foundation
Insurance Companies	Aviva Life, ICICI Prudential, Birla Sunlife, SBI Life, Royal Sundaram, ICICI Lombard and Bajaj Alliance Life Insurance, United India Insurance Co., LIC, New India Insurance Company, Agriculture Insurance Company of India, People Mutuals, Madurai
Commercial Banks	Indian Bank, Microsat Branch
Regulatory Agencies and Government undertakings	IRDA, NABARD, Insurance Ombudsman of Chennai, Tamil Nadu Corporation for Development of Women Ltd.

The first workshop focused on operational issues hindering the promotion of microinsurance in India, and participants were mainly operating personnel, the second workshop was designed based on the outcomes of the first workshop, to focus on the strategic and policy issues in the sector. Participants were from higher management levels. The composition of workshop participants is presented in Table 1.6.

The workshops provided opportunities in putting the findings and insights from the field in perspective, through discussions with potential suppliers of insurance, intermediaries, experts and policy makers. They also provided

a forum to share and understand each others' concerns. The interactions and exchange of views were very useful in identifying specific pointers on operational and policy issues. This helped in identifying ways to address the double bottom line:

- The social bottom line, with affordable coverage that was also responsive to the needs of the rural poor, and
- The financial bottom line, ensuring commercial viability of insurance operations for sustainability

Overall, the field work and consultations proved a valuable exercise, complementing the secondary research and providing very useful insights into the potential for the microinsurance sector. This facilitated the exchange of information, experience and differences in perspectives across clients, intermediaries, suppliers and policy makers, and helped to arrive at very specific suggestions for the way forward.

1.4 Limitations

The study has three clear limitations. The results should be read and interpreted keeping them in mind.

1. India is so large and diverse that it is not possible for this relatively small study, with field investigations covering a limited number of states, to claim to represent the country as a whole. Many areas in the uplands of the north-east could display quite different risk patterns and delivery issues (for example, travelling on mules), requiring location-specific solutions.

Table 1.6

Composition of Workshop Participants

Type of Organization	Number of Participants		Organizations Represented
	Workshop 1	Workshop 2	
Insurance Companies	16	10	AVIVA, Birla Sun Life, Cholamandalam MS, ICICI Lombard, ICICI Prudential, ITPL Pondicherry, Met Life, Royal Sundaram, SBI Life, IT PL Pondicherry, AMP Sanmar, Weather Risk
Commercial Bank	1	1	Indian Bank
Regulatory Agency, Government	-	1	IRDA
Micro Finance Institutions	11	11	SNFL (Tamil Nadu), SKS Micro Finance Ltd, BASIX, Ankuram Sangam, Sonata Financial Services
Media	-	1	Business Standard
Non Governmental Organizations	7	2	AP MAS, Asa (Tamil Nadu), Youth for Action, PWDS, DATA, Kalvi Kendra, Gandhigram Rural Institute, FWWB
International Development Organizations	1	3	UNDP
TOTAL	**36**	**29**	

2. The short duration (six months, October 2005 to March 2006) and limited budget available for field-cum-technical work leading up to the stakeholder consultations with a zero draft was a challenge. This prevented a full scale sample survey and necessitated being strategic in identifying respondents for the focused group discussions and interviews in order to obtain maximum feedback.

3. The qualitative nature of analysis, while providing insights, could lead to biases of the respondents and / or inadvertent generalizations.

This rapid assessment of the microinsurance sector provides insights on the issues, constraints and opportunities in the sector. The findings were shared with a broader, national level audience in the workshops, where they were widely accepted. To that extent, one can take the findings of the study to be robust, providing a basis for further investigation. Keeping the limitations in mind, it is hoped that, given the relative newness of the microinsurance industry in Asia and the Pacific, this study will contribute useful insights and concrete ideas relevant for India and beyond the Indian subcontinent, suitably adjusted to local circumstances.

INSURANCE IN INDIA

2
Chapter

2.0 Introduction

Of the total global insurance premium, estimated at US$ 4,060.87 billion in 2007, India's share of the insurance market accounted for 1.34 percent, up from an abysmal 0.73 percent in 2005. This amounts to US$ 54,375 million for the year against US$ 25,024 million for 2005, improving India's spot from 19th to 15th out of 88 countries. Among emerging markets India ranked second, after China. Of the total for India, most was accounted for by life insurance premiums with a turnover of US$ 47,132 million in 2007, more than doubled to US$ 20,176 million in 2005 (which was 11.38 percent of total emerging markets). Though non-life premiums comprised just US$ 7,243 million in 2007, they were up from US$ 4,848 million in 2005 (which was 3.31 percent of total emerging markets).[12] Insurance penetration, an indication of the level of risk awareness in the population and significance of insurance in an economy, increased from less than half to 63 percent of the global average between 2005 and 2007. Insurance density, used to measure progress of the insurance industry relative to other countries and its maturity in the economy, increased from about 4 percent to 7.7 percent of the world average (Table 1.1).

As suggested by these statistics, the overall insurance industry in India is still at a rudimentary stage of development, in spite of its large population and the varied risks people face. This points to an enormous scope for growth. The potential is even higher when the untapped rural population is considered. At present, only 10 percent of India's population is served by the insurance industry, thus excluding about 950 million people, mostly in rural areas. The present outreach of microinsurance in India is around 5.2 million people, covering only two percent of the poor in the country. Moreover, it is largely supply driven, as most insurers repeatedly indicated during discussions. Considerable work remains for the potential to be realized. Recent changes in national policies have brought about an expectation of new dynamism in the insurance sector, inducing a shift from the past, with a clear signal to the industry to expand in the direction of the rural poor. Yet, some questions remain.

2.1 Evolution of Insurance in India

The insurance sector has undergone many twists and turns over its nearly 190 years of operation, with a recent emphasis on growth and efficiency followed by an attempt to incentivize a rural and pro-poor focus. In India the formal insurance industry started in 1818 with the establishment of the Oriental Life Insurance Company in Calcutta. General insurance business (non-life) came into existence in 1850 with the commencement of the Triton Insurance Company. The first Insurance Act was formulated in the pre-independence period in 1938.

Almost a decade after India's independence from the British in 1947, the Government of India merged 240 private insurance companies to form the government owned Life Insurance Corporation of India (LIC) in 1956. The stated aims of nationalization were countering high levels of fraud and improving the spread across the country for better security for people. Non-life insurance companies also were nationalized in 1972 and taken over by General Insurance Corporation (GIC) and its four subsidiaries - United India Insurance Company Limited, Oriental Insurance Company Limited, National Insurance Company Limited and New India Assurance Company Limited.

Though public sector companies have been offering a wide range of life and non-life

The overall insurance industry in India is still at a rudimentary stage of development,in spite of its large population and the varied risks people face; this points to an enormous scope for growth

products, their outreach has overwhelmingly been to those in urban areas with formal employment. Unlike the financial services industry, public insurance companies did not penetrate rural areas despite nationalization. Coverage also has been largely for men. Lack of appropriate products and challenges of delivery channels, coupled with limited demand arising from low awareness, have resulted in a rather low penetration of insurance services outside urban areas. Thus, the rural poor have largely remained outside the old of insurance in India.

Major changes in the financial services sector, caused by increasing liberalization of the economy starting in 1992, resulted in greater competitive pressures and a premium on efficiency. Insurance also was recognised as an integral part of financial services. Soon after, in 1993, the Malhotra Committee[13] was appointed to look into the insurance industry and make recommendations for the expansion of this sector. Critical recommendations included:

- Reduce Government equity in insurance-companies to 50 percent and give companies more independence in operations
- Privatize subsidiaries of the General Insurance Corporation
- Open market to competition by allowing entry of private players; lower minimum capital requirements to INR 1 billion
- Allow foreign companies to enter the market though joint ventures with domestic companies
- Alter the Insurance Act and establish a Regulatory Body
- Require companies to pay interest on payments delayed beyond 30 days
- Increase the use of technology to achieve greater operational efficiency

Clearly, efficiency and growth were the focus of the recommendations. Based on the recommendations of the Malhotra Committee report in 1994, the Insurance Regulatory and Development Authority (IRDA) legislation was passed in 1999. The legislation was a milestone in the insurance industry in India, playing a catalytic role in development of the sector. As per the provisions of IRDA Act (1999), the Insurance Regulatory and Development Authority was established in April 2000 in Hyderabad, to protect the interests of clients and regulate, promote and ensure healthy growth of the insurance industry. As of 2007 IRDA has established 38 regulations, adding 11 more to the 27 regulations of 2005, on a number of issues such as registration of insurers, regulation of agents, solvency margins, re-insurance, obligations of insurers to rural and social sectors, investment and accounting procedures, and protection of client interests.

In 2000 IRDA relaxed barriers to entry in the industry to attract private players. Foreign companies were allowed to enter through joint partnerships with Indian companies (their equity stake was restricted to a maximum of 26 percent). By December 2007, private life insurance companies totalled 16, while there was only one public life insurance company. In the non-life segment there were 11 private and 6 public insurers. The list of private and public sector insurance companies operating is in Table 2.1.

Premiums underwritten by the insurance industry, which had nearly doubled from INR 456,776 million (US$ 9,516 million) in 2000-01 to INR 836,451 million (US$ 17,426 million) in 2003-04, jumped again to INR 1,809,471 million (US$ 37,697 million) in 2006-07, a hundred percent plus increase in three years. While levels are low by global standards, growth has been rapid and has initiated healthy competition among public and private players, resulting in product innovation and better customer service. As per the ILO / STEP (2005)[a], as many as 51 products under microinsurance were identified as available

Table 2.1

Insurance Companies in India, 2007

Life Insurance Companies

Private Sector	Public Sector
Bajaj Allianz Life Insurance Company Ltd, Pune	Life Insurance Corporation of India, Mumbai
Birla Sunlife Insurance Company Ltd, Mumbai	
HDFC Standard Life Insurance Company Ltd, Mumbai	
ICICI Prudential Life Insurance Company Ltd, Mumbai	
ING Vysya Life Insurance Company Pvt Ltd, Bangalore	
Max New York Life Insurance Company Ltd, Gurgaon.	
Metlife India Insurance Company Pvt Ltd, Bangalore	
Kotak Mahindra Old Mutual Life Insurance Company Ltd, Mumbai	
SBI Life Insurance Company Ltd, Mumbai	
TATA AIG Life Insurance Company Ltd, Mumbai	
Reliance Life Insurance Company Ltd, Chennai	
Aviva Life Insurance Company India Pvt Ltd, Gurgaon	
Sahara India Life Insurance Company Ltd, Lucknow	
Shriram Life Insurance Company Ltd, Hyderabad	
Bharti AXA Life Insurance Company Ltd, Mumbai	
Future General India Life Insurance Company Ltd, Mumbai	

Non-Life Insurance Companies

Private Sector	Public Sector
Bajaj Allianz General Insurance Company Ltd, Pune	National Insurance Company Ltd, Kolkata
ICICI Lombard General Insurance Company Ltd, Mumbai	New India Assurance Company Ltd, Mumbai
IFFCO Tokio General Insurance Company Ltd, Gurgaon	Oriental Insurance Company Ltd, New Delhi
Reliance General Insurance Company Ltd, Mumbai	United India Insurance Company Ltd, Chennai
Royal Sundaram Alliance Insurance Company Ltd, Chennai	Export Credit Guarantee Corporation Ltd, Mumbai
TATA AIG General Insurance Company Ltd, Mumbai	Agriculture Insurance Company of India Ltd, New Delhi
Cholamandalam Ms General Insurance Company Ltd, Chennai	
HDFC Chubb General Insurance Company Ltd, Mumbai	
Star Health & Allied Insurance Company Ltd, Chennai	
Apollo DKV Insurance Company Ltd, Delhi	
Future General India Insurance Company Ltd, Mumbai	

to customers. Including other products identified during the study phase (October – March 2006), the number adds up to 102, split between life (38 products) and non-life insurance (64 products).[15]

Yet despite this recent growth and estimates of a middle class of around 250 million, overall insurance coverage - even among the non-poor - continues to be very small, and more so for non-life products. Insurance is not well understood even among the middle income groups. The perception exists that insurance is an investment with a return – a perception strengthened by life insurance, which has become a popular tax saving device yielding an assured return after a prescribed period. The 'contingency cover' aspect of insurance is not yet fully understood or accepted, needing much more communication for changing attitudes. Most non-life products have to be 'sold;' only health insurance is 'bought.' For example, motor vehicle insurance is compulsory, as is housing insurance when purchased through financing.

Given these weaknesses, the insurance industry in India has a long and challenging path ahead in order to overcome the 'exclusivity barrier' and begin catering to the currently excluded rural population, the vast majority of whom, are poor.

2.2 Development of Microinsurance

Rural microinsurance in India was encouraged by financing institutions primarily to hedge their own risks while lending to the poor under the requirements of directed lending. Rural insurance products, therefore, tended to address the needs of the poor only incidentally – responding primarily to the needs of lending banks. Rural insurance, guaranteed by the Government under poverty alleviation programs, was built into the credit package as a compulsory element. Credit recipients often perceived it as part of the cost of borrowing from banks, without fully understanding the concept of insurance or its benefits. Crop and animal husbandry loans were commonly covered by insurance. Most non-life insurance companies had a master policy with the banks at the apex level, with little or no contact with the insured, resulting in substandard service and limited products and creating a negative image of insurance companies.

Rural insurance products tended to address the needs of the poor only incidentally – responding primarily to the needs of lending banks

In 2002 IRDA established rural and social sector targets for insurance companies. All insurers entering the business after the commencement of IRDA Act 1999, therefore needed to comply with obligations toward the rural and social sectors in a phased manner. The obligations are prescribed under guidelines for insurance companies as summarised in Table 2.2.

Originally, the 'rural sector' was defined quite strictly, with a specification of standards such as a population of fewer than 5,000 with more than 25 percent of the male population employed in the agricultural sector. But upon requests from insurers, the IRDA later modified its definition of a rural area, diluting it.[16] The 'social sector' includes unorganized, self-employed individuals, vulnerable population, and disabled persons, among others. For life insurers IRDA has fixed a floor percentage for policies in the rural sector in order to increase insurance business in this target market segment. For non-life insurers, on the other hand, IRDA

Table 2.2

IRDA Guidelines for Insurance Companies, 2002

	Year 1	Year 2	Year 3	Year 4	Year 5
			Rural Sector: Life Insurer		
Percent policies written in the year	7	9	12	14	16
			Rural Sector: Non-Life Insurer		
Percent of gross premium collected in the year	2	3	5	5	5
			Social Sector: Life and Non-Life		
Number of persons covered, both, life and non-life in a year	5,000	7,500	10,000	15,000	20,000

Source : Insurance Regulatory Development Authority (IRDA), Annual Report 2003.

has fixed a floor percentage for premiums, to encourage a higher number of persons covered. This works well because the sum insured in the rural areas is generally lower than in urban centres. As seen in Table 2.2, the minimum required percentage for both life and non-life insurers increases over a five year period for rural and social sector coverage. Those insurers existing on the date of commencement of the IRDA Act had to ensure that the quantum of insurance business was no less than they recorded or the previous accounting year, ending in March 2002.

Very recently, under its new regulation of November 2005, IRDA has for the first time strengthened its focus on microinsurance. It has defined both general and life microinsurance products. The former refers to any health insurance contract protecting assets such as a hut; livestock, tools and instruments; or an accident contract, either for an individual or a group. The latter refers to any term insurance contract, with or without return of premium; endowment insurance contract; or health insurance contract, with or without accident rider, either on an individual or group basis. For each of these policies, the minimum and maximum for amount of cover, term of cover, and age at entry have been specified. Companies have to design products under these specifications and get special approval from IRDA for them to qualify as microinsurance products.

The rural and social sector obligations have forced insurers to extend some insurance products to these sectors to meet pro-poor policy objectives. In practice, however, it is the social sector products that have tended to better satisfy the essence of microinsurance. In contrast, under the rural sector requirements, most companies have preferred to sell insurance for expensive farm equipment such as tractors, harvesters and commercial dairy farming machines, used by the relatively well off. This is primarily because targeting rural populations requires revisiting and revising insurance models, which is a challenge in the short run. This challenge is further exacerbated when the poor are perceived less as a potential business opportunity and more as a charity oriented social obligation, a requirement that needs to be ful-filled to meet Government regulations.

Statistics on microinsurance business under rural and social sectors and on product innovation (Table 2.3) also support this.

Insurance companies prefer to meet the rural targets rather than the social sector ones because larger farmers can be covered. During 2006-07, all 16 private life insurers and the LIC met their rural sector targets. However, under the social sector two private companies, Bharti Axa and Shriram, did not meet their targets, with a shortfall in the number of lives covered under the social sector. By publishing and sharing this information, the Government is taking its first steps in encouraging compliance with its pro-poor policies. For example, two non-compliant companies (Tata-AIG and Om Kotak) were no longer in the list of 2006-07. Non-compliance can lead to penalty and/or cancellation of licence. Among the eight private non-life insurers in 2006-07, all met the rural and social sector targets. All the four public sector non-life insurance companies achieved their rural targets. The one public sector insurance company that did not achieve the social sector obligations - New India Assurance Co Ltd. - faced a financial penalty for non-compliance (IRDA, 2007).

The rural and social sector obligations have forced insurers to extend some insurance products to these sectors to meet propoor policy objectives

Around one-third of India's population earns less than US$ 1 per day and 52.4% of population earns under US$ 2 per day. Out of the total Indian population of 1.08 billion, the population earning less than US$ 2 per day is estimated at 569.64 million. This indicates the potential at the BoP.

Product innovation by life and non-life can be seen in Table 2.3. The life products

Table 2.3

Insurance Products During the Financial Year 2006-07

All insurance products and those under microinsurance	Life products		Non-life products		Total products	
	Public	Private	Public	Private	Public	Private
All insurance products	8	185	30	92	38	277
Microinsurance products	-	1	6	4	6	5

Source : IRDA, 2007.

cleared by IRDA and the non-life products filed by insurance companies under 'file and use' procedure during the financial year 2006-07 are summarised. Among the 315 products (38 public; 277 private), only 11 were microinsurance products (6 public; 5 private). The small share of microinsurance in all insurance products in 2006-07 suggests that most insurers do not invest much thought in treating microinsurance as a business opportunity, considering it more as a Government obligation to be satisfied with the least effort.

In August 2004 IRDA released a concept paper on microinsurance and used it as a platform to engage a variety of stakeholders in a consultative process to discuss future prospects. The result was the revised set of microinsurance regulations published in November 2005 discussed in Section 2.4 below. The years ahead are expected to be hectic for the insurers, with possible launch of several microinsurance products with support from international development organizations.[17] Annex 5 provides a list of products and Annex 6 includes details on some of these products observed in the field. While a much larger number of products are available on the books, only a limited number are actually operational, as found during the field investigations and discussions.

It is useful to identify some of the macro factors that are contributing to emerging opportunities

2.3 Emerging Opportunities for the Growth of Microinsurance in India

The growth of microinsurance depends on many factors. It is useful to identify some of the macro factors that are contributing to emerging opportunities. These help explain the changing national context for the microinsurance industry in India.

a. Economic

The Indian economy had a robust growth during 2005-06, with a real GDP growth of 8.4 percent. The projections for 2006-07 stand at real GDP growth of 8 percent. Real GDP has increased to 8.9 percent during the first quarter of 2006-07. Pro-poor economic policies are resulting in directing sizeable investments into rural employment, self-employment and other development programmes for the poor such as the National Rural Employment Guarantee Programme (NREGP), the Sampoorna Grameen Razgor Yojana (SGRY), the Swarnajayanti Gram Swarozgar Yojana (SGSY), Prime Minister's Rozgar Yojana (PMRY) and the Swarna Jayanti Shahari Rozgar Yojana (SJSRY). Even with all these limitations, overall growth, combined with focused opportunities for the poor, especially those in rural areas, is contributing to increased income generation among rural households. The poverty percentage fell from about 50% in 1980 to about 40% in 1990,18 although concerns about inequalities persist. In contrast with a policy focus on income generation, relatively little attention has been paid to protecting assets and incomes.

b. Financial

Government of India has increased attention to lending to the rural sector through banks using self-help groups, resulting in increased propoor credit flows. Agricultural lending through formal financial institutions soared from INR 462,680 million, or US$ 10,281.78 million, in 1999-2000 to INR1,574,800 million, or US$ 34,995 million, in 2005-06. At the same time, lending to self-help groups from formal financial institutions has increased from INR 1,360 million (US$ 30.22 million) in 1999-2000 to INR 44,990 million (US$ 999.77 million) in 2005-06.19 This increased credit flow has contributed to more entrepreneurial activity, both farm and non-farm, increasing income earning avenues in rural areas. Out of the total lending to self-help groups, 90 percent has gone to women; this has increased direct finance in women's hands, exposing them to financial institutions, enterprise and external markets.[20]

c. Social including Gender

The self-help group movement is resulting in a silent revolution in rural India, transforming society from within. Individuals from poor households and excluded sections of the population, particularly women, now have opportunities for economic empowerment and greatly improved self-confidence. They are better able to effectively articulate their demands to Government and non-Government agencies and have the social cohesion to push for increased voice and social space within their communities and achieve community goals. As a result, women are increasingly being involved in decision- making forums at the local level. With increased incomes, they are investing in the education and health of their families as well as upgrading shelter. Many have enrolled in literacy programmes. In states like Andhra Pradesh, Maharashtra and Tamil Nadu, the SHG movement also has contributed to increased mobility of women – they travel outside their villages in the course of their work (banking, marketing, group meetings), capacity building (training, workshops, exposure visits) and even for pleasure (sightseeing, pilgrimage). Out of 1,600,000 self-help groups as of March 2005,[21] a quarter were more than three years old, with well established operations, (having received more than one loan from formal financial institutions) and on the verge of graduating to manage larger micro-enterprises. While there are instances of male backlash, by and large, men have supported women's participation in SHGs. SHG members are ready for commercially oriented risk management options. There is also strong demand for microinsurance products to secure life and assets in areas with social unrest and communal tensions, where womentend to be relatively severely impacted.

d. Technological

India has more than 600,000 villages spread over 29 states and 6 union territories.[22] With an area of 3,287,263 sq. km and a total rural population of 777 million - of which the adult population is 524 million - an enormous pool exists from which will come the potential clients for microinsurance services. It is estimated that more than 87 percent of villages[23] now have at least one public telephone. These telephone booths are increasingly being used as social focal points where villagers get together to exchange information and news and share ideas across age, socio economic status and ethnic groups. Because India is emerging as a global leader in providing information technology services, leveraging these to increase the outreach of microinsurance is not a distant goal.

e. Cultural

Increased media exposure is affecting rural life styles and culture. As per the 2001 census, it is estimated that 31.5 percent of rural house-

The self-help group movement is resulting in a silent revolution in rural India, transforming society from within

holds have radios and 18.9 percent have televisions or radios which provide exposure to new ideas and experiences even to semi-literate populations. Field investigations indicated that most households with television sets view programmes via cable and satellite. They are thus able to access knowledge of major events in real time and be exposed to ways of doing things outside their immediate milieu. This is dramatically impacting rural households and providing avenues for change - many superstitious beliefs and customs are being questioned, traditional approaches are being re-examined and new ways of thinking explored. This provides an opportunity to overcome traditional reluctance to insurance services through appropriate exposure, education and marketing.

f. Technical

International development organizations such as the UNDP, ILO, GTZ, Interpolis Re (a subsidiary of Robobank Group), World Bank and USAID are promoting the development of microinsurance through technical assistance, investing in product development, creating a database on rural households, and sharing experiences through workshops. The Inter - Agency Consultative Group to Assist the Poor (CGAP) has established a working group to document good and bad practices in microinsurance. It has documented some successful experiments in India, for example, innovations in microhealth insurance. Some user friendly processes have evolved which are emerging as models for others to consider for suitable adaptation. Even stand-alone health insurers may have a niche business opportunity. With better availability of accumulated field experience and focused technical studies, the IRDA may revisit the current guidelines, including entry norms and lowering capital requirements, for stimulating supply.

g. Environmental

Rapid urbanization and the focus on economic growth have contributed to environmental neglect. The poor tend to pay a disproportionate price for this neglect. Often the poor dwell in high-risk areas that are highly polluted or disaster-prone. For example, households living in encroachment areas on the banks of rivers or canals are adversely affected during sudden floods. These households are beginning to realize that their exposure to risk can be managed and attempt to acquire insurance cover for their household assets like televisions, grinders, sewing machines and refrigerators.

h. Institutional

Reaching rural households for financial services, including microinsurance, is a distribution-challenge. Creation of a separate distribution channel can be very costly - hence, impractical for affordability and financial sustainability. Therefore, existing institutional structures need to be used effectively. Existing institutions include non-Governmental organizations, selfhelp groups, microfinance institutions, post offices, commercial banks with branches in rural areas, regional rural banks, and agricul tural cooperatives. Overall processes need to be simplified and modified to be made to suit each institutional structure.

i. Legal

In October 2004 India's central bank, the Reserve Bank of India, permitted Regional Rural Banks (RRBs) to undertake insurance business as a 'corporate agent' without risk participation. Because RRBs have a network of branches in rural areas, they could play an important role in increasing outreach. Though the 2005 IRDA regulation on microinsurance has some restrictive aspects, it has a number of positive features. Its most innovative feature is legally

recognizing non-Governmental organizations, microfinance institutions and self-help groups as 'microinsurance agents.' This has the potential of significantly increasing rural insurance penetration.

All these factors have contributed to increased potential for business and an enabling environment. The microinsurance industry seems poised to make a quantum leap in India Even though the microinsurance market has some challenges inherent to the rural target population (high distribution costs, inadequate knowledge, inappropriate products) and other challenges common to all insurance activity (pre-transaction adverse selection, post-transaction moral hazard, risk assessment), the success of the self-help group movement has demonstrated that many of these challenges - especially those specific to the BoP market - can be overcome.

2.4 Implications of the November 2005 Regulations for the BoP

IRDA's regulations of November 2005 (Annex 7) mark a turning point in signalling policy support to the 'micro' segment of the insurance industry. Although some issues still need to be addressed, overall the regulations are viewed as highly favourable for the growth of this sector by insurance companies, microfinance institutions and NGOs. It remains to be seen how these regulations are being used and what wrinkles needing ironing surface. Key issues addressed under these regulations, are highlighted below.

a. Easing Distribution Challenges for Inclusion

- **A wider and more inclusive definition of microinsurance agents:** Non-Governmental organizations, microfinance institutions and self-help groups have been explicitly named as agents, thus legally accepting them. Local institutions now can be tapped for provision of services. This is a major change that could multiply the pool of agents exponentially, utilizing those already operating in rural areas - especially the self-help groups - many of which also would be part of the client population. This can facilitate distribution through a substantial jump in outreach.

- **Allowing the same company to provide life and non-life cover:** Clients now can have their life and non-life insurance needs handled by the same insurance company. It also will be convenient for poor rural clients, since they will no longer need to deal with different institutions for different needs. This also is expected to minimize avoidable paper work and travel for suppliers and customers alike.

- **Permitting composite products:** These will allow a 'single window' for life and livelihood protection services, facilitating the work of agents as well as clients. For the agents, it could make their work easier - convincing new clients about an insurance product that provides multiple benefits is easier than having them take a number of policies for different risks. For clients as well, composite products are beneficial because they can receive multiple benefits through a single window. This is an 'enabling' provision and does not preclude un-bundled products also, that are preferred in some circumstances (e.g., by women).

- **Revising commission structure upward:** To meet higher distribution costs in rural areas, commissions have been increased. Insurance companies are required to provide 10 percent commission on life (single premium) products, 20 percent on life (multiple premium) products, and 15

Although some issues still need to be addressed, overall the regulations are viewed as highly favourable for the growth of this sector by insurance companies, microfinance institutions and NGOs

percent on general insurance products. Earlier, the rates of commission varied between 5 to 15 percent; for example, for tractors and gobar gas insurance it was 5 percent, for silkworm and honeybee insurance 10 percent, and for livestock and hut insurance 15 percent. This will increase incentives for agents and facilitate expansion of the sector.

- **Fixing upper and lower coverage limits:** The new directive has specified the upper and lower coverage limits of insurance products to ensure that products are useful for clients, while insurance companies retain a focus on 'micro,' aimed at the poor. These are given in Table 2.5.

Reducing Procedural Bottlenecks

- **Permitting premiums to be collected and remitted by micro insurance intermediaries and agents to insurance companies**: This change will reduce transaction costs of insurance companies, improving operational efficiency.

Table 2.4
IRDA Prescribed Minimum and Maximum Cover

Type of Policy	Cover (INR) Minimum	Maximum
Life term	5,000	50,000
Endowment	5,000	30,000
Health, individual	5,000	30,000
Health, family	10,000	30,000
Personal accident	10,000	50,000
Crop	5,000	50,000
Livestock	5,000	50,000
Dwelling and its contents, other tools or assets	5,000	50,000

Source : Insurance Regulatory Development Authority, New Policy Directive, November 2005

- **Allowing agents to distribute policy documents to clients:** This change also will reduce transaction costs, contributing to operational efficiency.

- **Contracts in vernacular languages:** This will empower clients with knowledge about both the benefits and the conditions on their insurance policies. It is surprising that this was not the norm even for the urban population.

- **Lowering the required training period for agents:** The training period for insurance agents has been lowered from 100 hours to 25 hours. This will enable rural people to become agents, given the time and resource limitations they face.

Reduced transactions costs will help insurance companies offer better prices to clients while improving viability. The four modifications above also are expected to create confidence among clients regarding service delivery, currently a challenge

- While the pool of permissible microinsurance agents has been substantially increased, it is yet to be seen how this will be operationalized and what criteria will be adopted for a microfinance institution, non-Governmental organization or self-help group to be qualified as an agent. Clearly, not all would have the required strengths to handle insurance operations.

- Although companies will in the future be permitted to provide both life and livelihood cover, insurance companies are currently not set up to provide both types of services. How this will be resolved is yet to be seen. It will depend on the adaptability of insurance companies in providing a far more flexible product line.

c. Residual Concerns

- Reduced training duration could lead to a dilution of skills unless it is part of an overall rationalization and specialization exercise to widen the pool of agents more suitable for the new client group. New, shorter training curricula may need to be designed, as well as new trainers identified and provided with appropriate training of trainers.
- The pressure of profits because of increased marketization and competition could contribute to increasing fraud, high turn over among agents, and other negative practices, which can hurt customer confidence.In identifying agents, concerns about fraud also need to be addressed to ensure uniformity in procedures.

RISKS FACED BY THE RURAL POOR

3
Chapter

3.0 Coping with Risks

The rural poor have to grapple with both adverse events and their limited capacity to weather shocks. In combination, they face income fluctuations and sudden asset depletion. Those around the periphery of a poverty line, however defined, also are vulnerable, since small shocks can push them deeper into poverty. They do have their own informal and traditional coping mechanisms, including belt tightening and forbearance. Self insurance strategies include diversification of small income sources, 'doing without' by reduced consumption of food, and cutting down on all 'non-essential' expenses such as schooling. Other traditional risk management strategies include reliance on patrons, drawing down past savings, borrowing from moneylenders, family, friends and neighbours, and temporary migration.

Though helpful in addressing one-time, low impact shocks, such as minor accidents or small illnesses, informal and traditional systems are inadequate for a number of reasons. The traditional *jajmani* (patron-client) system[24] is breaking down, and zamindars (landlords) have disappeared as the system was dismantled after independence. In any case, these systems are inadequate in addressing repeated or larger risks sustainably. The strategies have a small reach and range. They can negatively affect self-esteem and burden rural households with reciprocity obligations. They also are quite unsuitable in addressing risks that affect households across the board, such as floods or droughts. Moreover, these coping mechanisms significantly reduce the ability of poor populations to withstand future shocks, limiting their capacity to earn, save and accumulate assets, leaving them even more vulnerable to future risks and, in many cases, further driving households into poverty. A number of Government run poverty reduction and social security schemes have replaced traditional systems, but they have limited coverage and do not address vulnerability to risks and shocks.

Coping with risks and shocks without insurance further limits potential for income growth, savings and asset accumulation. These shocks affect poor rural households in many adverse ways, including reduced capacity to work, low productivity, increased absenteeism from work, reduced food consumption and nutrition security, high drop out rates of school children, and homelessness, aggravating overall deprivation and human poverty. Understanding risks among the BoP is essential in formulating appropriate supply side responses through appropriate products, pricing and procedural innovations, as well as in facilitating the growth of demand through education and marketing.

Coping with risks and shocks without insurance further limits potential for income growth, savings and asset accumulation; though helpful in addressing one-time, low impact shocks, informal and traditional systems are inadequate for a number of reasons

3.1 Risk Categorization

Risks and shocks arise from many different factors, unanticipated and anticipated. Unanticipated events are harder to budget for at household level, but can be much more easily addressed at an aggregate level. These may include, accidents, disasters, death of the breadwinner, death of animals, crop failures, market fluctuations and personal events like illness, abandonment, widowhood or disability. Anticipated events (marriage, child birth and old age) also can set back poor households substantially. In the Indian context, social norms require households to incur relatively high, one-time expenses on such occasions – dowries, feasts,

gifts and medical expenses. Households require lump sum funds on such occasions, which can be a problem for the poor.

Shocks can be covariant or idiosyncratic. Covariant shocks affect all households in a certain geographic area, such as a flood, drought or earthquake. The October 2005 Pakistan earthquake and the December 2004 Asian tsunami are examples of covariant shocks. Idiosyncratic shocks are restricted accordingly to a particular household, such as theft, illness or accident. These differences have implications for designing suitable products and their pricing.

High frequency risks are relatively harder to cover; low frequency risks are easier to insure but harder to sell

In risk assessment terms, events can be categorized by frequency and impact. Chart 3.1 presents a simplified schematic picture of frequency and impact of shocks. Examples in the boxes may be seen as illustrative, since the intensity of impact and frequency can vary by household circumstances.

Chart 3.1

Schematic Representation of Risks: Examples by Frequency and Impact

IMPACT	FREQUENCY: High	FREQUENCY: Low
High	Serious ill health, accident, harvest failure, fire	Cyclone, earthquake, riots, death, crop price drop, theft
Low	Bullock hit, snake bite	Minor occasional illness, falls

High frequency risks are relatively harder to cover; though the cost of insurance may be high, it is much needed. Low frequency risks are easier to insure but harder to sell. In situations of great need (high impact, covariant risks) insurance by itself may not be adequate – it could support an overall risk management programme.

Risks identified by rural households are discussed below, combining secondary sources and field research.

3.2 Risk Perceptions and Prioritization by the BoP

During field investigations, respondents were asked to identify and rank four top priority risks. Tables 3.1 presents the risks identified in each of the three states while Table 3.2 presents a prioritization by the poor of risks they perceive, categorized by location. Considerable variation was found within states, with location a key factor. The range of risks is, of course, much wider than presented in the table (discussed in section 3.3), but the tables are indicative of the perceptions and priorities.

Table 3.1

Overall Risks in Selected States

State	Type of Risks
Orissa	Poor health, drought, loss of business or household assets (from theft or damage)
Rajasthan	Drought, poor health, loss of life
Tamil Nadu	Loss of life, accidents, poor health, loss of business or household assets (from theft or damage)

Thus, risk perception and prioritization for insurance by low income rural households is found to be highly location specific. Prioritization differs widely by local agro-climatic conditions and the local economy, which influence livelihood options, security perceptions in the area of normal residence, degree of exposure of the area of residence to risk, and awareness of risks. For the asset less poor in tribal and dry areas, where personal labour is the primary or

Table 3.2

Prioritization of Insurance Demand by Location Based on Risk Assessment by the Poor in the Three States

Location type (predominant)	Priority 1	Priority 2	Priority 3	Priority 4
Tribal areas	Health	Life	Not identified	Not identified
Dry areas	Drought	Health	Life	Not identified
Coastal areas	Life	Accident	Business assets	Health
Urbanized rural areas	Life	Accident	Health	Household assets
Rural economy areas	Life	Accident	Health	Livestock
Riot prone areas	Business assets	Life	Not identified	Not identified
Areas along highways	Accident	Life	Not identified	Not identified

even the only source of livelihoods, health insurance was among the top two priorities; life was identified as a third priority. In coastal areas, fisher folk feared death and accidents on sea; protection of assets and health also were concerns. Urbanized rural areas had similar risk prioritizations, but the accident sources were quite different. In other rural areas, it was life, accident, health and livestock. Finally, loss of business assets were a top priority risk for insurance in riot prone areas, followed by life. Those living along highways prioritized road accidents as the top risk.

3.3 Range of Risks

a. Crop Losses

Agriculture is subject to many uncertainties like droughts, floods, pest attacks, untimely rains, and price fluctuations. Agricultural risks vary among agro-climatic conditions, types of crops grown, types of irrigation facility, pests and diseases, and prices of the final produce. Some agricultural risks can be controlled through better management practices, whereas others need to be tackled through commodity exchanges and appropriate insurance services. Many challenges arise in developing appropriate insurance products. Product development requires historical data on prices, costs, benefits and losses, which are not currently available. Even for products offered, administering them poses another set of challenges because of difficulties in assessment, measurability and estimation of value of the loss and compensation. The suitability of data lands and units of area for determining compensation have been contentious issues. These problems have deterred insurance companies by providing full-fledged crop insurance to farmers.

Risk perception and prioritization for insurance by low income rural households is found to be highly location specific

Where cultivation is on the basis of institutional finance, there exists an element of compulsion in insurance for the protection of lender interests. An interesting example is the World Bank funded and Krishna Bhima Samruddi Bank initiated pilot programme in India on Innovative Rainfall-Indexed Insurance.[25] The programme draws on rainfall-indexed insurance (combined with other financial services) to decrease risk and advance the supply of financial services to clients. Weather indexed insurance is innovative because it does not suffer from the usual moral hazard, unfavourable selection and high administration costs of tra-

ditional crop insurance, and therefore is better suited to small farmers who depend on rainfall. Banks also can benefit from secured lending and decreased default rates, enhanced collateral and a greater volume of lending amounts and savings in rural areas. The public sector is in a position to benefit from a decreased need to supply emergency assistance.

b. Livestock Losses

The distribution of livestock is more equitable than land among rural households. Though 63 percent of rural households classify as small landholders (owning less than 2 hectares of land), they own only 34 percent of arable land. In contrast, they own 67 percent of bovines, 65 percent of bovines, 70 percent of pigs and 75 percent of poultry. Livestock in rural households not only augments income, employment, and food security, but also serves as a storehouse of capital and insurance against shocks. It is estimated that income from livestock constitutes 20-30 percent of income of the average rural household. Women tend to have a greater control over livestock as compared with land. Livestock related risks faced by rural poor that came up in field investigations were death of cattle, sheep or goats, stoppage of milk yield, theft of animal, non availability of fodder for the animal, and outbreak of livestock diseases during the monsoon season. Livestock insurance is an important means of protecting income generating and supplementing assets, though administering it poses many challenges. The most commonly reported challenge by insurers is identification of the insured animal.

c. Premature Death

Premature death is a major risk faced by the rural poor. For India, 2002 data on age-standardized mortality rates per 100,000 persons by cause revealed 750 deaths from non-communicable diseases, 428 from cardio vascular diseases and 109 from cancer. Deaths due to injuries from natural calamities and sectarian riots stood at 117 per 100,000 persons.[26] Further, figures for 2004 indicated deaths per 100,000 persons due to tuberculosis amongst HIV-negative people stood at 28, while the figure for HIV-positive people was 2 per 100,000 persons.[27]

Untimely death of an earning family member leads to severely reduced income, which in turn can contribute to forced coping mechanisms that destabilize family structure and cause a host of social challenges arising, for example, from trafficking or child labour.

The Ministry of Health and Family Welfare calculates the mortality rates for rural persons aged 15 – 59 in Table 3.3, showing higher rural mortality amongst the rural working age population.

Table 3.3

Age Specific Mortality Rates Amongst Working Age Population in India, 2002

Age in Years	Rural	Urban	Rural, All Ages	Urban, All Ages	All India
15-19	1.7	1.0			
20-24	2.6	1.5			
25-29	3.0	1.8			
30-34	3.1	1.9			
35-39	4.4	3.2	8.7	6.1	8.1
40-44	4.4	4.4			
45-49	7.2	5.4			
50-54	9.8	8.7			
55-59	16.2	12.7			

Source : Mare Socquetl, 2005. ILO / STEP, Microinsurance Workshop, October, Hyderabad.

d. Accidents and Ill Health

For those with limited or no productive assets, labour is the primary income source. For such persons illness, or even small accidents, represent an on going threat to their income earning capacity. Accidents and ill health were a source of anxiety among the poorer sections because they contributed to loss of work days - and hence, wages - directly affecting loan repayments, current consumption, savings and any potential for building assets. The direct costs of treatment also forced affected households to borrow. Those with productive assets faced losses due to asset sale or pledging to raise funds for treatment. In either case, economic costs were a concern.

Risks and shocks reported in field investigations included disability caused by accidents while using a harvester or thresher, injuries arose by falling down in a muddy field, bullock hits, falling into a well while drawing water, being hit by toppled trees during high velocity winds, snake bites, inhaling pesticides while spraying crops, boat capsizing during fishing, getting dragged into the sea while spreading fish nets, falling down from camel carts, and road accidents for those living by the side of highways and in urbanized areas. Under ill health, economic implications differed depending upon whether hospitalization was required. In case of hospitalization, loss of wages of the attendee also needed to be accounted for. Almost 80 percent of diseases causing ill health are either waterborne or caused by water bodies (cholera, diarrhoea, typhoid and hepatitis A), particularly relevant for rural populations whose access to protected water cannot be taken for granted. Communicable diseases also are reported, adding to health risks faced by individuals and communities.

The average rural household spent INR 90 (US$ 2) on an illness without hospitalization and INR1,044 (US$ 23.20) in case of hospitalization.[28] Under the former, major components of costs include - 71 percent on medicines, 8 percent on diets, and 14 percent on transport. In case of hospitalisation, major components of cost are 52 percent on medicines, 15 percent on clinical tests, 12 percent on transport, 8 percent on surgery, 8 percent on diet and 4 percent as hospital charges. The Network for Education and Empowerment of Rural Artisans (NEERA)[29] conducted a health survey in 2002 among 1,748 self-help groups in southern Tamil Nadu - a population group where women are relatively empowered and are more likely to seek health care - the results of the 2002 health survey suggested that 9.32 percent of all members had been hospitalized for in-patient care. Their average stay in hospital was 14 days in a year and the average hospital expenditure was around INR10,344 (US$ 230). Hospitalized members met 72 percent of expenses by borrowing and 13 percent by selling assets. Among lenders, local moneylenders were foremost at 39 percent, followed by newer sources of credit such as financial institutions and self-help groups. The NEERA survey supported a World Bank study[30] that hospitalization impoverishes one-fourth of the hospitalized Indian population. Gender implications are important as well. When expenses are a concern, in a patriarchal society, women's health tends to be much more neglected – with adverse implications not just for their productivity, but also for their well being and status in the household. Insurance can expressly provide for such contingencies.

Relatively poorer households spend proportionately more on health as compared with better off households.[31] Health expenditures account for 7.8 percent of the household income for households with annual income below INR18,000 (US$ 400) in the NEERA survey however, this proportion falls to 2.3 percent for households with annual income above INR54,000 (US$ 1,200).

For those with limited or no productive assets, labour is the primary income source. For such persons illness, or even small accidents, represent an on going threat to their income earning capacity

e. Loss of Assets

The rural poor own assets such as huts, tools, livestock and carts. Artisans and crafts persons own basic machinery such as pottery wheels, spinning wheels and weaving frames. These assets are susceptible to idiosyncratic contingencies such as fire, theft and breakdown. Most of these assets are low priced, hence repairable and replaceable so the overall impact of such shocks on poor households, though temporally adverse, is not extreme from an insurer's perspective. However, this occurrence suddenly interrupts household income generation. Impact is more severe when assets are on borrowed funds or are pawnable (like gold or silver), as that further pushes the vulnerable into a downward spiral of indebtedness and poverty. Some shocks observed during field investigations were theft of electric motors in the dry season, when they are in higher demand for pumping water, mud house collapse during rainy season, theft of household articles such as radio, television or sewing machine, hut fires, loss of fishing nets while at sea, theft of boats, and boat engine breakdown.

Box 3.1

Drought – An Inadequately Recognized Natural Disaster

Drought is a regular feature for Kolasar, a remote and poor village in western Rajasthan. People estimate that they expect to see a good monsoon once in six to seven years. The monsoon brings with it a bumper crop that is used to clear all debts accumulated during the previous non-monsoon years. Of the 241 households in Kolasar, 40 have migrated to other areas. Among those who live there, adults leave the village for employment in brick kilns in neighbouring areas. Of the 400 children enrolled in the local school, only 150 attended. The remainder had dropped out for paid work to support their families during the drought. This is the ground reality for rural areas facing environmental risks.

f. Natural Disasters

The Indian subcontinent is highly prone to natural disasters, and floods, droughts, cyclones and earthquakes are recurrent. Among the 35 states, 25 are disaster prone. More than 8,000 km of coastline is exposed to tropical cyclones, and an additional 40 million hectares of land is prone to floods. Landslides, hailstorms and avalanches also are common. It is estimated that 56 percent of the country is prone to earthquakes and 68 percent to drought. Natural disasters affect the vulnerable poor populations much more than the better off. The devastating effects of the 2004 tsunami on the coastal areas are well known, the tsunami which hit 12 coastal countries killed around 280,000 while successfully damaging infrastructure and production facilities. All this has underscored the need for insurance, perhaps not as a stand alone instrument, but certainly as a part of overall risk mitigation for areas prone to such covariant risks. Droughts also can be disruptive, though their risks are underestimated because they do not happen suddenly. In Rajasthan severe droughts are a prominent risk, as the illustrative case from Kolasar demonstrates in Box 3.1.

g. Life Cycle and Female Oriented Risks

Financial shocks associated with the life cycle affect rural households because of the demands they impose on the household. These are different from premature deaths, as they are predictable in nature. Women and young girls are a more vulnerable segment within this group. They face financial expenses and health risks associated with pregnancy and childbirth, infertility treatment, exorbitant expenses and dowry requirements during marriage. Widowhood and abandonment of the wife and children also occurs, causing disruption of income streams, though these are harder to predict.

Domestic violence induced injuries is another risk that directly affects regularity and capacity to work. In a traditional set up, some of these risks were managed through social support networks such as extended families sharing wages and food. Female relatives looked out for each other, helping during pregnancy and childbirth, sharing the heavier workload and even ensuring better nutrition through various religious and cultural customs and rituals. Customary practices of confinement before and after childbirth saved women from domestic burdens. Maternal mortality, while common, was handled through support within the extended family. Even children with both parents alive were brought up by the whole family. This system also took care of the aged and ill. These arrangements have become eroded and need to be replaced with alternate social security mechanisms to reduce their adverse impact. Yet they are often left un-addressed. Diseases faced by women, for example, are often neglected due to ignorance and high cost of treatment.

Women's risks have received little attention among mainstream insurers, but these may well form half or more of the client group. Health insurance needs to be designed to include gender specific health needs of women like coverage for delivery expenses, female infertility treatment, and gender violence induced injuries. Most insurance companies do not so there is a need to examine for whose education has education insurance been used for.

With the exception of health related risks, most other risks for women are societal in nature and hence not be typically covered by insurance. Even in situations where they are well understood, insurance as a cover to protect women and girls receives the lowest priority in a household. Such deliberate neglect for generations as a result of social norms has been a key impediment in protecting vulnerable women and girls.

Over the last decade, the self-help group phenomenon is changing the way women are seen and the way they perceive themselves. Physical mobility, handling finances, micro-businesses, and mutual support through group membership are yielding economic and social spaces to women; this is starting to generate interest in self-protection and insurance among them. Some products even are tailored to cater to women and girls, for example, the Rajarajeshwari Mahila Kalyan Yojana and the Mother Teresa Woman and Child Policy under welfare schemes. In the case of life insurance, however, concerns have been expressed against making payouts to the husband of the deceased woman. This was a deterrent for purchasing life cover because women were wary of providing a financial incentive to the husband for their deaths, freeing up opportunities for taking on another wife. During dialogues with insurance companies women proposed that the payout could be to their daughters. This would secure the financial position of the daughters, without adding to the risk to their lives.

Women's risks have received little attention among mainstream insurers, but these may well form half or more of the client group

h. Male-oriented Risks

A risk particularly relevant to males is alcohol or drug addiction. Alcohol or drug abuse results in loss of work-days, and job losses. It also diverts limited household income toward unproductive expenses, contributes to ill health and expenses for treatment, and increased indebtedness. Domestic violence is a side effect that can reduce income of the wife as well. Another concern is male infertility treatment, which can drain household resources. These risks are rarely included under health insurance.

i. Market Risks

In addition to loss of assets, production and consumption capabilities, insurance cover for 'exchange losses' due to market fluctuations also is important. As the country's economy be-

comes increasingly open, the rural population faces far more market risks, for example, those arising out of price fluctuations. Small poultry farmers faced heavy losses in Madhya Pradesh because a market crash for chicken when avian influenza affected a neighbouring state. Demand declined even though the local poultry was not affected, and prices fell dramatically. More open trade also is expected to contribute to greater price fluctuations. When crops are based on agricultural credit, whether through banks or other money lenders, the effects of a price fall on sellers can be devastating, as stories of farmer suicides have demonstrated. Market risks are faced not only by individuals, but also by organizations like SHGs, where group produce is involved and risks of default or delays in repayment can be real, jeopardizing future credit access.

In sum, the BoP population faces a variety of risks and shocks in very diverse contexts that can result in severe economic hardship, with implications for social stress, health and nutrition, children's education, shelter and, more generally, the quality of life. Risks can be of high or low frequency, high or low impact. They could be idiosyncratic or co-variant. Risks also vary by location. Traditional coping mechanisms exist, but are not only inadequate but also limit the potential of rural households to jump a level in their economic status. Crop losses, livestock losses, premature death, accidents and health, asset loss, natural disasters, life-cycle and female-oriented as well as male-oriented risks, and market risks - all can suddenly set back a poor household. A better understanding of the risks and their prioritization for insurance is a prerequisite for (a) facilitating the development of demand through appropriate information, education and communication customized for potential clients could also benefit marketing efforts; (b) designing appropriate supply responses through innovations in products, pricing and processes; and (c) modification of policies and regulations needed for the development of the sector.

Complementing an understanding of risks, in Chapter IV, the study looks at what is already taking place through a review of the literature.

SIX KEY ISSUES FOR CATALYZING THE MICROINSURANCE MARKET

4
Chapter

4.0 Introduction

This chapter presents a brief review of literature on microinsurance, focusing on but going beyond India, and including relevant material from other developing countries. Because the sector is relatively new, and in order to be forwards looking, the review is based on an examination of more recent secondary material. This material also informed the overall analytical framework for the study and guided the field investigations. The review helped in identifying six key issues for catalyzing the market for microinsurance, as follows:

- Demand and supply
- Product design
- Pricing
- Distribution and outreach
- Procedures
- Regulation

We discuss each in turn.

4.1 Demand and Supply

Even though there is need, it often is not translated into effective demand. Available products tend to be supply driven or compulsory, and more recently, driven by the quota system imposed on insurers under rural and social sector obligations. Demand and supply issues tend to be intertwined: demand is influenced by the suitability of what is supplied and how it compares with existing coping mechanisms; supply is influenced by perceptions of willingness and ability to pay.

Inadequate knowledge, affordability, supply of unsuitable products and lack of trust are some relevant factors inhibiting demand. Willingness to pay is important, but affordability is not all that restricts demand. Demand creation involves a strong element of explaining what insurance means and demonstrating its benefits and limitations.

An assessment of the need for microinsurance, based on major adverse events experienced during the previous 10 years, was made in a study of rural households in India.[32] The study, over 18 months, covered 60 villages, from which about 600 rural poor individuals (300 men and 300 women in Sharanpur district in UP, Bharatpur in Rajasthan and Raichur in Karnataka) and 110 rural branch officers were canvassed, using structured questionnaires. An in depth analysis was carried out of more than 600 loan records and 750 deposits. This was supplemented by a review of available published material and analysis of financials of National Commercial Banks (NCBs) and a number of Regional Rural Banks (RRBs) and cooperative institutions. The survey found that 44 percent of the households reported losses due to floods or heavy rains, 39 percent due to drought, and 27 percent due to pest attack. It also revealed that only 15 percent of respondents possessed an insurance policy, while 64 percent wanted some form of insurance.

Even though there is need, it often is not translated into effective demand; available products tend to be supply driven or compulsory

Similar findings were reported in a CGAP working group case study of VimoSEWA.[33] Immediately after an event causing loss, people perceive the need for insurance cover and demand goes up. Following the massive earthquake in Gujarat in January 2001, the number of insured through VimoSEWA soared from 30,000 to 92,000. The comprehensive insurance scheme has two levels of asset loss components. Scheme I covers asset losses up to a maximum

It is the poor who are most affected by natural disasters as they tend to live in disaster-prone high risk areas

of INR 10,000 and Scheme II up to a maximum of INR 20,000. The benefits of asset insurance were demonstrated after the communal violence in Gujarat in 2002 and floods in 2003-04. Insured members received funds to replace the loss of equipment and huts, enabling them to return to productive employment quickly. This resulted in increased demand.

A 2003 rapid study in the predominantly rural Dindigul district of Tamil Nadu, revealed that out of 59,695 self-help group members, 17 percent of women had taken some form of insurance cover.[34] A survey in Chennai among the Mahilar Thittam NGO network[35] showed that of 68,535 self-help group members, 11 percent[36] had taken insurance. Though low by international standards, these figures show Tamil Nadu is relatively developed in insurance, contrasting with Rajasthan and Orissa, where coverage is less than 1 percent. This also indicates that in circumstances where the rural population is already aware, organized and networked – as the case of SHGs – the need for insurance may be more easily translated into effective demand.

Potential demand is also influenced by type of vulnerabilities. An analysis of natural disasters related vulnerabilities in India[37] estimated that 54 percent of total area is earthquakes prone, of the total area of 328 million ha, 12.20 percent is flood prone, 8 percent is cyclones prone and 68 percent is susceptible to drought. Such risks affect about 30 million people, on average, in a year. It is the poor who are most affected by natural disasters as they tend to live in disaster-prone high risk areas. Integrated disaster management does not in most cases include a social insurance component to cover the poor exposed to disaster risk.

Health insurance was perhaps in greatest demand, but in short supply

A primary concern in rural areas is to address health related problems. Indeed, there is a huge unmet demand for health insurance, showing economic and well-being implications. As noted earlier, women's health issues tend to recieve a low priority in India. The National Family Health Survey 1998-99 revealed that 39.2 percent of women report at least one reproductive health problem, with states like Meghalaya and Jammu and Kashmir reporting the highest percentages of more than 60 percent. Among these women, as many as two thirds did not seek advice or treatment.[38]

Hospitalization is low in India, with 40 percent of hospitalized people borrowing money or selling assets to cover hospital expenses; among those hospitalised, one fourth fall below the poverty line.[39] One reason for low hospitalization rates could be affordability, coupled with lack of insurance services. Even if a part of out-of-pocket expenses on health is channelled through an insurance risk-pooling mechanism, the poor would get better protection and financial security. Thus, health insurance, especially for women, is a priority in the rural areas, as was confirmed during the field investigations.

In a position paper submitted to the Parliamentary Committee on Public Undertakings, the Government[40] presented preliminary findings of a project on Strengthening Micro Health Insurance Units for the Poor in India, which surveyed 4,900 households in seven locations. The survey revealed that half of the households at the bottom of the pyramid spend more than INR 2,400 per year on health care, and that the poor prefer to have insurance benefits for hospitalization costs, drug costs and compensation for loss of earnings due to hospitalization. However, less than 2 percent of the population is covered by health insurance.

The study found that health insurance was perhaps in greatest demand, but in short supply, because of difficulties in operating health insurance schemes.

An exploration of actuarial data availability[41] reported that need for health insurance was influenced by changes in population characteristics. Demographic changes such as increasing life expectancy result in an increase in the dependency ratio; with a larger segment of retirees, more will need to be spent on health care. This contributes to an increase in demand for insurance and pension products.

Willingness to pay likewise is an important indicator in realizing latent demand (see also Section 4.3 on Pricing). Even in a country like Ethiopia, one of the poorest in sub-Saharan Africa, one study found that the poor are willing to pay up to 5 percent of their monthly income for a scheme that can take care of their illness related costs.[42] In India an overview of community health insurance found that the most insurance schemes charged a premium in the range of INR100 per member per year, while clients were willing to pay only around INR20 to INR60.[43] Findings from the field confirmed this. The wages for unskilled rural workers are INR30 to INR50 per day. The latter study also took the view that community health insurance could be an important intermediate step in the evolution of a more equitable health financing mechanism, comparable to social health insurance in Europe and Japan.

A quantitative study under the Microfinance Centre for Central and Eastern Europe and the New Independent States, in exploring demand for microinsurance in Georgia, found that 32 percent, 20 percent and 16 percent of households declared a willingness to buy health insurance, life insurance and property insurance, respectively.[44] Of the three, willingness was highest for health insurance. The main reasons stated by the respondents for not possessing insurance were ignorance about insurance (nearly 45 percent of respondents had never heard about insurance or did not have enough information), lack of trust (36.2 percent), and high cost (31.6 percent).

An examination of the demand for insurance vis-à-vis affordability also in Ethiopia concluded that lack of demand for insurance need not necessarily be the result of lack of affordability alone, but may also be the result of other institutional rigidities such as credit constraints.[45] The study found that if the poor are allowed to borrow against their future incomes, demand for insurance will go up.

Does it make a difference if insurance is mandatory rather than voluntary? A comparison of the options was presented, using VimoSEWA's example, at the microfinance programme of the Boulder Micro Finance Training Institute, held at the International Training Centre of ILO in Turin.[46] In 1992 and 1993 VimoSEWA enrolled 50,000 members for its insurance programme when it was made mandatory. In contrast, when the insurance product was offered on a voluntary basis in 1994, the number of insured dropped to 10,000. While compulsion can increase enrolment and eventually stimulate demand, customized insurance products accepted on a voluntary basis indicate real client demand in the long run. It is this real demand that could push service providers to innovate in creating new products and processes that respond to client needs and priorities.

4.2 Product Design

Standardized product designs do not respond to client needs, which tend to be localized. Moreover, such products tend to be relatively expensive, excluding access by low income households.

Standardized product designs do not respond to client needs, which tend to be localized

An ILO / STEP (2005)[a] working paper[47] on insurance products provided by insurance companies to the disadvantaged in India listed

Pricing of insurance products for low income populations is a critical issue; premiums alone may not be adequate to provide full risk cover while covering costs in early years

83 microinsurance products of which 55 percent (as many as 46 products) covered a single risk only. Most products covered life, which is a relatively simple entry-point for microinsurers. Client perspectives were hardly sought or incorporated.

In an examination of the performance of standard products for the poor, it was found that despite a target of covering 1,000,000[48] lives under the Universal Health Insurance (UHI) policy announced by the Government and implemented by the four public sector non-life insurance companies, a mere 9,000 UHI policies had been sold, i.e., less than 1 percent of the target. This indicates that standardized products across a large country may not serve far more localized client needs, resulting in a minimal response to purchasing of insurance products.[49]

In East Africa, meanwhile, another estimate demonstrated that as compared with the cost of a comprehensive policy that bundles in and out-patient coverage, the option of an in-patient only policy could reduce the cost of coverage by two thirds to three quarters of the comprehensive policy.[50] Depending on local circumstances, offering separate, unbundled products as an option in addition to comprehensive products can offer wider choice to clients, allowing more enrolment.

Again, examples from elsewhere demonstrate that product innovations that respond to circumstances of poor households can be beneficial to clients. In particular, a policy of the MFI Pulse Holdings Limited in Zambia pays off loan repayment instalments (a maximum of three) due for the period when an insured client is ill.[51]

A serious consequence of having unsuitable products is a high dropout rate. In an analysis of the health insurance schemes for the poor in India, it was highlighted members left the scheme if they did not get the benefits they needed.[52] The study emphasized the need for inclusion of high frequency, low cost out-patient care to provide such needed coverage. Provision of out-patient care can be expected to have spillover effects on in-patient care because it can reduce hospitalization rates and cost of being an in-patient.

4.3 Pricing

Pricing of insurance products for low income populations is a critical issue linked to supply and demand. Premiums alone may not be adequate to provide full risk cover while covering costs. Thus early years of microinsurance offerings require soft funding to cover start up costs.

A VimoSEWA India case study[53] for the CGAP Working Group on Microinsurance assessed good and bad practices. Other unaudited financial results of 2004 showed that VimoSEWA suffered a net deficit of INR4.1 million without taking into account the donor grant income. A revised business plan projected it would take seven years time to attain viability. This indicates that for sustainable microinsurance operations to stabilize financially, substantial donor grant support is essential to finance initial operational deficits.[54]

Rural households in India are estimated to spend more than 6 percent of total household expenditures on health, in a report by the National Commission on Macroeconomics and Health.[55] The Indian per/capita household expenditure on health for 2004-05 was estimated at INR1,012, accounting for 73.5 percent of per/capita total health expenditure from all sources. At the same time cost estimate for providing a comprehensive package of services that ad-

dressed more than 95 percent of health care needs was INR1,160 per /capita[56] -- around 15 percent higher than the per/capita household expenditure.

Female clients especially could benefit from lower premiums. In an analysis of mortality variations in India at the 7th Global Conference of Actuaries, held in New Delhi in February 2005, it was pointed out that because female mortality rates are lower than male, a need exists to reflect this phenomenon in pricing of life products.[57]

Insurance provision for the poor could be a key factor enabling economic recovery after a catastrophic loss, but as a constituent part of a catastrophe management plan, since stand alone insurance would have to be priced exorbitantly. The December 2004 tsunami is a case in point. The Report on Natural Catastrophes and Man-made Disasters[58] estimated a total damage of US$ 14 billion in 2004. Out of this, the share of insured property loss was only US$ 5,000 million, indicating the low spread of insurance, especially among the poor. In India the estimated loss of facilities and infrastructure due to the tsunami was US$ 6.5 billion and loss of production was US$ 2.1 billon. According to an IMF estimate,[59] tsunami affected countries faced direct reconstruction costs ranging from 0.5 percent of GDP (India) to as much as 23.8 percent of GDP (Maldives). Such catastrophic events and consequent costs of rebuilding can affect macroeconomic indicators, resulting in deterioration of fiscal and trade balances, rising inflation and interest rates. Covering catastrophic events through affordable insurance is not financially viable given that risks are covariant across potential clients. However, as a part of a broader catastrophe management plan, Governments can ensure a minimum level of insurance provision. This was demonstrated in Turkey in 2000, following the 1999 Marmara earthquake, by making earthquake insurance compulsory with the setting up of the Turkish Catastrophe Insurance Pool (TCIP) through the domestic reinsurer Milli Re.

4.4 Distribution and Outreach

Distribution for better outreach to low income populations is a serious challenge. Some examples of distribution for better outreach in rural areas exist -- generally using intermediaries like NGOs or MFIs already working among the target population -- but their financial viability seems to depend on availability of soft funds for initial market penetration and development of distribution channels.

Better outreach to low income populations is a serious challenge; some examples of distribution for better outreach in rural areas exist but their financial viability seems to depend on availability of soft funds for initial market penetration

A micro-agent model in India was developed by Tata-AIG Life Insurance Company Limited with a matching grant from the DfID's Financial Deepening Challenge Fund (FDCF). Under the model, Community Rural Insurance Groups (CRIG) registered as partnership firms were formed with the help of NGOs who sold and serviced microinsurance products. It was observed that in the shortrun, premium payments alone could not result in profits, since relatively large costs of US$ 0.24 million were incurred in the development of distribution channels for rural and social products. This compared total premium revenues of US$ 0.12 million from the corresponding client group since inception of the model in March 2002.[60]

A CGAP Working Group case study on good and bad practices in microinsurance identified AIG Uganda as the first commercial insurer in the world to enter the microinsurance arena and successfully upscale operations to cover 1.6 million people in three countries.[61] Further, its microinsurance portfolio brought in a profit of 20 percent on premiums collected. Once established, AIG also was able to extend cover to persons affected by HIV/AIDS. Initial-

ly, however, the cover excluded deaths due to AIDS. Over time, it became increasingly clear that people do not die of AIDS but of diseases like tuberculosis or pneumonia, to which AIDS patients are also vulnerable. Further, HIV/AIDS status in Uganda is highly protected, therefore making it hard for an insurer to determine the HIV status of a client. Following this, AIG Uganda dropped the policy saying that it was unenforceable and difficult to explain to clients. Once extending insurance cover to HIV/AIDS patients, however, it was shown from 2000 to May 2004 that only 0.1% of total claims to AIG Uganda were made giving the reason of "AIDS death."[62] In India, coverage of HIV/AIDS patients through Tata AIG insurance is purposely avoided as a "high risk group" and areas that have high levels of HIV/AIDS (such as truck stops) are avoided.[63] Further, microinsurance agents have an incentive to avoid selling to these and other "high risk clients" with pre-existing health conditions. The agents desire repeat clients from whom they can continue to earn commission. Initially, the first year's commission was subject to a claw back if the policy lapsed in the first six months. The claw back had a harmful effect on the agents' motivation and was consequently discontinued.[64] There are, however, microinsurance schemes in India that extend coverage to people living with HIV and AIDS. The Karuna Trust is implementing a pilot health insurance scheme with the National Insurance Company and UNDP India in Karnataka State; pointing to a potential for change in this approach. Under this pilot scheme, antiretroviral drugs will be covered for all insured clients in three select field locations.[65]

An assessment of the impact of microinsurance in Kenya, Uganda and Tanzania showed that expanding distribution of micro health insurance policies to low income holders contributed to access to better health care, as compared with those who remain uninsured.[66] Similarly, an investigation regarding whether increased outreach through community based health insurance schemes improved poor people's access to health care in Senegal found that insured members used hospitals more often than non-members, and their out-of-pocket expenses for health care were lower -- thus, better outreach did improve financial security. At the same time, it was also noticed that while the community health insurance scheme succeeded in attracting the poor people, the poorest of the poor remained excluded.[67] This underlines the need for an ongoing focus on improving outreach, while recognizing that, at least in the beginning, the worst off may not be immediate clients.

Unsuitable procedures can lower service quality and add to operating costs; procedural innovations can be critical in obtaining and retaining clients while improving viability

4.5 Procedures

Unsuitable procedures and procedural rigidities can lower service quality and add to operating costs. The consequent exclusion of potential clients undermines market development. Procedural innovations can be critical in obtaining and retaining clients while improving viability.

In East African countries – Kenya, Uganda and Tanzania – where the procedure is to pay the medical insurance claim directly to the health service provider, access to health care increased.[68] Cashless transactions not only had the added benefit of procedural simplicity from the client's perspective, but they also contributed to getting people care in the early stage of illness. From the insurer's perspective this provided greater control over costs and service quality. An innovative initiative is MicroCare in Uganda, which offers "SMART cards" to its clients, with their photo and details printed it on it. When swiped, the card brings up their photo for verification, as well as the entitlement and coverage against the database records. Following the clinical examination, the SMART card holder must return to the check-in desk to

have the transaction details recorded in a database, including the clinician's name, the diagnosis, tests done and drugs prescribed. This feature makes available the actuarial data and the assurance of cost containment necessary to secure the support of leading international reinsurance companies.[69]

An exploration of alternative approaches at a microinsurance conference in Munich provided the example of an MFI in Poland – TUWSKOK – which had linked the provision of microinsurance to savings rather than credit. This procedural innovation could help those not willing to be in debt with the MFI but wanting to avail benefits of insurance.[70]

In India some NGOs have functioned as effective intermediaries to overcome cumbersome procedures, including rigid payment schedules and documentation requirements, in partnership with insurers, promoting market development and renewal of policies. Some examples are Parivartan, DHAN Foundation and BASIX, whose specific procedural innovations were observed in the field and are presented in Chapter VI.

A reduction of microinsurance premium is possible with complementary procedures for reduction of vulnerability of insured assets. This is seen in the context of disaster risk management for developing countries in an analysis of premium versus vulnerability.[71] For India, in the state of Karnataka, a comparison of claim ratios in two areas brought out significant differences within the same UNDP sponsored health insurance project: the claim ratio in Narsipura Block of Mysore district stood at only 23 percent, as compared with 55 percent in Bailhongal Block of Belgaum district. The lower claim ratio in Narsipura could at least partly be attributed to (a) preventive intervention in the form of propagation of benefits of consuming herbal medicines for common minor ailments, and (b) provision of revolving funds to SHGs for on-lending, to cover health needs that financed out-patient care.

4.6 Regulation

Standard regulations may be unsuitable for microinsurance

Standard regulations may be unsuitable for microinsurance, as is seen in the examples below.

India's regulatory authority, IRDA, did not have different (lower) capital requirements even for those insurers willing to sell only microinsurance policies. The same high capital requirements as a commercial insurer were applicable – of INR1,000 million (US$ 21.7 million).[72] Nevertheless, numerous examples exist of lower capital requirements in this sector, for example, US$ 1 million in Uganda, US$ 1.2 million in South Africa and US$ 0.29 million in Sri Lanka. In the Philippines, microinsurers based on a mutual schemes basis are permitted to operate with lower capital requirements.

Some concerns have been raised regarding IRDA's August 2004 concept paper, Need for Regulations in Microinsurance in India. One was an implicit restriction of microinsurance to a partner-agent model for India, limiting the potential to innovate. The paper also was considered overly prescriptive regarding product design.[73] Further, in the context of health insurance for the rural poor, serious reservations were expressed by cooperatives, mutuals and NGOs that the paper perceived them only as agents with a limited distributional function. This blocked their way in evolving pro-poor processes and product features in an emerging sector, as was reported in the newsletter Microinsurance Update in June 2005.

Before working on an enabling and supportive framework, it would be useful to first demonstrate functioning of different cases of microinsurance operations at the grassroots

level, and then use the experience as evidence for policy advocacy.[74] There are around 230 microinsurance schemes in Asia according to AMIN (Asian Micro Insurance Network), which provides bottom-up feedback. This suggests using the micro to inform the macro in addressing regulatory issues to grapple with the challenges of financing and distribution.

Just as the poor have no access to insurance, micro-insurance institutions typically have no access to re-insurance under current regulations

Field level NGOs and MFIs that offer or facilitate microinsurance generally tend to do so for poor people living in relatively close proximity. Consequently, their risk pool is not well diversified across geography, occupation and age. It was necessary to transfer the risk, an important avenue for which was re-insurance. Just as the poor have no access to insurance, microinsurance institutions typically have no access to re-insurance under current regulations.[75] During the 7th Global Conference of Actuaries it was demonstrated that re-insurance was a cheaper alternative than holding high contingency reserves.[76] Creation of a facility that would reinsure MHIUs would improve their financial viability.

At a Round Table Conference on Microinsurance Regulations, organized by FICCI and IRDA in February 2005, it was proposed that smaller microinsurance organizations, such as NGOs and MFIs, be given the space and opportunity to grow by bringing them under the scope of regulations. However, the IRDA guidelines published in November 2005 did not consider these smaller players as insurers, even though some had pioneered interesting innovations in this nascent industry. They were thus left to operate in a legal vacuum.[77]

The review of literature signals and underlines the need for microinsurance in India and elsewhere. It highlights factors that have inhibited this market. Need has not been translated into demand. Non availability of customized products and perceived high premiums by customers can be compounded by poor distribution, resulting in low outreach. Procedural and regulatory factors can inhibit and facilitate. Yet it has also found that the impact of microinsurance is positive where new products and processes have been successful in responding to client needs. This helped the study team to develop a framework for exploring ground realities based on field investigations. Findings from the field are presented in Chapter V, which follows.

UNDERSTANDING GROUND REALITIES: WHAT WORKS AND WHAT DOES NOT

5 Chapter

5.0 Introduction

This chapter presents an analysis of ground realities based on:

- Primary field investigations in rural areas through focussed group discussions among possible clients, supplemented by interviews with insurers and intermediaries operating in the field

- Presentations, interactions and feedback from two consultative multi-stakeholder workshops

The aim was to understand ground realities in India through direct interactions, complementing and taking forward the brief review of recent secondary sources of Chapter IV, in order to (a) take account of differing perspectives of clients, insurers and intermediaries; (b) examine prevailing experiences in insurance in the field to identify what works and what does not; and (c) lead to an identification of concrete measures that could provide a fillip to the microinsurance sector. As discussed in Section 1.3, the states of Orissa, Rajasthan and Tamil Nadu were selected for the primary field investigations. Each state is quite distinct, allowing the work to capture considerable variability of circumstances relevant for rural insurance, as well as different stages of development of this industry.

Twenty focussed group discussions (FGDs) were conducted among potential clients in the three states, Rajasthan, Orissa and Tamil Nadu,[78] providing valuable insights. Two types of respondents were selected: those who had prior experience with insurance services (current clients) and those who had no past experience (potential clients) to capture as much diversity as possible. Separate interactions were held with the two groups in each state. Responses from the focus group discussions helped gain a deeper understanding of client perceptions.

Questions centred on exploring demand side issues, analyzing current challenges and the extent of willingness to pay for insurance services. An outline of the survey instrument used to guide the FGDs may be seen in Annex 2. The FGDs were structured to investigate.

- Demand for insurance based on factors like risk assessment and prioritization by clients
- Reasons for and against insurance
- Ranking of insurance preferences
- Gauging general awareness about insurance services
- Estimating willingness to pay and preferences regarding payment schedules

The states of Orissa, Rajasthan and Tamil Nadu were selected for the primary field investigations

In depth interviews with selected insurance suppliers helped in investigating supply side challenges faced, such as delivery of services, and tailoring products and payment schedules, which were bottlenecks to growth. The intermediaries helped in finding ways to bridge the divide between suppliers and clients and also shared their local experiences. For NGOs and insurance officials, a semi-structured schedule for conducting the interview was prepared and used as a guide (Annexes 3 and 4).

These state specific field investigations were supplemented by two consultative multi-stakeholder workshops – the first on operational issues (Hyderabad, 21 November

2005) and the second on policy level issues (Mumbai, 2 December 2005). Participants for both workshops were strategically selected and included insurance companies, regulatory agencies and intermediary microfinance institutions. The first workshop had more operational level staff as participants, while the second had more senior participants for strategic and policy inputs. The workshops provided opportunities to share the findings from the field with insurance companies and intermediaries, and to jointly discuss solutions.

Six sections follow; each takes up a key issue pertinent to the growth of the microinsurance industry. Section 5.1 discusses the reasons for low demand in spite of intense need. It also presents concerns of suppliers to help understand why there has been so little effort at market development. The rural market is characterized by limited and inappropriate services, inadequate information and capacity gaps. Section 5.2 identifies challenges related to product design, which results in a mismatch between needs and standard products on offer. The section also identifies reasons for inadequate effort in product development. Section 5.3 discusses pricing issues, including willingness to pay. It also highlights the criticality of building historical data for competitive pricing and discusses the vexed issue of subsidies. Issues relating to distribution for better outreach are analyzed in section 5.4. This is one of the most often repeated reasons for absence of rural insurance. The high costs of penetrating rural markets, combined with under use of available distribution channels, hinder the growth of rural insurance services. Cumbersome and inappropriate procedures inhibit development of this sector, as seen in Section 5.5. Section 5.6 summarizes the key issues, capturing contrasting perspectives of clients and insurers that aggravate the difficulties. Specific field examples and local innovations presented in each section provide ideas for addressing each issue.

Why was the willingness to buy insurance so low? Responses of potential clients and current clients were distinctly different

5.1 Issues in Demand and Supply

a. Low and Limited Present Coverage

Feedback from the three selected states supported what was observed at the macro level, in Chapter IV, that the vast majority of the rural poor did not have access to any form of insurance services. Insurance coverage was better in a relatively developed state like Tamil Nadu, varying by area and availability of active groups with NGO facilitation, as compared to Orissa and Rajasthan. Coverage was far more common in the case of life rather than non-life products, confirming that most non-life products needed to be 'sold' or made compulsory. This was true despite a very wide range of risks that the rural poor face and clearly articulate, as seen in Chapter III.

b. Willingness to Buy Insurance: Perspectives of the Target Population

The poor provided reasons for buying or not buying insurance products. The willingness to buy insurance was seen to depend on a number of factors, including recognizing need, understanding insurance, availability of a suitable product, awareness of the product, affordable price, trust based on observed reliable service, suitable period of premium payment, and availability of finance for premium payments. Why was the willingness to buy insurance so low? Responses of potential clients and current clients were distinctly different, as presented below.

Potential clients, i.e., those with limited or no previous insurance exposure, provided the following reasons for not buying insurance:

- Unaware of microinsurance products
- Could not afford the premium, because income was highly variable

- Annual cycle followed by insurance companies did not match the 6-8 month timeline that livestock owners needed for exchanging milch animals. (This is the usual duration, after which milk yield is reduced and animals need to be exchanged)
- No one was willing to visit them for sales and claim servicing because the village was remote, even though they were interested in finding out about insurance
- Unfamiliar with the local agent or company selling insurance products
- Thought that insurance was only for the old and sick
- Did not own enterprises, hence, did not think they had any insurable asset

Those with previous insurance experience, the current clients, had a set of different responses:

- Distrustful of insurance companies because they had seen a genuine claim rejected in the neighbourhood
- Products on offer did not cater to real needs
- Tired of the expense and time required for documentation and processes involved in claim servicing; in particular, obtaining a certificate from a veterinarian and ear tagging[79] required to insure milch animals was considered too cumbersome
- Paying premium each year even when no loss was incurred was seen unfair; so the motivation to insure was low, particularly when products were perceived to be priced high
- Too much time taken in receiving the payout
- Insurance forced by banks when animals (cattle) were purchased using a bank loan

The responses were interesting, specific and informative. These could help in building demand.

c. Perspectives of Suppliers

Staff of insurance companies confirmed that they provided minimum cover to this section of the population, primarily under the rural and social sector obligations to meet IRDA directives. Further, they preferred to fulfil the mandatory directives through rural insurance, rather than social sector, focusing on the relatively rich. As a consequence, the BoP households in most cases continued to remain excluded from commercial insurance services. Coverage of low income rural households has, by and large, been through special initiatives of NGOs and microfinance institutions. Some commercial insurers are now watching these operations with interest, with the aim of forging partnerships following a new interest in expanding their client base. They agreed that the rural sector had untapped potential, but insurers were daunted by the initial costs of market development because there was no guarantee that those investing would be the ones to reap profits. Incentive incompatibility was a concern -- insurers felt that benefits of incurring costs of market development could go to competitors, which they could not justify to their supervisors. Overall, the mainstream insurance players, both public and private, have yet to take this up seriously as a business proposition.

Incentive incompatibility was a concern -- insurers felt that benefits of incurring costs of market development could go to competitors

d. Low Awareness and Gaps in Understanding Concepts and Procedures

The field investigations revealed low awareness about insurance related issues, not just among the BoP population, but also among the facilitating agencies and field staff.

Among poor rural households, insurance services were so limited that there was little experiential knowledge. Self-help groups were ignorant about new, private insurance players. However, they were familiar with

There was low awareness about insurance not just among the BoP population, but also among the facilitating agencies and field staff

The purpose of insurance was differently understood by clients and insurers

the intermediary organizations, which worked much more closely with them; the intermediary organization's name and role was much more easily reported by the respondents, rather than ultimate insurers. Regarding knowledge about products, it was largely limited to life insurance and the Life Insurance Corporation (LIC). Awareness of non-life risk coverage, insurance products and insurance companies was abysmally low. Some awareness existed about crop insurance, but only a single beneficiary of crop insurance was found in the survey. Ironically, the field staff of implementing agencies also were ignorant about the technicalities of insurance, and were not always aware of the products' features and processes. Consequently, they were often misinforming clients as well.

Box 5.1

Staff Capacity Building Programme

New India Assurance Company Limited has conducted structured capacity building efforts in association with the Palmyrah Workers Development Society and Development Association for Training and Technology Appropriation coordination centre in Madurai, Tamil Nadu. The training covered NGO staff, federation leaders, self-help group leaders and members.

Programme I - Awareness raising

Programme II - How to collect premiums and orientation on internal procedures and documentation (e.g., forms and proposals)

Programme III - Claims procedures and documentation for claims

New India Assurance Company then sent its front-line staff dealing with these products for an exposure visit to an NGO based in Tiruchendur (the Council for Social Reconstruction) and the community availing the insurance product. This had a very positive impact on the staff, who started taking more interest in clearing papers promptly. Clients appreciated the service offered by the company and said one had even received a claim in three days.

Conceptually, the purpose of insurance was differently understood by clients and insurers. Both concepts were partial and led to a gap in the motivation for insurance. For the client, insurance mentally translated into savings,[80] whereas for the implementing agency it was a matter of equal return, if not more, to cover costs and make profits. In combination, inaccuracies and gaps in understanding led to false claims and non-renewal of policies, which in turn contributed to loss of faith in insurance services.

Educating prospective clients may not bring direct return to insurers, but such investment will go a long way in supporting market creation. While long term portfolio growth required investment in capacity building, insurance company officials revealed a reluctance to do so, because of incentive incompatibility. Nevertheless, examples of capacity building could be found. Box 5.1 shows an example of an effective capacity building program from Tamil Nadu.

e. Managerial and Operational Capacity Gaps

Provision of microinsurance services to the rural poor requires management and operational capacity at the grassroots level. Well established organizations, with professionals heading field units and operational procedures and systems in place, were most trusted by insurance companies because of their managerial and operational capacity. Examples were Bhartiya Samruddhi Investments and Consulting Services Limited (BASIX) and Development of Humane Action (DHAN) Foundation. These were used as first-tier partners for field level functions by insurance companies. Second-tier NGOs and microfinance institutions were those with experience in social intermediation and effective communication skills, who also were familiar with microinsurance. But NGOs that satisfied these criteria were very few in number.

The vast majority of medium sized and small NGOs require a great deal of capacity building to bring them up to par for delivering insurance services.

The first tier, well reputed NGOs and microfinance institutions, operating on a reasonable scale with established systems and procedures, have managed to negotiate good deals with insurance companies for more relaxed conditions and suitable insurance products at better prices. The same advantages need to be transferred to smaller organizations that could qualify to become agents. Box 5.2 shows an example.

Box 5.2

Negotiating for a Good Deal: Sharing Experiences

People Mutuals was established as an independent entity in 2003 to provide technical assistance to its community based insurance initiatives, launched on the basis of mutuality, and to facilitate linkages with mainstream insurance companies. As of March 2005, it had covered 10,274 members under LIC's Janashree Bima Yojana and 11,073 members under its Krishi Shramik Samajik Sangam (KSSSY) insurance product.

People Mutuals has succeeded in negotiating a deal with the Royal Sundaram Insurance Company, under which the cattle insurance premium was reduced from the market rate of 4 percent of the value of the animal to 2.25 percent. This is the lowest rate in the industry and has made cattle insurance possible for larger numbers of rural people.

Sharing such examples with other, smaller non-governmental organizations will help translate benefits to them.

5.2 Challenges in Design of Insurance Products

As we have seen, though public sector insurers claim the existence of more than 100 rural insurance products[81] (Annex 5) covering a range of crop, livestock and business assets, health risks and accidents, field investigations revealed only a few were operational on ground, e.g., cattle, life and accident insurance. The full range of products available on paper are neither promoted nor demanded in the marketplace. The primary weakness is the rigid design of products offered: since diversity is the hallmark of rural India, standardized designs for the entire country resulting in a 'one-size-fits-all' approach by insurance companies does not work well to serve the needs of rural poor. Serving this market requires insurers to understand the localized needs of their clients and to develop and promote customized products to meet these needs.

a. Mismatch Between Customer Needs and Products Available in the Market

As seen in Chapter III, survey findings show that needs are highly location specific - influenced by local livelihood options, agro-climatic conditions and other location-specific risks. The risks faced by the poor vary not only across states, but also within the state. For example, the risks faced by the poor in both Orissa and Tamil Nadu differ significantly between coastal and interior areas. Asset loss was more of a concern in coastal areas whereas priorities were different in the interior. Thus, drought and health (primary health), which influence livelihoods, were of greater concern for the poor than life *per se* in two states -- Rajasthan and interior Orissa. In the coastal regions of Tamil Nadu and Orissa the major concerns were losses in business or household assets, probably due to the frequency of cyclones and the recent tsunami experience. Undernourishment caused by drought-related food shortages and lack of primary healthcare were considered a higher risk factor than life per se in Rajasthan and interior Orissa as compared with coastal regions of Tamil Nadu and Orissa. Existing insurance products did not consider the different needs and priorities that varied by location. Basic market development

Though public sector insurers claim the existence of more than 100 rural insurance products, only a few were operational on ground

Basic market development activities such as identifying local needs and promoting products that addressed them was a significant gap

activities such as identifying local needs and promoting products that addressed them was a significant gap.

Apart from variations in risks, other local circumstances also were relevant in understanding client needs which products tended to ignore. A number of specific examples of mismatch were observed. Under life insurance inappropriate age limits were a deterrent. For example, the product Janashree Bima Yojana (JBY), offered by the Life Insurance Corporation, had an upper age limit of 60. In a country where average life expectancy is higher, at 63.3 (male - 61.8; female - 65), this was a major deterrent for rural clients. The deterrent effect was compounded in self-helps groups, where one or two women from a group of around 15 members, who were above the age limit, might be excluded, while the rest were considered insurable. This disturbed group cohesiveness, even while the insurers depended on the group for collection of premiums. The situation was worse in the case of private insurers, like the Housing Development Finance Corporation Standard Life and MetLife, which only covered clients younger than 50. Further, life insurance companies effectively exclude poor rural clients when they have a minimum endowment insurance plan for INR50,000 (US$ 1,100.00). Moreover, rural clients, like their better off urban counterparts, also would like to be compensated if they are alive after the duration of the life insurance policy, which was not found to be the case.

At times policies were found to be stricter for rural areas, virtually creating entry barriers, and shrinking demand. Though the JBY is sold to groups of 25 in rural areas, some units of insurers insist upon a minimum enrolment of 1,000 members, excluding smaller NGOs and self-help groups. In the case of endowments for education scholarships under the Shiksha Sahayog Yojana given to children studying in 9th to 12th grades, the entitlement was lowered in some cases from two children per household to one per household. There also were reports in the field whereby intermediary agencies had restricted scholarships without adequate and transparent eligibility criteria. In cases where grandchildren were being cared for by clients, children were excluded from the scholarship programme with no regard to differences in households and caretaking arrangements. This was another example of inflexibility in responding to client circumstances. Rigid payment plans, out of sync with cash flows of rural clients reflect the 'one-size-fits-all' approach of insurers. Because October is the month in which social security payments are made, clients postpone scholarship eligibility payments until then, paying for three-quarters in a lump sum, rather than following the prescribed quarterly schedule of payments. One popular product was the combined pension product for farmers, Krishi Shramik Samajik Suraksha Yojana, offered by the LIC in 2001. Despite high demand from women's self-help groups, this product was withdrawn from the market for unclear reasons.[82]

Women at the bottom of the socio economic pyramid also have limited access to formal financial resources, so they tend to depend on informal sources for most of their needs. Overall income streams are less regular and subject to seasonal fluctuations. Currently offered microinsurance products are not flexible and not priced suitably, as observed in the review of the literature and feedback from the field that helps understand ground realities (Chapter V). Even the minimum sum assured (INR 50,000) prescribed in certain insurance covers acts as an entry barrier to participation in these schemes.

Health insurance products were observed to be fraught with challenges in the field. In the case of mediclaim policies, the sub-limits

allocated to categories such as transport, room rent for hospitalization and surgeons' fees unnecessarily complicated reimbursement of expenses for rural clients. Simplifying reimbursement processes would ease procedural requirements for the predominantly semi-literate rural clients. Currently healthy persons also need to be motivated, through cumulative bonuses, to join or continue to participate in health insurance plans. Discussions with clients suggested that the 30 day waiting period until the policy comes into effect, along with exclusion of hospital expenses for the first year, are seen as deterrents. Exclusion of common health procedures like caesarean section operations for mothers-to-be also had negative market consequences. Absence of policy cover for HIV-positive people was a further problem in areas where such cases were prevalent; such exclusions affect women disproportionately because they are both the infected and affected, through being primary care-givers to an infected family member, while facing stigma and discrimination in the local community. Customized health insurance products were found to be piloted in just two cases, arising from the facilitating NGO's initiative in working with rural populations.

In case of death, households needed quick payouts to cover immediate expenses like costs of the funeral. No product addressed this need. But some NGO innovations were based on revolving funds of established SHG federations (Box 5.3).

A number of bottlenecks were unearthed under livestock and cattle insurance. As noted above the general cycle in milch animal raising is to exchange the animal after a period of six to eight months, when the milk yield is reduced. Rural clients with cattle look for insurance products with this timeframe in mind, rather than a year. Insurance companies sometimes offered short term products for other livestock; doing the same for cattle would help. For many clients milch animal theft was perceived as a high risk, but existing products did not cover this risk.

Box 5.3

Revolving Fund Works as a Stopgap Arrangement for Immediate Needs

Although IRDA stipulates that claims be settled within 7 days of receipt of the required documentation, the average time taken for claim processing is seen to range between 3 and 6 months. People Mutuals has initiated a revolving fund for 20 SHG federations to make resources available immediately for urgent expenses, such as funeral expenses in case of death or hospitalization in case of severe illness. The revolving fund is used to immediately provide INR3,000 (US$ 67) to the affected household on the day of death or the following day. This amount is adjusted later from the claim. This procedure is also being practiced in many federations promoted by DHAN Foundation. Such timely assistance builds rapport and trust between the NGO and the community and promotes faith in insurance.

Despite demand for insuring dwelling units and household assets, insurance coverage was only available if the house had been constructed using institutional sources of credit. The coverage available is INR5,000 (US$ 110) for the structure, and INR1,000 (US$ 22) for its contents. Given the demand for home insurance, a wider range of products and prices on offer would help tap into this business.

Bank managers recommended that credit life insurance products be offered by insurance companies linked to bank loans, as a small addition to the interest rate structure. Clients were open to the idea when it was well understood and accepted, rather than perceived as compulsory without understanding the benefits. Box 5.4 relates the case of a situation where such an arrangement could have helped save a self help group.

In case of death, households needed quick payouts to cover immediate expenses like costs of the funeral, but no product addressed this need

Box 5.4

Credit Life Cover

Kasammal, a widow aged 50, was a member in the Thangamalai self-help group of Keelasempatti, Madurai district, in Tamil Nadu. Through her self help group, like other women, she had taken a bank loan of INR 12,000 (US$ 267) for purchasing milch animals. Out of the 13 members who took bank loans, eight repaid their share in full, while the remaining five had outstanding amounts. In 2003 Kasammal died. She left behind a son to repay her outstanding loan balance. Her son, a day labourer making INR50 (US$ 1.00) a day, was unable to repay the outstanding loan of INR2,375 (US$ 52.78). The SHG was unable to close the loan balance of the deceased Kasammal. As Kasammal's loan account became overdue, the four other members stopped repaying their loans because they knew that their group would not get another loan from the bank until Kasammal's loan was closed in full. As a result, the entire loan balance of the SHG became overdue and the group lost its credibility with the bank. The bank blocked further credit, penalizing even those members who had repaid their loans fully and on time. Two years later, the self-help group was on the verge of disintegration. Had an insurance cover been taken for Kasammal, the turn of events might have been different. Her legal heir would have been protected, and the group could have continued to access bank credit. The bank also would have maintained a healthy portfolio.

b. Lack of Sensitivity to Gender

The challenges which women and other disadvantaged sections face have not disappeared. Women still face barriers such as limited mobility, access to resources, access to information and pressure on their time. Most insurance offices are located in far away urban centres. Hence, women and other socially disadvantaged groups such as tribal and scheduled caste households are not able to visit those offices often; conversely, insurance company messages do not reach these groups. For training, insurance companies invite trainees to urban centres. These groups tend to skip such trainings because they cannot commute to these centres daily. Sensitivity to the need of specific female and male oriented concerns was very limited. There was no anti-gender stance, but rather, very limited exposure and understanding of gender related issues, which limited the suitability of product design. For example, while SHGs, with their overwhelmingly female membership, were considered efficient vehicles to promote life insurance for women, the dangers of promoting it amongst all women members of SHGs including those living in conflict with husbands -- was not fully recognized. Safeguards in product design to remove incentives for domestic violence were needed. In cases of widows buying life insurance, the sharing of benefits between sons and daughters was a relevant question. Male alcoholism or drug abuse which directly affected household income was not covered. Under private health insurance, while payments to providers certainly promoted efficiency, cases of unnecessary caesareans and hysterectomies in Northwest India have been reported.[83] In a strongly pro-natalist society like India, childless couples spend a great deal of resources on fertility treatment, which was not considered for insurance. Policies for education expenses often were advertised primarily for sons and marriage expenses for daughters, reinforcing stereotypes in spite of changing social circumstances.

c. Inadequate Effort in Developing New Products

Overall, little or no effort in customization of products or development of new products was observed among insurers.

A major reported impediment to new product development was a near absence of historical data on the BoP population

A major reported impediment to new product development was a near absence of historical data on the BoP population. Lack of historical data came in the way of insurance companies understanding these markets better, building product features, excluding benefits, if any, pricing competitively, and developing

a conscious promotion strategy around a product. The question is, who should be doing such data collection and management, which is a public good that can help the sector at large? Individual companies were reluctant to invest in shared databases and pooling their claims history for the common good of the sector.

A second impediment was lack of trust between the insurer and the insured. Building of trust tends to be a time consuming process requiring investment from both parties and facilitation by intermediaries. Trust can be built based on a good track record, but short time horizons and concerns with immediate profits were inhibiting factors. At the same time, many facilitators also lacked adequate knowledge. Unless insurers saw value in engaging a facilitating agency (say, an NGO or MFI already working with the BoP population), it was going to be hard to bolster and retain trust.

Where insurers worked with intermediaries, the tendency was to see them primarily as a means of access to clients for collecting premiums, rather than a resource that could be involved in both product development and pricing. Insurers need to see a 'win' in a far more substantive engagement with intermediary agencies, going beyond treating them as a means for client access, in the absence of which customization would be difficult. Product development required a longer term horizon and an ongoing dialogue. Nevertheless, some innovations observed in the field (Box 5.5), though few and far between, provide pointers for the future.

While workshop feedback underscored the feeling by most insurers that microinsurance is primarily a social obligation rather than a business proposition. There was nevertheless new thinking and serious debate about this being a future area of thrust. However, at the time of the study, no strategic moves had yet been made by companies for substantial investments in new products or scaling up of the microinsurance business. A 'wait-and-watch' approach prevailed, though companies expected significant developments soon – it was only a matter of time.

Box 5.5

Innovations Facilitating Interactions Among Stakeholders

People Mutuals, Madurai, conducted 13 interactive workshops during 2004-05 involving people and insurance companies. These workshops have facilitated many policy changes by the companies (both private and public sector) in cattle, life and health insurance products.

Palmyrah Workers Development Society / Development Association for Training and Technology Appropriation (PWDS/DATA) continued negotiations on health insurance with the New India Assurance Company Ltd., Madurai, for nearly two years before the company finally developed a more pro-poor and flexible product. Around 2,000 members were covered under the new product in the first six months after its inception.

A second impediment was lack of trust between the insurer and the insured

Table 5.1 presents an outline of specific coverage and limitations of currently available products.

5.3 Pricing Issues

a. Willinness to Pay and Perceived High Price of Microinsurance Products.

The opportunity cost of money for the poor tends to be high. Not only are they price-sensitive, but their ability to pay also is low. Pricing of insurance services therefore requires considerable thought. Insurance companies have yet to devise ways to provide superior insurance services at competitive prices to cater to the BoP market.

Table 5.1

Coverage and Limitations of Current Products

Particulars	Life	Health	Livestock / Other assets	Crop	Disaster
Current products	Life – group and individual, endowment, credit shield	Mediclaim, PA, PTD, UHIS for poor families	Livestock, hut insurance	NAIS, rainfall insurance, farm income Insurance Scheme (FIIS)[84]	Property insurance covers losses due to earthquake, floods, etc.
Covered losses	Accidental and natural death	Hospitalization, loss of earning due to disability, critical illnesses	Loss of property due to fire, theft, burglary and riots, death of livestock	Yield loss, farm income loss	Loss of property and life
Design limitations	Lengthy terms and high premium make the product unattractive	Does not cover OPD or chronic illnesses[85] No coverage for transportation expenses, livelihood loss	Does not cover loss due to illness of livestock Hut insurance available only when institutional credit sources were used and coverage for household assets limited to Rs1,000 Lack of data makes it difficult to assess losses	Coverage not available for several crops due to unavailable data. Crops excluded include vegetables and horticulture No distinction in sum insured to irrigation according or topography	Many natural disasters, such as heavy downpour, remain uncovered
Claim servicing	Documentation required is complicated and time consuming	Claim settlement is delayed since loss assessment process is lengthy and costly[86]	Claim settlement is delayed since loss assessment process is lengthy and costly	Crop insurance claims often are delayed	Often delayed and cease to have the relief effect
	Prolonged transfer time in the absence of bank accounts	TPAs not active in rural areas	Absence of veterinary network in an area delays claim settlement	Payout based on district averages resulting in high base risk	

Respondents among the SHG women reported that they had developed their own back up systems to tide over unforeseen circumstances and therefore were reluctant to pay what they considered high premiums. They indicated a willingness to spend, about a day's wage per month on insurance overall for their particular risks and priorities. This worked out to a sum in the range of INR360-600 annually (US$ 8-13), assuming wages to vary between INR30-50 a day. The relatively poorer ones were willing to pay in the range of around INR100-300 a year on insurance. Conservatively, a reasonable average starting range for insurance companies to consider seems to be around INR300-400 a year premium to begin with, with variations across specific client groups and products.

Expenditure toward insurance premiums as a proportion of the total annual household income for relatively well-off families in urban areas is estimated at be around 8-10 percent. A low income household with an annual household income between INR 9,000 and 15,000 may not pay out and maintain such percentages over the years, more so for products considered sub-standard. Survey results indicate that premiums exceeding a day's wage per month on average will be difficult for clients to accept, at least in the early stages.

Currently, the break even price (premium) for a simple health insurance product for a family for four, assured a sum of INR10,000 is estimated at INR350-400, while the break even premium for other products such as crop or livestock insurance is much higher, in the range of INR750-1,500. Clearly, this is beyond a poor family's capacity to pay.

Interestingly, existing premiums charged were seen as high, not just by clients, but also by insurance experts themselves. Expert opinion was that insurance companies, both public and private, tended to overprice products (Box 5.6).

Box 5.6

High Premiums

A prominent and popular life insurance product under the Janashree Bima Yojana (JBY) of the LIC has a premium of INR200 per member per year. Of this sum, the LIC collects a share of INR100 per member from the individual insured and INR100 from the Government of India social security fund. This premium of INR200 was considered unduly high for a natural death term cover of INR20,000 and accidental death cover of INR50,000. According to an insurance expert interviewed, the JBY-equivalent insurance cover, if priced on an actuarial basis, could be competitive at just INR132 -- that is, 66 percent of what LIC charged. Hence, the LIC premium was considered high. The scheme worked because of the premium-subsidy component, so that individuals insured paid only half the total premium from their pockets.

b. Inappropriate and Unclear Basis for Fixing Premiums

Insurance company staff explained that prices most often were fixed on the basis of macro-economic and secondary data. Such data are remote from the BoP population and not quite relevant. It was difficult to arrive at competitive pricing in the absence of reliable local data. Location-specific data could help build actuarial costs and facilitate more competitive pricing. For example, BASIX was able to reduce premiums based on historical data of its own programme with one of the leading private insurance agencies. Building historical data on claims could help companies lower premiums.

Prices tended to be higher when risks were spread over a relatively small population with limited variety in client profiles, as in the cases of small pilots undertaken by a single agency. Scaling up pilot projects within and outside a state could help in spreading risks over a wider population, thus reducing price, as could competition in this market.

Existing premiums charged were seen as high, not just by clients, but also by insurance experts; when facilitating agencies did not clearly understand the logic of the pricing structures, they could not explain the reasons for the perceived high prices to the beneficiaries

Lack of historical data on risks and claims experience makes it challenging to calculate premiums on any actuarial basis; insurance companies therefore fix premiums over-cautiously, adding cushions

Pricing mechanisms often were not clear. When intermediary facilitating agencies, particularly grassroots organizations, did not clearly understand the logic of the pricing structures, they could not explain the reasons for the perceived high prices to the beneficiaries. Intermediary agencies working at the grassroots said that, with their local knowledge, they would play an important role in contributing to competitive pricing. For example, historical data from BASIX and similar organizations, when pooled, would be very useful for insurance companies entering this market.

c. Lack of Data and Information Management Systems

Lack of historical data on risks and claims experience makes it challenging to calculate premiums on any actuarial basis. For example, in assessing premiums for health insurance, poor information exists on the health status and claims history of the rural poor within a region. This makes it difficult for any scientific calculations. Insurance companies therefore fix premiums over cautiously, adding cushions, such as basing the health insurance premium on the age of the eldest in the family as well as the number of family members. Moreover, systems to pool and manage information about microinsurance clients are absent. Even basic information, for example, on product performance or comparisons of different microinsurance products was not published regularly. When no historical data are collected from clients, insurers are unable to price products actuarially.

Even so, some information exists based on small experiments, NGO programmes and individual insurance company experience. But these data were not shared or pooled, because no individual insurer had the motivation to make available information to competitors.

Box 5.7

Claims Data Can Lower Prices Over Time

BASIX, a sustainable rural livelihood promotion institution, started out as a microfinance organization providing small loans to the poor. After three years, it conducted a study through Indian Market Research Bureau to assess the impact of its lending programme. Results showed that despite access to credit, poor households faced many risks causing severe financial strain, reversing gains made through microcredit. This led BASIX to introduce insurance services for its clients. In partnership with Aviva Life Insurance, it launched a customized product, 'Credit Plus,' offering coverage of 1.5 times the loan availed, subject to a maximum of INR50,000 (US$ 1,110). This is a compulsory product in which cover starts automatically when the loan is disbursed and continues till the loan is closed. The eligible age group is 18 to 54 years. In case of the death of the insured borrower, the claim amount is first adjusted to clear up the outstanding loan balance, while the remainder is given to nominees. As of 2005, 160,000 lives were covered under Credit Plus, with a projected client base of 1 million by the end of 2008.

To start with, BASIX, working with Aviva, followed a conservative pricing policy, because no historical data were available on borrowers. The premium rate was INR6.89 per INR1,000 sum assured (US$ 0.15 per US$ 22), and annual administration charges were INR137 (US$ 3) per annum. BASIX also put in place a management information system using the Insurance Distribution and Administration System software to build an insurance database. Two years into the programme, the data were used to analyze the claim rate, which stood at 2.1 per 1,000 insured. The information helped BASIX further negotiate with Aviva and bring down the premium by 42 percent, to INR3.98 per INR1,000 sum assured.

BASIX now is trying to include clients' spouses under the insurance cover. Efforts are also being made to capture data through the internet from some of its operational areas. Because connectivity is a bottleneck in small villages, the process is slow and not extendable to all areas. Once the online system is established, it is expected to reduce time and administrative costs, increasing client satisfaction.

Management and pooling of such data is vital for insurers and intermediaries to be able to offer the best prices -- even reduce them over time. Box 5.7 illustrates how data can be used in pricing decisions. The SMART Card system of MicroCare in Uganda (see Section 4.5) also is illustrative of how shared electronic databases updated in real time, have helped adjust prices for medicines and treatments as well as monitor diagnostic practices for microinsurance clients.

d. Subsidies

Insurance was being subsidized in part because of the need to meet quota obligations. The question of whether or not to subsidize was much discussed among insurers and intermediaries. The predominant opinion opposed subsidies.

Insurers and intermediaries argued that subsidies were highly detrimental to the long term development of this new market. It was important for long term sustainability that rural insurance products be designed and priced to be affordable and financially viable on their own. However, NGOs and some insurance staff wondered why the sector should not benefit when soft funds were available. This group felt that a measure of subsidization through Government grants or donor funds was even necessary for certain aspects of insurance – i.e., those of common interest to all insurance suppliers.

The two positions were only seemingly contradictory. On further probing, there was agreement that financial support was useful - even essential -- for a limited time during the market development, creating and strengthening complementary services and establishment of a database as a 'public good'. Over time, cost and, thus, prices were expected to fall as data on claims history became commonly available and competition was established.

Box 5.8

Subsidies Could Lead to Distortions: An Example from Rajasthan

The Urmul Seemanut Samity operating in Bajju, Rajasthan, paid a premium of INR 13,000 (US$ 289) for rainfall insurance covering 21 farmers. Having become accustomed to this, they saw no point in paying the premiums from their own pockets. This also created a dependency on the NGO. The farmers were neither aware of product's features, nor whether it met their needs -- and they did not really care. The money spent on subsidizing insurance for a handful of farmers could have been better spent on educating a larger number about the risks they faced and insurance potential to address their real needs.

However, inappropriately applied and ongoing subsidies distorted the market. An example of an NGO from Rajasthan illustrates how price distortion can impact the market (Box 5.8).

While subsidies could distort incentives, the reverse is also taking place, with demand being sustained through subsidization of premiums. As seen in Box 5.6, the prominent life insurance product JBY is being sold for INR 200 per member per year, of which only half is paid by the insured. Although the price is considered unduly high for the cover provided, clients were buying the JBY because of the Government subsidy, helping market development. However, what would happen if the subsidy were suddenly withdrawn remained an open question.

The question of whether or not to subsidize was much debated

Well meaning social protection schemes initiated by the Government thus could distort the market for rural insurance and create avoidable confusion, as seen in a Tamil Nadu example based on donor funding from the International Fund for Agricultural Development, Rome (Box 5.9).

Box 5.9

Market Distortions and a Lesson

Under an IFAD funded women's development project in Tamil Nadu, an insurance product for rural women was introduced for members of self help groups. The premium charged to individual members was just INR12 per year (US$ 0.27), matched by an equal amount paid from the project fund. The product was not reinsured with a formal re-insurance agency, but was self managed.

The benefit was INR10,000 (US$ 222) to be handed over to the legal heirs on the death of the insured. However, the project had to withdraw the scheme in its second year. Women enrolled in large numbers, helped by the enthusiastic facilitation by motivated project staff and NGOs. But the claim payouts turned out to be much more than expected, hence, unsustainable. The scheme failed because the premium was not fixed on an actuarial basis, creating confusion when abandoned midway through the project with no explanation.

The organisation (and IFAD) has since learned from the experience, following which the management initiated interactions between office bearers of women's groups, insurance companies and commercial banks.

5.4 Distribution and Outreach Issues

Insurance companies found the cost of distribution in rural areas more expensive because of poor connectivity and the absence of a physical presence. Setting up office infrastructure with staffing involved overhead costs. The agency model, predominantly used in urban areas, was not considered cost effective for rural areas where business volumes were expected to be lower.

Insurance companies found the cost of distribution in rural areas more expensive because of poor connectivity and the absence of a physical presence

a. Underutilization of Existing Distribution Channels

Insurers preferred to tap into larger NGOs and microfinance institutions already working in rural areas, with a critical mass of beneficiaries. This limited their rural operations to collaboration with a few big NGOs with SHG members running into several thousand. Thus, while benefits reach the rural poor, especially women, through SHGs, smaller NGOs are excluded, as is the majority of the rural population.

Insurance companies and intermediaries clearly realized that the present outreach was seriously limited. Now that IRDA regulations have permitted NGOs, microfinance institutions and self help groups to act as microinsurance agents they could be used to scale up delivery exponentially.

b. Inadequacy of Commissions

As it now stands, the commission structure for rural agents is inadequate. As stipulated in the regulations, an insurer may pay a commission of 10-15 percent of the premium as compensation for expenses incurred on marketing and administration. In rural areas, poor connectivity and dispersed populations result in higher entry costs. The experience of large rural agents indicates that administration and marketing expenses stand at around 20-35 percent of the premium (for a customer base of 10,000), clearly higher than the present commission levels permitted. While larger NGOs may be able to cross-subsidize based on other operations and soft funds, this deters potential agents considering an entry in rural areas.

c. Potential for Other Delivery Channels

Potential exists for exploring other channels as well, such as the rural branches of nationalized banks and the network of Regional Rural Banks. For example, SBI Life Insurance has demonstrated the effectiveness of using its network of rural and semi-urban branches to sell insurance directly to rural customers. Similarly, agencies like BASIX have been linking their borrowers with insurance by providing life insurance services combined with a credit

product. Indian Farmers Fertilizer Cooperative Limited already is selling insurance as a bundled product with fertilizer bags. Another innovation has been selling non-life products through post offices by Oriental Insurance Company Limited.

Again and again local presence was named an important prerequisite for doing business in rural areas. The field survey revealed that farmers were unaware of the availability of crop insurance. This was primarily because the Agriculture Insurance Company had no field presence beyond state capitals. One way of accessing farmers to sell crop insurance is through reputed agricultural input dealers (say, fertilizer dealers), and following up with a field officer for monitoring and evaluation. United India Insurance initiated some field presence by setting up one man 'micro-offices.' These 'micro-offices' issue policies and collect premium, but for the present, do not process claims, which is a service bottleneck. The focus appears to be primarily on 'getting the business' rather than servicing client needs, which can affect credibility. Commission on sales would be a great incentive for rural insurance agents, with little capital investment.

Box 5.10 is an example of how insurance companies could expand outreach at low cost, while simultaneously benefiting the poor.

In the case of the LIC's Janashree Bima Yojana, the location of their Pension and Group Schemes division in the state capital -- with no local outreach in spite of an NGO tie-up -- has resulted in enormous costs and delays in claims processing, as Box 5.11 illustrates.

Office bearers of successful SHGs have acquired a prominent position in the local communities because of their credibility and close social interaction with both the local population and formal institutions including the elected village panchayats, banks and local government agencies. Commercial interests are beginning to tap into this new resource and hire SHG leaders to sell a variety of products. Insurance companies have yet to tap into this in a big way. Table 5.2 puts together a list of possible channels identified.

Many SHG leaders were found to be taking up the work of agents in private sector financial companies that provide insurance cover that is unapproved. These companies take a master policy with other formal insurers for products

Access to client information was a challenge; this resulted in far greater concerns regarding adverse selection[87] and moral hazard[88]

Box 5.10

Expanding Outreach Using Self Help Groups

In the district of Madurai, Tamil Nadu, a large private company selling fast moving consumer goods, Hindustan Lever Limited, had contracted Deivam, the leader of the SHG named Maya, to sell consumer goods in surrounding villages. Deivam visits a minimum of four villages daily, which brings her into contact with 40 to 50 clients. Asked to come up with an estimate for insurance policies, Deivam reckons that it would be possible to sell about 40 policies a month among rural households. Of course, this would depend upon whether she undertakes the work on a full or part time basis. Allowing the number of policies to range between 20 and 30 and assuming a premium range of INR100 to 200, Deivam could mobilize premium payments in the range of INR 2,000 to 6,000 each month.

This estimate seems conservative compared to an independent estimate by Tata-American International Groups sales projections, which claims that 50 new policies can be sold in rural areas each month. Rural women like Deivam could benefit from commissions on sales, providing them with the option of an additional income source. However, this would require that they be given basic training on insurance products and their workings.

Box 5.11

Distribution Challenge

Parivartan, a non-governmental organization in Bhawanipatna, Orissa, took up the Janashree Bima Yojana master policy with Life Insurance Corporation's Pension and Group Schemes Division, located in the state capital, Bhubaneswar. The NGO sends its claim papers directly to the Bhubaneswar office through a staff member. One-way travel involves catching a bus and travelling more than 18 hours, and costs around INR500-600. After all this effort, there is no guarantee that the job will be accomplished in one visit. Even though LIC has an office in Bhawanipatna, the same town as the NGO head office, it cannot deal with the local office because the policy is administered at Bhubaneswar. The time and costs incurred by Parivartan are enormous. Naturally, its officers want the insurance company to delegate administration of the policy to their branch office.

like accident risks. The SHG leaders have mobilized sizable deposits for such unapproved schemes from the members of SHGs in their own and nearby villages. This phenomenon was widespread in Madurai and Villupuram districts of Tamil Nadu, and could lead to unscrupulous practices.

To discourage unscrupulous practices, NGOs could work with the SHG leaders, weaning them away from the fold of such unapproved companies, and could propose legitimate insurance companies train such self-help group leaders as insurance agents to expand their reach, furthering outreach and providing them business. Instituting visible and well publicised certification for approved providers also would reduce the potential for unscrupulous practices that could severely damage the fledgling market.

Table 5.2

Possible Delivery Channels in India for Microinsurance

Self-help groups linked to banks	1,618,476
Non-governmental organizations as development facilitators (approx.)	200,000
Non-governmental organizations involved in microfinance	3,024
Rural and semi-urban commercial bank branches	33,388
Regional Rural Bank branches	14,446
Private fertilizer dealers	192,000
Primary Agricultural Cooperative Societies	105,735
Post offices in rural areas	138,756

Source: National Bank of Agriculture and Rural Development and Reserve Bank of India, Annual Report 2006

5.5 Procedural Challenges

a. Cumbersome Processes

Access to client information was a challenge for insurance companies across the board. This resulted in far greater concerns regarding adverse selection[87] and moral hazard[88] - concerns applicable for all insurance services, not just rural. In the case of rural populations, insurance companies' distance from clients, gave rise to a greater discomfort factor on the part of insurers contributing to exceptionally cumbersome procedures, particularly in claims servicing. This intimidated both beneficiary and the nominee, contributing to non-renewals and mutual suspicion.

Some stipulations were difficult to fulfil such as having local authorities certify the occurrence of an event, or a government doctor certify that death was not suicide. Obtaining such certificates was very hard for the poor and prolonged claim servicing. These time consuming, cumbersome processes were a major deterrent to enrolment and renewals. For example, life insurance payouts required a death certificate to be issued by the Revenue Department authorities in case of a natural death, and a Police Inquest Report in the case of an accidental death. Companies also required a certificate from a doctor verifying the cause of death.[89] In some rural areas, accessing a doctor can be a challenge, and obtaining a death

certificate in the case of sudden death, when the person was not hospitalized was difficult. Box 5.12 provides a real life example from Tamil Nadu.

However, the documentation challenge did not stop there. Some insurance company staff carried it further, going as far as charging a higher premium from clients who could not produce a formal proof of age through documents such as a birth certificate, hospital certificate, passport or school records. This creates an entry barrier for those clients for example who were born at home or did not enrol in the formal education system. The local equivalent of a birth certificate, such as religious documentation, janamkundli or jathakam, or certification by sarpanch, should be identified and accepted by suppliers in these cases.

Procedural challenges affect livestock insurance as well. Insurance companies need a way of verifying the identification traits, health and value of the insured animal. This requires tagging the insured animal's ear, and obtaining certification from a veterinarian, and costs time and money to clients. Genuine claims for cattle insurance often were rejected by insurance companies because of a lack of an ear tag," sending a discouraging signal to clients and reducing future business. Clients were frequently unaware of how to address their grievances when genuine claims were rejected. At the same time some interesting innovations for livestock certification were observed in the field (Box 5.13).

Rigid payment schedules also deterred clients. Many SHG members expressed difficulties in paying insurance premiums of INR100 or more in one lump sum. In fact, it was the poorer clients who found it hardest, even though they were eager to enrol in health insurance schemes perceived as beneficial.

Box 5.12

Documentation Can be a Challenge

Banumathy, a 40-year old woman, was a member of Kadal Muthu self help group in Chinnamudaliyar Savadi, Tamil Nadu. Banumathy, along with her husband, died in an accident on April 6, 2005, leaving behind a son and a daughter. It was a major accident, causing the death of three other people, and reported in the local press.

Banumathy had held a JBY life insurance policy with LIC. Saravanan, the son, obtained the First Information Report (FIR) from the local police and the death certificate, and filed the claim. Life settled the claim in August 2005 as a natural death, not the accidental death that it was. The difference in benefits was enormous: the benefit for natural death is INR20,000 (US$ 444), whereas in case of an accidental death it was more than double, INR50,000 (US$ 1,111.11). Citing inadequate documentation, the claimant needed to submit the Police Inquest Report and not the First Information Report. Upon follow up with the police, they refused to give the PIR without a bribe. Finally, the police negotiated a payment of INR5,000 through an intermediary before giving the inquest report in October 2005. This report was then submitted to the LIC. The case was being watched closely by the community.

They asked for flexibility to be introduced such as paying the premium in monthly instalments. However collecting premiums monthly added to administration costs. This dilemma could be eased if an SHG could pay the premium to the insurance company from its common fund and collect it from individual members in easy monthly instalments, making premium payments affordable and convenient. Potential solutions are illustrated in Box 5.14.

Non-renewal by clients was seen across all states, and clients need to be educated in the benefits of continuity of policies. 'No-claim bonus discounts' are offered as reduced in premium payments for clients who had a claim free year. These are limited to vehicle and poultry insurance. Extending this to other types of insurance will provide a positive incentive for claim-free clients to continue. In addition, renewal processes need to be simple

Genuine claims for cattle insurance often were rejected by insurance companies; clients were frequently unaware of how to address their grievances when genuine claims were rejected

Box 5.13

Process Innovations: Customising Certification to Local Circumstances

Royal Sundaram Insurance, a private company, has relaxed the livestock certification system for self help group members through an agreement with one of the larger NGOs of south India, Development of Humane Action (DHAN) Foundation. By delegating certification authority to DHAN Foundation's professionals at the federation level, the company enabled its clients to get their animals certified at much reduced cost and time.

Another innovation by BASIX in collaboration with the insurance company, for livestock and life insurance products, has removed certification by veterinarians and no physical document is required for enrolment. An electronic enrolment form is sent by BASIX to the company, which suffices. Further, BASIX pays directly to the beneficiary in event of a claim, after verification. The amount is settled later with the insurance company upon submission of required documents. Such procedural innovations also helped clients who did not have bank accounts and eased the process of settlement.

Such customization to local circumstances is not common, but provides promising ideas.

and systematic to help continuation. Box 5.15 presents an innovative example of how this can be accomplished even in a remote tribal village.

Many SHG members asked for flexibility to be introduced such as paying the premium in monthly instalments; however collecting premiums monthly added to adminis-tration costs

Claims settlement remains predominantly centralized. More experienced public sector insurers preferred centralization, not so much because of cost consciousness, but more to suit audit requirements. Centralization also was observed among private players that were relatively inexperienced in rural insurance. Nonetheless this often led to delays in settlements, leading to loss of faith in insurance among rural customers, who not only needed the payouts, but also needed them at critical times. Easing these processes and decentralizing claims servicing, while ensuring suitable checks is an important condition. There are also gender issues. Existing processes of enrolment and claim settlement followed by the insurance companies are time consuming, some requiring at least four to five visits to different offices; e.g., visits to veterinary hospitals and Government authorities for tagging and obtaining certificates. Poor women have severe time constraints, working more than 16 hours a day on average in paid and unpaid work that includes taking care of children, spouse and other relatives; household work such as cooking, water collection, fuel wood collection, washing and cleaning; and the farm related work such as crop production and maintaining cattle and other animals. Poor women thus tend to avoid joining microinsurance programmes, depriving them of access to insurance products.

Other practical problems included a weak postal infrastructure and inadequate addresses of clients which hinders delivery of claims and receipt of documents. In Orissa, for example, it was reported that 20 to 25 percent of policy documents sent by insurance companies do not reach their destination. This underlined the importance of expanding the potential role of intermediaries as third parties in administering claims processes. However, while the role of intermediaries could be widened, some caution is called for in using their services. Exceptional delays in settlements when third parties are used could mean misappropriation of funds. Field evidence indicated that third-party claims administrators could at times create more havoc than good, as seen in Box 5.16.

On the other hand, New India Assurance Company Limited in Madurai had processed claims of self-help group members of Network for Education and Empowerment of Rural Artisans without engaging any third party help. The clients reported they were satisfied with the speedy claim settlement processes.

Box 5.14

Innovations in Premium Payment

The SHGs of Kadamalaikundu (Theni district, Tamil Nadu) using Kadamalai Kalanjia Vattara Sangam have decided to use their common funds to finance the cost of health insurance for members. The age of each self help group (an indicator of stability and financial strength) was used to determine the contribution for group members, with older groups receiving more from the common fund. In addition, they collect insurance premiums through an annual campaign.

Age of Group	Contribution to Health Insurance Premium From		
	Common fund (%)	Members (%)	Total (%)
5 years or more	75	25	100
3-5 years	50	50	100
1-3 years	25	75	100
Less than 1 year	00	100	100

Some groups chose to pay the insurance premium first and later deduct the amount from the members' cumulative savings, rather than the common fund.

In another case, the SHG Bathrakaliamman in Poonthottam village (Tuticorin, Tamil Nadu), promoted by the Council for Social Reconstruction, paid the health insurance premium for its 11 members, based on the age of the eldest member and number of family members covered. It treated the premium as an interest-free loan to members, who paid the monthly. The annual premium ranged from INR287 to INR766 (US$ 6 to 17) per member.

b. Local Language

Surprisingly, many insurance companies did not follow what seemed like common sense, such as producing materials in the local language. Choosing English was unsuitable becuase most rural clients were not only illiterate, semi-literate or less educated, but education they had was predominantly in the local language. Even those who could read some English found it hard to understand and interpret what was written. However, processes are often not clearly understood by the facilitating agency staff either, when the forms and instructions are not available in local languages. This built enormous information barrier, since clients and even facilitators needed interpreters to understand policies and fill out documentation. While this is a problem for men and women alike, women are less likely to have access to education in general and English in particular, aggravating the communication gap. This becomes a problem at later stages, for example, when NGOs find that terms and conditions, particularly exclusion clauses, cannot be properly explained to clients before enrolment.

As insurance companies have recognized the potential of this new market, some were taking steps to rectify this common practical problem. For example, New India Assurance Company Limited had designed application and claim forms in Tamil for a special Mediclaim Policy offered to self help group members.

Problems of non-transparency likewise could be solved through printing of leaflets and forms in the vernacular. IRDA regulations now require insurance companies to print a policy brief in the local language and distribute it to all clients.

c. Inadequate Transparency - Incomplete Information to Clients

Language is a natural barrier, but insurance agents did not always give complete

Non-renewal by clients was seen across all states; claims settlement remains predominantly centralized ... this often led to delays in settlements, leading to loss of faith in insurance

Box 5.15

Process Innovation for Renewal

Ma Dharani self help group was established by Parivartan, a non-governmental organization in Duruduri, a remote tribal village in Orissa. All 20 members paid INR1,000 (US$ 22) each to their federation as a deposit toward the insurance premium. Of this amount, INR100 per member was paid to the Life Insurance Corporation as a premium for the first year under the Janashree Bima Yojana policy. The remainder was rotated as petty loans among members at 18 percent per annum. Interest earnings of INR162 were adequate to pay the annual insurance premium of INR100 plus a bonus of INR50, with a surplus of INR12. The remainder was retained as a service charge to meet administrative expenses.

Such process innovation helps in automatic renewal of policies with additional incentives. For example, in the event of a death, the nominee is immediately paid INR900, deposited with the federation, to meet funeral expenses.

information to clients while selling products. Sometimes they acted callously, not explaining the terms and conditions of the policy to clients, which created misunderstanding and lack of trust between clients and insurers. This was particularly so for health insurance products, where claims are portioned into sub-categories and reimbursement requires keeping track of expenses within each sub-category. Agents were, in short, not completely transparent in explaining all aspects of coverage, non-coverage and claims processes.

Surprisingly, many insurance companies did not follow what seemed like common sense, such as producing materials in the local language

This was the case with the Kaliamman self help group in E. Pudupatti village of Madurai district, Tamil Nadu. Rajathi had been leading this SHG with 18 members for 10 ye five years. Upon the death of a member, the group lodged a claim, which was rejected. It was only then that the members learnt that their life insurance only covered accidental death, not natural death. The members felt frustrated and cheated because this had not been explained to them while shopping for life insurance; it would have been an important factor in their decision. They have now changed their life insurance company and have a policy with the Life Insurance Corporation.

5.6 Summary

The core issue in microinsurance lies in the gap in perspectives between the insured and the insurers, leading to low customization of products and low demand for what is available. For the rural poor, a product should fulfil needs, be affordable and reliable. When these criteria are met, there is willingness to pay for the service. The poor are specific about their need for insurance to cover high frequency risks, many of which are low impact events, such as common illnesses, crop loss due to pests and drought, and illness of livestock. Insurance products are sometimes sold by rural agents who are not always convincing, and sometimes not easily traceable. One bad experience in a small, well-knit community can have long term adverse effects on client faith in insurance services.

On the other hand, for the insurer many of the needs of the poor (especially high frequency occurrences) do not translate into an insurable proposition because of questionable profitability. Insurance products exclude these frequent risks, reducing relevance to the customer. From the insurer's perspective, frequently occurring adverse outcomes are difficult to cover through insurance products, since they are harder to design, price and administer. This makes them a challenge for insurance companies with limited rural infrastructure. This misalignment of incentives, schematically presented in Chart 5.1, is a key impediment to growth of the microinsurance sector. In addition is the problem of deliverability. Insurers in some cases fail to effectively use appropriate

distribution channels. In agricultural insurance, microfinance institutions and rural banks, though ideally suited for reaching clients, are not being used. If the bank adds on the premium to the loan amount, farmers could pay the premium from future cash accruals while protecting themselves from crop losses.[90]

This mismatch has prevented insurance companies from investing in new product development and providing appropriate services. Staff of insurance companies felt that there should be systematic interactions between themselves and facilitating agencies (NGOs, MFIs) who are closer to the ultimate clients in order to understand client needs. They also recognized the need to seek help from facilitating agencies in building a database, even as they realised the 'public good' nature of a database with a pooled claims history, which led to reluctance of an individual company to invest.

Intermediary organizations also have their own set of issues, including existing distribution channels not considering insurance as an add-on service. Insurance burdens the system without sufficient returns; cumbersome enrolment and claim settlement processes and inappropriate product design can make it a logistical nightmare for intermediaries. Moreover, the income earned from insurance does not justify the current costs involved in administration. Service inefficiencies are increased by insurance companies' centralized service processes.

Claim servicing is usually a centralized service set up to minimize costs by not developing the necessary infrastructure in rural areas. It also simplifies meeting audit requirements. But centralization leads to delays in settlement, giving rise to frustration and reduced trust among rural clients.

Box 5.16

Possible Problems in Using Third Party Administrators

An NGO in Kallikudi, Tamil Nadu, bought a master health insurance policy from the National Insurance Company for their self-help group members, enrolling 87 members. Some members received their claims only after three to six months through third party administrators, while as many as 59 claims that were more than a year old were still pending. Such long delays raise suspicion about misappropriation of funds. Hence, caution needs to be exercised in such innovations, with insurance companies working closely with the third parties rather than fully 'sub-contracting' the work.

In sum, client perspectives and feedback from NGO intermediaries highlight the key obstacles that need to be addressed. These relate to addressing customer satisfaction (demand-supply gaps, appropriate products and pricing); distribution efficiencies for better outreach; and procedural issues for easier renewals and claims settlement. Currently most suppliers are operating on a short-run perspective, waiting and watching, rather than investing substantially in market development. Addressing the factors identified above requires a longer term perspective for unleashing the incipient potential for growth in this sector. The field investigations provide new ideas based on examples of local innovations as well as policy recommendations for the way forward, which is the subject of Chapter VI.

Insurance agents did not always give complete information to clients while selling products

Chart 5.1

Contrasting Perspectives of the Insurers and the Insured

Insured's perspective	*Insurer's perspective*
Necessity	Insurability
Affordability	Profitability
Reliability	Deliverability

WAY FORWARD

6
Chapter

6.0 Introduction

Development of the microinsurance sector needs a longer term perspective that combines responsiveness to client priorities with market development and financial viability, replacing the current preoccupation with immediate profits. This chapter identifies a set of prudent recommendations in nine areas. It concludes with identifying five strategic areas for immediate external support.

After accounting for exogenous factors, the first three recommendations cover products, pricing, distribution and processes for efficiently using resources. Appropriate product design and pricing can improve responses to customer priorities and contribute to repeat purchase, thus retaining clients. Distribution can provide adequate scale, wider and deeper markets and better pro-poor coverage. Improved claims settlement can better address client needs and increase efficiency. Put together, this can build customer satisfaction and make insurance viable. Building a database will help sharpen actuarial calculations, better aligning risks with pricing. Supporting the testing of innovations, including establishing a risk pool fund, will provide a space for experimentation on new concepts. Benchmarking will help identify desirable features for insurance products. India's history with microcredit can provide early indications regarding some of the problems that microinsurance could face, providing an opportunity to take advance action against undesirable practices. Specific recommendations are proposed for insurers, intermediaries and Government, including IRDA.

This chapter also identifies strategic ideas for external support, with preliminary cost estimates, to complement national efforts. These could form the ingredients for possible programme development to catalyze the microinsurance sector, possibly with private sector partnership.

6.1 Factoring in Exogenous Constraints

Some inherently exogenous factors hamper development of the microinsurance industry and should be explicitly recognized. At very low income levels, the affordability of insurance is also low; hence, social protection schemes would be more relevant. Suitable client groups should be identified for whom insurance can be a useful tool for managing life and livelihoods risks. Complementary services and infrastructure for claims settlement may be inadequate or absent. For example, it is difficult to process livestock claims in areas where there are not enough veterinarians. It is difficult to settle health claims in the absence of nearby or suitable hospitals. These are structural issues with which an insurer has to live, and are linked to the overall macroeconomic development of the country. A strategy for the development of microinsurance must factor in such constraints, aligning the strategy with expected developments in future.

6.2 Recommendations Regarding Product Types and Design

The core problem of contrasting perspectives should be addressed by focusing on key factors holding back insurers from covering high priority risks. The approach needs to vary by

Development of the microinsurance sector needs a longer term perspective that combines responsiveness to client priorities with market development and financial viability, replacing the current preoccupation with immediate profits

individual product requirements. Designing of products should take into account the following considerations as guidelines:

- Focus primarily on risks related to income generation or livelihoods protection activities; very low income activities undertaken by the poor can have a lower priority for insurance purposes, the poor themselves undertake multiple low income activities to diversify income sources as a strategy against inherent risks.

- Allow for premium amounts to be paid through against future cash flows, including borrowing, to be able to cover lower end workers. Product design should take this into account.

- Deliver the benefit immediately when needed; delays in receiving the eligible benefit amounts reduce the value of insurance to clients. To the extent possible, benefits of insurance should be cashless, such as cashless medical services under health insurance.

- Monitor the utility of products designed for the poor; a useful check is to track reduction in earnings volatility per rupee of premium charged. The higher the reduction in volatility per unit of premium, the better it is from the insured's perspective.

- Broaden the scope of product design with a readiness to customize, replacing legal jugglery and remote actuarial calculations with a proactive drawing of inputs from different institutions like MFIs and CBOs involved in promoting rural insurance. This would involve restructuring of existing roles and processes.

- Close the 'communication gap' between insurance companies and rural clients by creating versions of brochures, pamphlets and forms in vernacular languages so that poor people can understand the terms and conditions more clearly.

- Insurance companies could customize their products to match with the different segments amongst the poor. They could cover only the prioritized risks and price the products at a lower and more affordable level. In case of premium lapses, insurance companies could recognize the inherent seasonality of rural incomes, giving a longer grace period to restart payment or building in greater flexibility to poor women to continue their premium payments in flexible installments, instead of standardized fixed installments.

- Recognize that on a stand alone basis, insurance will not be practical for high frequency risks because costs will invariably be too high to be affordable. For such risks, use insurance as a part of an overall risk management programme, including the use of group funds. For example, it can induce desired behavior in the community, including a more efficient use of community funds, thereby reducing costs of the overall programme. Lessons can be learnt from community initiatives like those of AKHS and SEWA Bank.

- Treat products meant for asset protection against natural disasters as a form of complementary social security, with insurance being a cost effective medium to facilitate percolation of benefits from Government schemes and subsidies. Such products cannot be sold commercially on a large scale.

- Consider concepts like 'mutuals,'[91] which leverage social equity to address problems of adverse selection and moral hazard. This can limit the frequency of occurrence, thereby making risks more insurable. Mutuals could be particularly relevant in situations where high priority risks occur that need coverage, but where transparent claims settlement is an issue. Box 6.1 provides an illustration.

Box 6.1

An Illustration of the Concept of a 'Mutual' to Cover the Common 4D Risks Faced by Women: Disease, Death, Delivery and Desertion

A group of women (500-1,000 to begin with – possibly members of a federation of SHGs) form a mutual to protect each other against specified risks. This would involve a regular annual payment of INR150-200 per member. From this amount, INR50-60 can be used for minor health insurance (managed through a local health centre), INR20-30 toward life, INR40-60 toward delivery and desertion and the remaining INR40-50 toward institutional group health insurance. The amounts could be varied as needed and agreed.

In case of minor illnesses, desertion or other incidents, expenses incurred by individual members can be covered through the funds collected, with all settlements being managed at the level of the mutual. For more serious illnesses such as tuberculosis, serious accidents or medically recommended surgeries, the institutional insurance component would kick in with pre-specified cash payouts or cashless settlements to a pre-qualified medical establishment.

Administration would need to be at two levels: one at the interface level, with an individual member and the mutual, and the second, at a higher aggregated level, by a specialized entity like a microinsurance agency, with adequate back-up through a regulated insurance company. The administration would include agreements with health service providers for the users.

- Explore different technology solutions, taking advantage of evolving techniques, which can improve transparency. Technology not only reduces long run costs, but also facilitates speedier claim settlement. It must, of course, be recognized that these technologies are at different stages of development. Examples of possible uses of technology and their limitations include:

  * Weather and satellite imagery data are increasingly available and can be used for crop insurance to settle crop loss issues. A beginning has already been made in using weather and satellite imagery based crop settlement, with fine tuning still underway

  * Livestock claims could be settled using RFID-GSM[92] technology, though this is yet to be tried out in the field. A fair amount of developmental work is required to be done here.

  * Disaster claims could be settled using transparent disaster indices.

The use of such technologies requires a minimum scale. Moreover, it needs to be recognized that claims settlement through technology is not free from error, which needs to be weighed against the gained efficiencies.

6.3 Suggestions Regarding Pricing

As seen in Chapter V, premiums always have been an issue for both the insurer and the insured. Survey results indicate that premiums

exceeding a day's wage per month, on average, will be difficult for clients to accept, but current premiums are higher for common insurance needs like crops, livestock and health. Apart from being beyond a poor household's capacity to pay, it is hard to convince the poor to pay for what they consider sub-standard products. For the intermediary, permissible commissions have been inadequate to cover rural transaction costs.

Three cost components determine the premium from a suppliers' perspective: Risk expectation (R), administration (A), and preventive-promotional expenses (P). To achieve viability and affordability, pricing should take account of the following suggestions:

- Meet risk costs, R, through user fees at any given point, ensuring that risk is met through premium amounts.
- Use subsidy or grant funds toward covering partly or fully the A and P expenses, while putting in place a plan of reducing them over time by:
    * Supporting increased usage of products, thereby increasing spread and reducing fixed costs per customer (A and P)
    * Reducing administrative costs (A) through capacity building, technology interventions and so forth
    * Improving products and innovation by better data use and its management
    * Reducing risk incidence and its impact (R) by preventive and promotional care
- Collect, pool and share data on risk incidence and claims among insurers for improving actuarial calculations over time.
- Reduce the use of soft funds in a phased manner as data improve, coverage increases, and fixed costs per client come down.
- Use the experience of pilot projects available in the field.
- Involve experienced intermediaries more directly in the pricing process, not just in outreach.
- Plan to reduce premiums over time as better data management and competition results in actuarial pricing of customized products, replacing the more macro- assumptions being applied to rural populations.
- Consider giving a longer grace period to restart payment in case of premium lapses and ensure greater flexibility in paying instalments for the poor, especially women.

6.4 Strategies for Distribution

To achieve a reasonable scale and better poverty outreach, it is recommended that distribution strategies identify appropriate channels by geography and product, and where required, develop new channels. For this, specific suggestions are:

- Select geographic areas where exogenous conditions are suitable for operation of insurance -- like income levels being appropriate and claim support infrastructure in place or likely to be in place. Without conducive macro-conditions, any distribution strategy would be short-sighted.

It is also important to demonstrate early success.

- Insurance companies could use the services of the intermediaries like NGOs, MFIs, PRIs, CBOs and commercial banks to reach the people effectively. Insurance companies also could go to villages and organize flexible training programs by scheduling the timings in the afternoon, so as to ensure the participation of more women.

- Partner with facilitating agencies, rather than individual agents, that have a role in a livelihoods or comprehensive risk management programme for low-ticket insurance. In such cases, commission income alone may not be attractive for individual agents.

- Partner with channels like banks and/or MFIs for crop and livestock insurance.

- Follow the guiding principle of 'deep mining,' focusing first on maximizing returns with a few selected partners. For example, insurers could treat a rural branch of an MFI or RRB as a service unit and allocate resources to the unit according to its earnings potential. This approach has worked for some insurers, leading to higher premium collections.

- Create new channels where absent, provided insurance supports an operating livelihoods promotion or a comprehensive risk management programme. Insurance growth should be tied to the growth and success of such a programme. New channels cannot, in all likelihood, be built exclusively around insurance sales – there must be incomes to insure. For health insurance, tying up with a broad based, comprehensive health management programme would be a better bet in the long run than enrolling health insurance agents just for hospitalization cover.

- Disseminate the insurance concept for selected risks (frequent occurrences with low impact) through local micro-organizations rather than selling an individual insurance product. For example, risks such as livestock illness can be managed within smaller groups (as the lower the risk impact, the lower the customer base required for diversification of the risks), by following simple principles of mutuals.

- Scale up such simple, useful and easy to implement ideas after success has been demonstrated on a smaller scale. Various forms of mutuals are being explored around the world. It would be prudent to experiment with a set of promising concepts on a small scale to understand fully the nuances in the delivery of mutuals. The idea, with further refinement, then can be scaled up with appropriate promotion tools. The benefits of this strategy have been demonstrated time and again – be it the "green revolution" in northern India, the "white revolution" in western India, or the SHG movement in many Indian states and other countries. The key to success lies in the simplicity of the idea and its demonstration on the ground before scaling up.

6.5 Improving the Claims Process

Apart from the products and pricing being suitable, speed and accuracy in claims settlement are necessary. The recommendations for rural products are:

- Adopt a decentralized claims settlement approach for rural products. Private players have successfully experimented with decentralized settlement process in urban product categories. Now is a good time to do this for rural products as well, which have a much lower sum assured and thus are much less risky than their urban counterparts.

- Build a cadre of decentralized microinsurance agents, anchored with local MFIs or other similar agencies. This will not just facilitate the claims process, but will also help in building demand for insurance and disseminate accurate information.

- Authorize local insurance officials to settle claims up to a certain level.

- Channel claims through identified CSOs that have a good grasp of the extent of damage and people affected.

- Use technology to improve the claim process through better speed. Internet facilities in rural areas, particularly at the block level, can be a key driver. Technology can facilitate issue of certificates to clients, collection and remittance of premiums by microinsurance agents. This also can reduce costs.

- Improve accuracy and independence of data available to the insurer and customize for local conditions, reducing subjective assessments and buffers. This can help build confidence in the claims process. For example,

    * Collect and analyse decentralized weather station data for rainfall insurance
    * Develop disaster indices and track health of livestock through RFID-GSM technology

- Innovate and use examples from local experiments to simplify claims settlement. Such examples already are available for life and livestock insurance, as seen in chapter V, and also have been accepted by insurance companies. Innovations such as depositing advance claims with a facilitating agency are of interest.

- Use local languages for better customer satisfaction.

- Disseminate process innovations to facilitate positive demonstration effects leading to scaling up.

6.6 Building and Managing Data

As seen in Chapter V, insurance companies currently use macrodata to design products for a local community. Unsure about its accuracy and relevance at local levels, they add additional reserves, thereby increasing the premium. In the case of insurance products like health, life and crop, building good, clean, location-specific historical data and properly managing the database can help to design products relevant for specific clients, period and place. For insurance companies, it can reduce the costs of risk coverage and re-insurance. For clients, it can reduce premium costs.[93] Other long-term benefits are:

- Facilitating collaboration with an external insurance partner in developing and offering suitable products to targeted communities.

- Increasing operational efficiency of microinsurance divisions in insurance companies, through efficient policy

issuance, premium collection and claims settlement.

- Helping counter issues arising from moral hazard and adverse selection.

Specific suggestions on data are:

- Pool and categorize data for health, life and crop for the rural population from different locations; organize the data architecture using sampling techniques and design for representativeness at the national, state, district and block or taluka levels.

- Use appropriate statistical techniques for an actuary to be able to price specific insurance products for a given rural location without adding the usual surplus reserve cost, thereby bringing down the premium.

- Hire an actuary as part of a team of consultants for advice on database building and management and operationalizing of a concrete strategy. Identify data sources taking into account actuarial advice.

- Digitize data from different sources and build a common database organized in a form that allows periodic updates. Distributing SMART or swipe cards for customers could be an option. Check the credibility of existing data against new data for necessary modifications or adjustments as may be needed for decision making.

- Identify an agency for data management and distribution to users. Using the services of persons and/or institutions with experience in microinsurance sector would be preferred. The database can be anchored with a Government agency or an external agency like a consulting firm engaged in data management. While an MFI also may be possible, selection of a single MFI may be problematic if it competes with others in the business. An association of MFIs with a full time unit for database management, or a bureau with user representation in management, could be options. The work should include distribution of data to interested companies and clients. It would be useful for the agency to be 'equidistant' from competitors.

- Plan and budget for one-time and recurring costs for data management. Cost components include:

  * *Fixed costs* - Infrastructure, hardware and software costs, and initial data collection and digitization costs (data collectors, data entry operators)

  * *Recurring costs* – Ongoing management of the data, its updating and distribution to users

6.7 Supporting the Testing of New Concepts and Products

Where need clearly exists but insurance is yet to be proven feasible -- like high frequency and low impact situations -- support can be extended to develop alternate mechanisms, with or without participation from insurance companies. These could include events like floods or cyclones or even primary health care needs. Mutuals are a case in point – the concept of mutual insurance can be explored on a trial basis, even without insurance company support to begin with. To operationalize this:

- Support a risk pool fund through a development agency.

- Establish benchmark levels for claim sum(s) to be settled within or outside the mutual insurance group.

- Settle small claims up to the agreed sum(s) within the mutual insurance group.
- Settle claims beyond the agreed sum(s) from the risk pool fund during the trial period.
- Extend such support to the experiment until the product is standardized and insurance companies are willing to treat it as a business opportunity.

Table 6.1 illustrates health risk management based on a holistic set of interventions, combining preventive and

Table 6.1

Steps in Designing a Comprehensive Pro-Poor Rural Health Insurance Cover

Phases	Steps	Details	Expert Resources
I	**Assess effectiveness of present healthcare model**		
	Identify disease incidence in different demographic segments	1. Children, adults and the old 2. Special focus on chronic, epidemic and pregnancy-related	Epidemiologist, health economist, health related IT/data management specialist
	Assess direct costs of healthcare	Details by location, disease: 1. Transportation cost of patient and one relative 2. Cost of tests / diagnostics 3. Cost of treatment 4. Cost of medicines	
	Assess indirect costs of healthcare	1. Loss of work and wages of patient and one relative 2. Interest on loan taken for treatment 3. Loss of income from asset sold	
	Study current healthcare situation in identified locations	1. Availability of curative healthcare services, both public and private systems 2. Status of preventive and promotive healthcare	
	Outline existing health financing system prevailing in the area	Assimilate information about various sources of finance available with the rural poor 1. Govt. grants and facilities 2. Savings 3. Credit 4. Insurance 5. Existing community programs, if any	
	Study effectiveness of each source of financing	Have these sources result in: 1. Proper treatment of the poor 2. Reduction in overall healthcare cost 3. Reduction in disease incidences 4. Improvement in healthcare infrastructure	

II	**Explore improvements in present primary healthcare program**		
	Suggest an improved model	The following options can be explored • Negotiating rates with private or public health-care providers and enrolling them for providing cashless healthcare services to members • Centralized drug procurement and supply on local indent • Mobile primary health care delivery model	Health care management expert, actuary, IT/data management expert
III	**Design an appropriate preventive healthcare program**		
	Detail technical design features	• Identify specific diseases that can respond to preventive care • Design programmes for the identified diseases, do a cost-benefit analysis • Detail administrative procedure, organization structure	Medical practitioner, health economist
IV	**Design an improved health financing model**		
	Suggest an improved model	The following would be explored • Negotiating rates with private or public health care providers and enrolling them for providing cashless healthcare services to member • Centralized drug procurement and supply on local indent • Mobile primary health care delivery model	Health care management expert, actuary, data/IT expert

curative care, and using the concept of mutual insurance. A comprehensive, viable health delivery model can be developed, based on the three pillars of a) focused preventive care, b) cheaper and efficient curative care, and c) a comprehensive health finance model using the social infrastructure of existing community initiatives. Design details will differ by location based on local disease profile, health care infrastructure, present community initiative programmess, and other factors, which must first be understood. The example is indicative of the type of work envisaged in concept design and its development.

An approach as described above would provide comprehensive health coverage for the poor, combining mutual insurance (for preventive and primary health care) with health insurance (hospitalization). This design needs to be further tested. Support would be required for carrying out the study and possible testing of the idea through an interested agency.

6.8 Benchmarking: Identifying Desirable Features in Products for Common Risks

In developing new microinsurance products, it is useful to identify desirable features. Table 6.2 presents a summary of such features. These may be taken as indicative guidelines to be considered in the development of new products

Table 6.2

Features Desirable in Microinsurance Products

Particulars	Life	Health	Livestock	Crop	Disaster
Product Design[94]	• Sum assured to vary by premium paid • Policy to be sold in groups • Short term • Premium to be collected in installments • Products to be designed for mutuals – helps address moral hazard issues	• Out-patient types I and II illnesses to be covered through mutuals • Livelihood and transportation costs to be covered	• Illnesses to be covered through mutuals • Death of animal	• Products to be designed for other crops • Product specifications to vary by extent of irrigation, topography • Weather-based index systems • Price hedging	• Settlements to be based on transparent disaster indices
Distribution Channels	• Promote through mutuals, self help groups and so forth • Consider village as unit; this would allow premium to be collected at panchayat level, make monitoring data collection easy, and reduce moral hazard	• Same as for life	• Promote primarily through banks and MFIs, input suppliers; borrowers purchasing animals through loans perceive higher asset risks and tend to be more willing to pay premiums, making banks and MFIs convenient vehicles. Breeders may also be an option	• Promote primarily through banks and MFIs, input suppliers; same as for livestock	• Cover through umbrella policies taken by Government or other agencies
Claim Servicing	• Adopt decentralized claims settlement models – e.g. advance claims can be deposited with facilitating organization like NGO, SHG, or the local insurance officer may be authorized to settle claims up to a certain level	• Same as for life • Non-cash settlement to health care providers	• Adopt decentralized claim settlement models • Upgrade use of technologies such as RFID	• Upgrade technology use such as weather based or satellite image based settlements	• Channel claims assessment and settlement CSOs, which have a better grasp of the damage extent of and people affected

Macro Initiatives for a Supportive Environment	• Build database	• Build database and use SMART/swipe card technology to create electronic data • Invest in upgrading of rural health infrastructure	• Build database • Invest in improving rural veterinary services	• Build database • Invest in data and modeling of crop losses on account of different perils	• Build database • Invest in data and modeling of natural disasters

for five common risks that can be covered through life, health, livestock, crop and disaster insurance.

6.9 Learning from Second Generation Issues in Microcredit

India's long and varied experience with microcredit can provide early awareness of possible second generation issues that microinsurance is likely to face – an awareness that should be taken into account to help in being prepared in advance. Microcredit is currently facing three types of competition (a) between non-governmental MFIs and subsidized Government schemes, leading some states to start regulating NGOs; (b) between different NGOs/MFIs themselves, resulting in attempts to control clients; and (c) between moneylenders and NGO/MFIs. The former seems to be due a 'battle of ideas,'[95] while the latter two involve competition for clients as the business becomes financially viable. Competition for ideas and clients increases the availability of options, providing choice to the poor, but questionable practices by some NGOs provide a justification for governments to regulate. Overall, this turmoil may have positive consequences, such as the introduction of a code of conduct similar to one used among providers of microcredit, which could be replicated within the insurance business, and a recognition that every agency has to abide by external or self imposed regulations. Governments, for their part, need to recognize the critical role that NGOs/MFIs can play in poverty reduction, and that the existence of some unscrupulous elements does not mean that the entire non-government sector aims to exploit the poor. Some have argued that there may even be a role for traditional moneylenders and other support systems, given their familiarity with rural circumstances and the fact that clients still use their services for situations that cannot be covered by banks and MFIs. Co-opting moneylenders and reviewing money-lending regulations may be an option as part of linking micro-credit, income generation and insurance, but one which should be approached with some caution.

6.10 Recommendations for Service Providers and Government

Recommendations for Service Providers – Intermediaries and CBOs

Intermediaries consisting of non-governmental organizations and microfinance institutions play a critical frontline role in the distribution and outreach of microinsurance services. While very important, their role is far too restricted. Those with microinsurance experience can work together with insurers for innovations in product design, pricing and claims settlement. They can also form insurance committees at a grassroots level and build in community participation to tackle problems of adverse

India's long and varied experience with microcredit can provide early awareness of possible second generation issues that micro-insurance is likely to face – an awareness that should be taken into account to help in being prepared in advance

selection and moral hazard. Establishing these systems will help build trust between insurers and grassroots organizations.

At present very few organizations have administrative capacity and technical experience in this sector, though many have excellent contacts at the community level. Investment in training will optimize the full potential of intermediaries.

Community-based organizations like federations of self help groups are starting to take on more responsibilities. These organizations can be trained to handle day-to-day management of insurance services, while the facilitating NGOs take on an advisory role, providing strategic guidance to the CBOs. This can reduce costs and compensate for high staff turnover in many NGOs. In addition, NGOs and CBOs can promote insurance products and services. Engaging these organizations in developing training manuals and providing 'training-of-trainers' for CBOs will facilitate information dissemination and the growth of the industry.

Recommendations for Service Providers - insurance companies

Insurance companies should develop a range of marketing tools for promoting microinsurance in rural areas. Tools such as videos, illustrated banners, posters can be used and pamphlets should be distributed at public carnivals in rural areas.

It has been demonstrated time and again that rigidly standardized products with little flexibility are not going to help penetrate the rural market in India. Insurers should customize products in consultation with experienced intermediaries to cater to the different needs of the target population. This will help them achieve scale in this potentially large, but untapped market.

Insurance companies should organize capacity development programs for their management and field staff. Training programmes should include study visits with current and potential microinsurance clients to get a first hand feel for perspectives of the target group.

Insurers need to simplify operational procedures for both client satisfaction and cost-effectiveness. Routine fieldwork can be outsourced to intermediaries with suitable checks, with core underwriting retained by insurance companies.

Apart from NGOs, other delivery channels need to be utilized, such as branches of commercial banks, regional rural banks, cooperatives, postal offices, agricultural input dealers, self help groups and sales persons to improve outreach.

Joint ventures, like the Indian Association for Savings and Credits model,[96] should be tried by insurance companies to derive benefit from synergies in penetrating the rural market.

Insurance companies should partner with microfinance institutions for a 3-5 year term so that institutional adjustments can be made within their organizations to successfully provide microinsurance services. Insurance companies should also consider seconding staff to their partner microfinance organization when the client base exceeds a certain critical level, say, 100,000 clients. This will help build the capacity of the field-based organizations while microinsurance programmes are being built, and also ensure better customer service.

Re-insurers should create a special pool for high-risk clients, like HIV-positive clients and those living in disaster-prone areas, by accessing subsidies through government or donor agencies. Though idiosyncratic risks are being managed fairly well through community-based organizations, managing co-variant risks is a challenge. This is primarily due to an un-diversified risk pool and limited technical expertise. Re-insurance facilities should be offered to microinsurers, so that low income households can protect themselves in cases of co-variant risks.

Recommendations for Government and IRDA

The Government service tax of 10.2 percent on premiums adds to the price of insurance. To help keep premiums low for the rural poor, Government could consider a waiver of the service tax on microinsurance products for a limited period, as an incentive to low income rural and social sector insurance suppliers.

The Government should end programmes that subsidize microinsurance premiums and encourage actuarially sound prices that will be sustainable. Market distortions will hamper the growth of this sector. Subsidies should be restricted to 'public goods' like capacity building and database development and management for a limited period.

Recommendations for IRDA

Though recent IRDA guidelines have recognized self-help groups operational for at least 3 years as microinsurance agents, it has not given them the legal authority to directly take up insurance cover in a SHG's name. IRDA needs to recognize self-help groups and CBOs as eligible entities and possibly allow insurers to issue policies in their names. Guidelines for selecting SHGs and CBOs can be developed, so that those with adequate capacity to safely manage the complexities of microinsurance are selected. The capacity of established CBOs/ SHGs can be simultaneously strengthened through approval of suitable courses, which will enormously expand distribution and outreach. Without this change, the challenge of reaching rural clients is likely to continue.

International donors are supporting some community managed microinsurance programmes. These have not been recognized and therefore lack any legal status in IRDA guidelines. These should be brought under IRDA regulations as pioneers in the industry, so that mainstream insurers can learn from their field experiences.

The present capital requirement of INR1,000 million (US$ 22 million) is an entry barrier. IRDA could prescribe lower capital requirements (like Uganda and Sri Lanka) to attract foreign microinsurers to enter the Indian market. This will bring international expertise to India and help develop this new industry.

IRDA should designate selected institutions as 'Resource Institutions' on microinsurance. This will help in capacity development of smaller NGOs and help them adopt systems and procedures for effective management of microinsurance. External support for developing training and learning materials and conducting initial training can be considered.

A multi-media campaign to create awareness about microinsurance should be used. Multi-media will help pull in potential clients of varying literacy levels, language groups, and socio-economic status. Audio-visual presentations through television and local cable, radio and print media should all be used simultaneously to achieve impact.

The present targets for coverage under social and rural sectors are low, and unless they are increased it may take insurers more than a decade to reach a sizable segment of the target market.

A database to record historical information on rural and microinsurance trends is needed for insurers to price products more accurately, using actuarial standards. Since this is a common good to facilitate the growth of this sector, IRDA should facilitate the creation of a 'national microinsurance information unit' to undertake information gathering and sharing among stakeholders. Management of a common data base is critical – it should be equidistant from all data users. During the initial establishment phase external support, including contributions from the industry, can be utilized.

IRDA should collect and publish product-wise disaggregated data on microinsurance players quarterly. This will help insurers compare their performance and create healthy competition.

A 'national consultative group' can be created by IRDA to supplement these efforts by serving as a forum for policy dialogue. Technical expertise from internal and external sources can be invited for initial work.

It would be a good idea to provide incentives like an annual 'innovation award' in the field of microinsurance to foster improvement and create interaction between stakeholders. A fund (possibly with industry and external support) can be established for this award.

IRDA should revisit and revise specific clauses, such as the definition of family and product specifications in the November 2005 guidelines, to facilitate the expansion of this sector.

6.11 Identifying Strategic Areas for External Support

For microinsurance to take-off, financial and technical external support would be useful in specific areas, which would be difficult for insurance companies to sponsor – areas where the work is either of a germinal nature, or has public good characteristics, or both. A development agency like UNDP could work on a pilot project with IRDA, the Government and, possibly, the private sector as well, to play a strategic role.[97] Five strategic pilot project areas are identified in Table 6.3.

These recommendations capture some of the critical groundwork needed in developing the microinsurance market. Specifics are spelt out below for four of the five areas, where there is potential for immediate action. Rough cost estimates under each category for a three year period are also presented and summarised in Table 6.4

- *Support for innovations in concept design.* One of the key impediments faced by insurance companies investing in new product development is the high initial cost and costs of administration. There are also risks arising out of ignorance or neglect by rural clients. Support to facilitating agencies for developing new products in collaboration with insurance companies can be proposed. A risk pool fund can be created, which will cover insurance scheme risks beyond a certain claim ratio. Technical support can be provided through funding of experts, such as an actuarian and persons with relevant experience in other countries. This ought to be carried out over a minimum three year period, allowing time for the nuances of new ideas to be fully understood. An estimated lump sum of INR4.0 million per year is required

Table 6.3

Possible Pilot Project Areas for Market Development

Innovations in concept design - products, pricing, distribution **Processes**– facilitating experimentation and exchange	• Innovations in design of mutual insurance for life, health and livestock; piloting concepts and testing in a few locations • Customizing designs for crop insurance • Innovations in management of micro insurance operations, for example, decentralized claim settlement • Channeling Government funds for large, covariant losses like disaster risks - routing of premium subsidies for disaster products through various insurance schemes • Awareness creation among Government agencies about the potential and utility of such combinations so funds can be channelled for maximum benefits to the affected when losses are covariant • Support a *risk pool fund*
Database management	• Collection and pooling of data available with Government agencies and NGOs in various geographic locations • Building a common data base with provisions for regular updating • Putting in place an institutional structure for database management
Capacity development for insurers, insured and facilitators	• Building knowledge among insurance companies about risks faced by the poor and appropriate local management • Orienting current and potential clients, including SHGs, community leaders and opinion makers about insurance • Urgent building of knowledge about microinsurance among the facilitating agencies (MFIs, NGOs), including banks
Technological innovations	• Study to assess potential for possible use of RFID technology to track livestock related claims • Introduction of SMART/swipe card technology in health insurance • Process improvements in weather and satellite imagery based settlements for crops • Disaster modelling to enable disaster claim settlement
Policy dialogue	• Studies, workshops, documentation of pilot project and their dissemination among policy makers and practitioners • Participating in national task force or consortium on microinsurance (or, more broadly, microfinance)

to supporting these projects. The cost estimate for a three year period is INR12.0 million.

- *Support for initiating database building and management.* For the long term development of affordable, customised products, financial support for building a database that would contribute to systematic management and dissemination is estimated to cost INR8.4 million in year 1, with lower amounts of INR7.4 each in years 2 and 3. The cost estimate for a three year period covering both design and manpower expenses is INR23.20 million.

- *Support for capacity development.* To give a boost to this sector by facilitating the rolling out of products and creation of awareness in rural areas, providing support to fifty MFIs and two microinsurance agents in 500 villages each year for three

years on a trial basis is proposed. This is estimated to cost INR7.5 million each year adding up to INR29.85 over three years. Support to joint workshops for insurers and intermediaries at a higher level is also recommended and is estimated at INR6 million over three years. A total of INR32.85 million is estimated for capacity building.

- *Support for development of technology usage.* To foster process innovation and thereby reduce administrative and claim settlement costs, technology adaptation and use needs to be supported. This type of support could involve a major investment, as well as minimum period of support, depending upon a strategic decision from international organizations, perhaps, together with other donors and the private sector. Hence costs are not estimated. However, this area for support should be kept in mind for co-financing.

- *Support for policy dialogue.* Medium to long term particiaption in an ongoing

Table 6.4

Catalytic Support for Microinsurance in India: Indicative Cost Estimates (INR million)

Area of support	Particulars	Year 1	Year 2	Year 3	Total
New concepts designing	Lump sum	4.00	4.00	4.00	12.00
Sub-total		***4.00***	***4.00***	***4.00***	***12.00***
Database building	Statistical packages	2.00	1.00	1.00	4.00
	Experts	3.60	3.60	3.60	10.80
	Data analysis	0.60	0.60	0.60	1.80
	Data publication	1.20	1.20	1.20	3.60
	Unanticipated & overheads	1.00	1.00	1.00	3.00
Sub-total		***8.40***	***7.40***	***7.40***	***23.20***
Capacity development	50 MFIs	2.45	2.45	2.45	7.35
	2 microinsurance agents in 500 villages per year	7.50	7.50	7.50	22.50
	Workshops for insurers and facilitators	1.0	1.0	1.0	3.0
Sub-total		***10.95***	***10.95***	***10.95***	***32.85***
Policy dialogue	Provision for meetings, documentation, workshops, dissemination	2.00	2.00	2.00	6.00
Sub-total		***2.00***	***2.00***	***2.00***	***6.00***
TOTAL		**25.35**	**24.35**	**24.35**	**74.05**

policy dialogue process on microinsurance (or the broader microfinance sector) can be considered. UNDP can support workshops, documentation of the pilot projects and dissemination. UNDP could also be part of a Catalytic Consortium or Task Force on microfinance, which will contribute to Government efforts. Including this type of support in the country programme for the sector could be considered. The present pilot study is a starting point. A lump sum provision of INR 2 million per year, i.e., INR 6 million over a three year period is proposed for ongoing policy dialogue.

These are rough cost estimates which should be refined in consultation with the UNDP India Country Office.

The total estimate of INR 74.05 million works out to an investment of approximately US$ 1.5 million over a period of three years, or around US$ 0.5 million on average per year for three years. This support could be contributed by any development agency, either singly, or through a co-financing arrangement, to achieve a reasonable scale for an impact in the sector.

6.12 Conclusion

It is evident from the study that microinsurance, which was poised for a take off in India in 2005, has in fact done so. With heightened interest from different stakeholders, stimulus provided by the November 2005 directives of the IRDA, and better awareness overall, by 2007 the sector witnessed rapid growth and established a growth trajectory closely linked to the overall growth of insurance in the country.

From the viewpoint of insurers, microinsurance is starting to demonstrate its business potential. While investment from their side is still sporadic and limited to tie-ups with some facilitating agencies, most companies are eying microinsurance as a real business opportunity of the near future. Efforts by a few NGOs and MFIs have resulted in the introduction of microinsurance as an add-on to their existing micro-credit projects, demonstrating its potential and utility for the rural poor. These institutions have also managed to attract some companies to provide the necessary re-insurance. Their work can provide useful insights for the development of the sector.

Asset provision and income generation schemes, by themselves, are not adequate for securing livelihoods in the face of risks faced by the poor. Under Goal 1 of the MDGs, poverty reduction also involves risk management to secure assets and income streams. Microinsurance is yet to take the shape of a movement, as has happened in the case of microcredit in India. This is mainly due to novelty of the concept, low demand for services from the potential clients on account of inadequate exposure and knowledge, a 'wait and watch strategy' adopted by companies, as well as lack of adequate infrastructure and an enabling environment. The study has proposed concrete steps to address constraints which will help demonstrate the 'insurability of the poor' in the near future.

Microinsurance, which was poised for a take off in 2005, has in fact done so. However, it is yet to take the shape of a movement, as has happened in the case of microcredit.

ENDNOTES

Chapter 1

1 Policies, programmes and innovations directly aimed at poverty reduction have typically focused on income generation through microcredit based self employment or rural works based wage employment. A few other types of interventions are also seen, for example, land redistribtion.

2 See CGAP 2003a. Donor Brief number 11, March, 2003, Washington D.C.

3 For example, see Bello, 2006.

4 *Insurance Penetration* is Gross Insurance Premium as a percent of Gross Domestic Products (GDP). It is used as an indication of the level of risk awareness in the pop lation and significance of insurance in the economy.

5 *Insurance Density* is calculated as Per Capita Insurance Premium. It measures the progress of the insurance industry and is used as an indicator of the industry's maturity in an economy.

6 Like that observed in parts of India or East Africa.

7 IRDA, 2007. (Exchange rate used for converting to US$ is INR 48 = US$ 1. The dollar-rupee exchange rate has been fluctuating from 43 to 49 during last two quarters of 2008. By December 2008 the exchange rate was around US$ 1= 48 INR. Exchange rate fluctuations will affect the dollar values of the estimates).

8 Many poor prefer wage employment to self employment; others need pensions or other forms of social security. Microcredit works best for self employment, for those who can be motivated into entrepreneurial activity, where lack of finance is a binding constraint. It is relatively a painless and effective inclusive mechanism for the marginalised, especially women (unlike land reforms, for example), and can bring about an extent of rural transformation.

9 *World Development Indicators* in World Bank, 2006.

10 Anuradha Rajivan worked as Chair and Managing Director of a joint GoI-GoTN public sector undertaking (1998-2002) that linked poor women to financial services through commercial banks in India and did advisory work in Sudan, Myanmar and Nepal. Her work explored the bottlenecks and potential for microinsurance at the field and policy levels. However, the type and extent of support needed to unlock the bottlenecks was only partly understood and not fully documented. The present study provided an opportunity to work with other technical experts, Sourindra Bhattacharya and his team from BASIX, Sonu Agarwal from Weather Risk, and N.Jeyaseelan of Indian Bank, to attempt a deeper understanding, document the issues, and identify concrete areas for strategic support (UNDP, 2006b).

11 Government of India, www.india.gov.in

Chapter 2

12 Sigma Report 3/2008, Swiss Reinsurance Company, Zurich, Switzerland.

13 The Malhotra Committee looked into structural and regulatory issues, competition, investment and customer service issues in the insurance sector and recommended changes for a more efficient insurance industry.

14 Conversion rate for INR to US$ used is INR 48 = US$ 1.

15 ILO / STEP, (2005)a

16 'Rural area' is defined as an area unqualified as an urban area with municipality or corporation or cantonment board or notified town area.

17 These organizations included the UNDP, ILO, World Bank, DfID, USAID and GTZ

18 World Bank Development Indicators for India, 2006

19 NABARD, 2006.

20 This is not to downplay concerns regarding women's *de facto* control over assets and incomes.

21 NABARD Report on "Progress of SH Bank linkage in India 2004-05", Mumbai

22 Government of India, www.indiaimage.nic.in

23 The Rural Marketing Book- Text & Practice "(UNDP, 2006b)

Chapter 3

24 The *jajmani* system saved the poor in crisis situations, but equally, it kept them from ever making a level jump in their economic status through systematic appropriation of surplus. Between the *zamindar* (landlord) and the sahukar (money lender) peasants were certainly protected in bad years, and able to contribute in better years.
25 World Bank Agricultural Investment Sourcebook, 2004
26 WHO, 2006
27 Ibid
28 NCAER, 1995
29 NEERA, 2002
30 Peters et al., 2002
31 NCAER, 1995

Chapter 4

32 Price Waterhouse, 1997
33 Ms.Ela Bhatt, launched the Self-Employed Women's Association (SEWA), a trade union for female informal sector workers at Ahmedabad, India in 1972. SEWA's main goals are to organize women workers for full employment, so they can obtain income, food and social security. Besides forming a union, SEWA has created a bank, childcare co-operatives, a training academy, other cooperatives, a health programme—and has developed VimoSEWA to provide insurance benefits. In Gujarati, Vimo means insurance, and the pronunciation of SEWA means service. VimoSEWA began in 1992 as a "trust" operated by the SEWA union. It provides a voluntary, integrated microinsurance product covering the risks of death, accident, health and asset loss.
34 Study by Dr.N.Lalitha, "SHGs in Dindigul district – A position document 2004-05", CAPART, Hyderabad, unpublished paper
35 Jeyaseelan N., 2005, "Rapid study on microinsurance coverage in Mahalir Thittam SHGs in Chennai", Unpublished paper
36 Urban coverage being lower than rural among the SHG members is not surprising. Rural women's groups are much stronger than urban ones in Tamil Nadu (as in other states also). The influence of facilitating NGOs is also greater.
37 Naik, 2005
38 Ministry of Health and Family Welfare, Government of India, 2005
39 Peters et al., 2002
40 ECCP, 2005
41 Sze, 2004
42 Asfaw et al., 2002
43 Devadasan et al., 2004
44 Matul, 2005
45 Ahuja and Jutting, 2002
46 Michael, 2005
47 ILO/STEP 2005a
48 10 lakhs = 1 million
49 Walder, 2004
50 Cohen et al., 2003
51 Chakonta, 2005
52 Ahuja, 2005
53 Garand, 2005
54 Ibid
55 Government of India, 2005
56 Ibid
57 Kumar, 2005
58 Government of India, 2005
59 Ibid
60 Roth and Athreye, 2005
61 McCord et al., 2005
62 Ibid
63 Roth and Athreye, 2005
64 Ibid
65 Radermacher, 2005
66 Cohen et al., 2003
67 Jutting, 2003
68 Cohen et al., 2003
69 Leftley, Richard and Mapfumo, Shadreck, 2006.
70 Roth and Leftley, 2005
71 Interpolis Re, 2004
72 Roth, 2004
73 Roth et al., 2005
74 Socquetl, 2005
75 Ahuja and Jutting, 2002
76 Dror, 2005
77 Devadasan, 2005

Chapter 5

78 Tamil Nadu – 9 FGDs, Rajasthan – 5 FGDs and Orissa – 6 FGDs

79 Animals have a metal 'tag' inserted in the ear with identification markings to prevent unauthorised disposal through sale or substitution.

80 For example, many expected to get their premium money back with interest.

81 Forty-five products from the public sector insurers and fifty-seven from private insurers.

82 In some cases women face difficulties in being recognised as farmers, even when they regularly and actively undertake farming operations.

83 Ravindran, 2005.

84 Farm Income Insurance Scheme (FIIS) implemented by AIC in 20 districts during the 2003-04 Rabi season for rice and wheat on pilot basis. Under the FIIS the indemnity calculation is modified to account for income shortfall, not just yield shortfall.

85 Difficult to assess losses for OPD, chronic illnesses, further high incidence rates result in high premiums.

86 Though UHIS provides for cashless facilities for members at Government hospitals, many households are bereft of this benefit as they have to access private health care facilities due to poor conditions of the Government hospitals.

87 Adverse selection occurs *before* the event, in this case the event being purchasing insurance. If those prone to higher risks are much more likely to opt for insurance, we have a situation of adverse selection.

88 Moral hazard occurs *after* the event. If after buying insurance, people are more likely to behave in a risky way because they are covered, we have a situation of moral hazard.

89 One insurance expert commented that so much time, money and energy was spent in identifying the specific cause of death primarily to rule out that the death was not due to suicide. In normal insurance idiom, self-harm was not insured to prevent people from damaging their own property just to claim the payout. While suicides did occur, it would be rather far fetched to assume that there would be a spurt in rural people killing themselves just for the nominees to claim the payouts.

90 It is surprising that only 12 percent of agricultural borrowers are covered by insurance, including crops for which agricultural insurance is mandatory. Insurance coverage ratio dips to an abysmal 3 percent for non-compulsory crops. This coverage ratio varies across regions and institutions, for example in Orissa crop insurance coverage ratio is 3 percent, whereas in Andhra Pradesh it stands at 16 percent. This can be partly attributed to product design but mostly signifies under-utilization of the present available network (Sidharth, 2005).

Chapter 6

91 A mutual is a risk management mechanism wherein members of a community pool in funds and other resources to protect each other from risks they might commonly face, following mutually agreed upon management principles. A mutual as a risk management concept works best for uncorrelated, low to moderate frequency and moderate impact risks.

92 RFID - Radio Frequency Identification Devise; GSM – Global System for Mobile Communication.

93 As was seen during field research, there was a reduction in premium for customers of BASIX based on historical mortality rate for two years.

94 This is meant for new products. Design limitations in existing insurance products may be seen in Table 5.1.

95 Mathew Titus, of Sa-Dhan, an association of Indian microcredit institutions, sees the row as a "battle of ideas" between the non-government sector and those ideologically opposed to NGOs working with the poor. (*The Economist,* Aug 17th 2006).

96 With equity participation by HDFC, a financial institution, and PWDS, a non-governmental organization.

97 In the past USAID played a role in financial sector reforms in India.

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ANNEXES

Annex 1

Microinsurance Potential in India: an Estimation

LIFE INSURANCE

FACTS	ASSUMPTIONS*	MARKET SIZE
Total population 1,087.10 million **Share of population between 15 to 64 years** 62.3% **Hence potentially economically active population** 677.26 million **Share of population earning between US$ 1 – 2 a day** 17.7% **Hence potentially economically active population earning US$ 1 – 2 a day** 119.87 million **Share of population earning less than US$ 1 a day** 34.7% **Hence potentially economically active population earning less than US$ 1 a day** 235.01 million **Estimated average life cover premium** INR100 per person per year (Among the poor, the most popular life insurance product is LIC's JBY with premium paid per person per year of INR100)	**Possible coverage among potentially economically active population earning less than US$ 1 a day** (conservatively assuming coverage to range between 40% to 50% of this group) **94.00 million to 117.51 million persons** **Possible coverage among potenially economically active population earning between US$ 1 – 2 a day** (assuming coverage to range between 50% to 70% of this group) **59.93 million to 83.90 million persons** **Number of clients = 94.00 to 117.51 million**	**Premium = INR9,400 to 11,751 million** (at the rate of an average premium of INR100 per member) Number of clients = 59.93 million to 83.90 million **Premium = INR5,993 to 8,390 million** (at the rate of an average premium of INR100 per member)

LIFE INSURANCE POTENTIAL: INR15,393 to 20,141 million (US$ 320.69 to 419.60 million)**

NON-LIFE INSURANCE

FACTS	ASSUMPTIONS*	MARKET SIZE
Number of rural households 147.90 million **Share of cultivator households** 60.41% **Number of cultivator households** 89.35 million **Number of non -cultivator households** 58.55 million **Estimated average livestock premium** 4% of value of animal / unit per year	**Possible livestock coverage at 50% to 70% of rural households for both cultivator and non-cultivator households** **An average of 1 milch animal per cultivator household valued at INR10,000 per animal** **An average of 1 unit of other livestock per non-cultivator household valued at INR5,000 per unit (1 unit = 3 sheep or goats)**	**<u>Livestock</u>** **Number of insurable milch animals = 44.68 to 62.55 million** **Premium = INR17,872 to 25,020 million** **Number of other insurable livestock units = 29.28 to 40.99 million** **Premium = INR5,856 to 8,198 million**
Estimated average health insurance premium INR363 per household per year (Based on USAID project)	**Potential coverage 25% to 33.3% of rural households opt for health insurance**	**<u>Health</u>** **Number of clients = 36.98 to 49.30 million households** **Premium = INR13,423.74 to 17,895.9 million**
Cropped area (grains + pulses + oilseeds) 124.24+24.45+23.44 = 172.13 million hectares **Estimated average premium for crops** 3.15% of sum assured	**Possible coverage of cropped area 30% to 40%** **Sum assured = INR6,000/ha** **Premium per ha** (at 3.15% of sum assured) = **INR189**	**<u>Crop</u>** **Hectares = 51.64 to 68.85 million** **Premium = INR9,759.96 to 13,012.65 million**

Potential demand for milch animal cover @ INR400/animal	**=**	**INR17,872 to 25,020 million**
Potential demand for livestock cover @ INR200/unit	**=**	**INR5,856 to 8,198 million**
Potential demand for health insurance @ INR363/HH	**=**	**INR13,423.74 to 17,895.9 million**
Potential demand for crop insurance @ INR189/ha	**=**	**INR9,759.96 to 13,012.65 million**

TOTAL POTENTIAL FOR NON LIFE INSURANCE:

INR46,911.70 to 64,126.55 million
(US$ 977.33 to 1,312.05 million)

TOTAL MICROINSURANCE POTENTIAL (life + non life):

INR62,304.70 to 84,267.55 million
(US$ 1,298.01 to 1,755.57 million)

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*Based on Stakeholder's inputs and adjusted for PPP

** US$ 1 = 48 INR (The dollar-rupee exchange rate has been fluctuating from 43 to 49 during last two quarters of 2008. By December 2008 the exchange rate was around US$ 1= 48 INR. Exchange rate fluctuations will affect the dollar values of the estimates)

Sources: UNDP Human Development Report 2006, New York, Livestock Census 2003 and NSSO 2003, Agricultural Statistics at a Glance 2004, Ministry of Agriculture, Government of India

Note: If other risks related to lifestyle, damage due to riots, natural disasters, asset loss, etc., are added the market size is expected to increase

Annex 2

Guiding Questions for Focus Group Discussions

1 What events do you perceive as 'risky' in your life? Indicate in terms of frequency and level of impact.
- Life
- Health
- Assets
- Enterprise
- Natural calamities
- Others

2 What are your current coping methods? Explain both formal institutional mechanisms and informal mechanisms, such as individual and social.
- Life
- Health
- Assets
- Enterprise
- Natural calamities
- Others

3 If insurance services were available to you, which risks would you prefer to cover? Name and indicate priority.
- Life
- Health
- Assets
- Enterprise
- Natural calamities
- Others

4 Do you currently have any form of insurance?
A. Yes B. No

A. If 'Yes' explain.

Institution Premium Individual / Group
- Life
- Health
- Accidents
- Crops
- Livestock
- Assets
- Natural calamities

- Have you voluntarily taken up insurance cover, or was it compulsory, packaged with other financial services?
- Are you aware of the terms and conditions of the insurance policy? Have you been provided with any documentation to explain the features?
- Are you satisfied with existing insurance cover and premium payments?
- Are you satisfied with existing insurance services?
- Are you aware of alternate products and services?
- Have you renewed your insurance? If not, explain why.
- What improvements would you suggest for greater coverage?
- If suitable products are offered, what percentage of the population do you estimate would be willing to take up insurance?
- What are you willing to pay for individual and / or family insurance? Estimate annual premiums for different types of insurance.
- How would you prefer to make premium payments? Periodically or as a lump sum at one time in a year?

B. If 'No', explain.

- Why have you not taken insurance cover? Explain your reasons.
  * Personal
  * Unaware of products and service providers
  * Non-availability of products
  * Pricing too high for the existing products
  * No service providers
  * Other

- If suitable products are offered, would you be interested in taking up insurance cover?
- Who do you think can provide insurance services to you?
- What are you willing to pay for different types of individual and/ or family insurance?

- What payment schedule would you prefer to make premium payments?

5 Name an insurance company / companies you know of.

6 Do you know the office address and officials of insurance companies in your area? (a)Address; (b)Officials.

7 Can you specify some popular products of the above companies?

8 Do you know the features, processes and benefits of the policy/policies?

9 What more information do you need to make a decision to buy insurance?

10 How should insurance companies advertise their services and products?

Annex 3

Guiding Questions for Semi Structured Interviews with Insurance Officials

1. Do you perceive rural sector policies of your company as a profitable business or just to meet the target set by the regulatory authority?
2. How much of your present business is derived from the rural sector?

    a. Has your rural sector business over the last 3 years grown or decreased?
    b. If it has grown, what do you think are the reasons?
    c. If it has decreased, what are the reasons? And how would you change this?
    d. Up to what distance from your office can you effectively service the policies in the rural sector?
    e. As the competition in the cities is heating up after the entry of private insurers, have you evolved any strategies for penetrating the rural sector?
        i. If so, please give details.

3. What will be the easiest mode / frequency of premium payment to the rural customer?
4. Do you find any problems in premium collections by the insurance agents?
5. What is the drop-out rate in the rural sector?
6. If the insured fails to pay the premium on exact due dates, do you allow any grace period to pay the dues at a later date?

    a. If so, what is the maximum time allowed for remitting the delayed premium?
    b. With a fine or without?

7. In the rural sector, which are the fast moving products?

    a. For slow moving products, have you received any feedback from the customers and subsequently changed the product design?

8. How are you creating product awareness among the rural people?
9. How often do you conduct product promotion campaigns?

    a. After the campaign, how do you follow up with the prospective clients?
    b. Do you conduct these promotional campaigns during any particular period?

10. What is the time lag between preparing a product and getting it approved by the IRDA for the final launch of the product?

    a. How much time is roughly needed at each stage?
    b. Is it necessary to seek the approval of the IRDA for each product you design, or is your company's board approval enough?

11. Do you think that the premium for rural/social sectors should be subsidized?

    a. Is there any subsidy in the present premium charged to the rural/social sectors?
    b. If there is a subsidy element, do you plan to phase out this subsidy? How long can subsidized operations continue?

12. What is the field capacity you have for marketing the products in the rural sector?
13. What is the time frame for claims payments?
14. There is a general negative impression that when a claim is submitted, you will quote the exclusions which are used to reject a large proportion of cases. How do you plan to change this negative impression from the minds of the prospective customers?
15. If customers are not satisfied with your claim processing, how can they get redressal?
16. How many complaints do you receive on an average from rural clients?

    a. What is the major complaint prone area among rural clients?

17. What is the commission you pay to insurance agents?
18. Have you targeted SHG leaders to market your products?

    a. If not, why?

19. Do your executives visit rural areas to get first hand feedback from the rural population?
20. Have you come across any bogus claims in the rural sector?

    a. How you have dealt with these bogus claims?

21. How often do you train your staff on rural sector products?
22. What changes would you like to propose to make the penetration in rural areas easier?

23. Anything else you would like to share?

Annex 4

Guiding Questions for Semi Structured Interviews with NGOs

1. For what risks could poor people come forward to sign up for insurance cover?

    a. What, in your experience, is their order of priority for taking insurance cover?

2. What is the awareness level of the poor regarding the various insurance products?

    a. High
    b. Medium
    c. Low

3. Have you conducted any programs to upscale insurance outreach amongst your target groups?
4. Has any insurance company contacted you for insuring your target groups under group insurance?

    a. If so, have you taken insurance cover with any of these companies?
    b. If not, why not?

5. How aware are you about the different insurance product designs offered by the various insurance companies?
6. If you have taken insurance cover for your target groups, how do you schedule premium collection?
7. What is the strategy for collection of renewal premiums?
8. What is the percentage dropping out of insurance cover after a year?

    a. What are the reasons for these drop-outs?
    b. Have you have taken any steps to prevent these drop-outs?

9. Have you allotted any dedicated staff to deal with insurance related issues?
10. Have the staff has been trained in the basics of insurance?
11. When taking group insurance cover, do you give written documents in vernacular language(s) to the members? (E.g., mentioning the policy number, date of expiry, important exclusions, address of the insurance company for emergency contact, etc.)
12. What is the time lag involved in getting the policy from the insurance company after the payment of the premium?
13. Are you aware of the different steps in making a claim in case of loss for the clients covered?
14. Has the insurance company given you a checklist to help in preferring claims?
15. When a client is faced with a claim situation, which document(s) presents the most difficulties to the insured?

    a. In your view, how can these difficulties be overcome?

16. How much time does it take to receive the claim payment from the company?
17. In case of a death claim, do you follow a system of disbursing a lump-sum (say INR 3,000 to 5,000) on the day of the funeral to help the bereaved family? Later will this amount be adjusted against the claim amount received?

    a. If the above system is not followed, do you think it would be useful?
    b. If so, how it can be introduced in your place?
    c. If not, why?

18. If you did not know the process of a claim submission, did the insurance officials guide you through this process?

    a. Were you satisfied with their guidance?

19. Have you come across any fraud committed by the insured in preferring their claims?

    a. If so, what kind?
    b. What precautions do you take to prevent

such fraud?

20. Do you disburse the claim amounts in public meetings, so as to encourage others to opt for an insurance cover?

    a. If yes, what is the experience?
    b. If not, why?

21. Has the insurance company rejected any of your client's claims without any valid reasons?

    a. If so, please give details.
    b. In such cases, how you have followed it up further? Have you ever taken up these issues with higher officials or with an Insurance Ombudsman?

22. What is the general satisfaction level of the people with regard to the services being offered by insurance companies?

    a. High
    b. Medium
    c. Low

23. Do you operate any insurance scheme on your own?

    a. If so, please give operational details
    b. What are some of the positive and negative experiences for the last 3 years?.

24. Anything else you want to share?

Annex 5

Microinsurance Products by Public and Private Sector Insurance Companies in India

PRODUCTS OFFERED BY PUBLIC SECTOR INSURERS

Welfare Schemes

1. Raja Rajeswari Mahila Kalyan Yojana
2. Mother Teresa Women and Child Policy
3. Package Insurance for tribals
4. Bagyashree Child Welfare Scheme
5. Amartya Siksha Yojana
6. Students Insurance

Health Schemes

8. Gram Arogya Yojana
9. Universal Health Insurance
10. Swasthya Bima policy

Accident Policies

11. Grameen Accident Insurance
12. Janata Personal Accident Policy
13. Rasta Apoti Kavach Scheme
14. Road Safety Insurance
15. Kisan Credit Card Personal Accident Cover

Crop Insurance

16. Farmers Package Policy
17. Seasonal Rainfall Insurance
18. Coconut Insurance
19. Sowing Failure Insurance
20. Betelvine Insurance
21. Rose Insurance
22. Aquaculture Insurance
23. Sericulture Insurance
24. Mushroom Insurance

Livestock Insurance

25. Cattle Insurance
26. Poultry Insurance
27. Honey-bee Insurance

28. Unborn Calf (foetus) Insurance
29. Duck Insurance
30. Horse Insurance
31. Pig Insurance
32. Donkey Insurance
33. Fish in ponds insurance
34. Quail Insurance

Asset Insurance

35. Failed Well Insurance
36. Kisan Agricultural Pumpset Insurance
37. Animal Driven Cart Insurance
38. Household Assets Insurance
39. Biogas Insurance
40. Cycle Rickshaw Insurance
41. Shop Insurance
42. Brick Kiln Insurance
43. Artistes Insurance
44. Package Insurance for Credit Societies

Life Insurance

45. Jana Shree Bima Yojana

PRODUCTS OFFERED BY PRIVATE INSURERS

ICICI Prudential Life Insurance Company Limited

1. Prudential Suraksha Regular Term Plan
2. Prudential Suraksha Single Term
3. Prudential Mitra
4. Salam Zindagi

Bajaj Allianz Life Insurance Company Limited

5. Group Credit Care Plan I
6. Group Credit Care Plan II
7. Group Term Life Plan I
8. Group Term Life Plan II

Aviva Life Insurance Company Limited

9. Jana Suraksha
10. Amar Suraksha

11. Anmol Suraksha
12. Credit Plus
13. Group Shield
14. Early Life Plus

Birla Sunlife Insurance Company Limited

15. Bima Kavach Yojana
16. Social Development Plan

HDFC Standard Life Insurance Company Limited

17. Development Assurance Plan
18. Single Premium Whole Life Insurance
19. Loan Cover Term Assurance
20. Personal Pension Plan
21. Term Assurance Plan
22. Endowment Assurance Plan
23. Money Back Plan

SBI Life Insurance Company Limited

24. Swadhan
25. Super Suraksha
26. Scholar Plan
27. Sudharsan Endowment
28. Life Long Pension
29. SBI SHG Sakthi

Tata-AIG Life Insurance Company Limited

30. Kalyan Yojana
31. Karuna Yojana
32. Jana Suraksha Yojana

Metlife Insurance Company Limited

33. Group Policy for Social Sector

Om Kotak Life Insurance Company Limited

34. Kotak Gramin Bima Yojana

ING Vysya Life Insurance Company Limited

35. Securing Life – Endowment
36. Surakshit Jivan
37. Group Social Sector Insurance

IFFCO-Tokio General Insurance Company Limited

38. Sankat Haran Group Insurance

ICICI Lombard General Insurance Company Limited

39. Home Insurance
40. Weather Insurance
41. Merchant Insurance
42. Personal accident Insurance

HDFC Chubb General Insurance Company Limited

43. Group Personal Accident Insurance
44. Parivar Suraksha

Cholamandalam General Insurance Company Limited

45. Health Insurance
46. Accident Insurance

Bajaj Allianz General Insurance Company Limited

47. Critical Illness Insurance
48. Personal Guard

Royal Sundaram General Insurance Company Limited

49. Shakthi Health Insurance
50. Rural Micro Enterprise Insurance
51. Janata Personal Accident Insurance
52. Sakthi Security Shield

Reliance General Insurance Company Limited

53. Indian Mediclaim
54. Agricultural Pumpset Insurance
55. Cattle Insurance
56. Farmers Package
57. Janatha Personal Accident Insurance

Source: Compilation from 2005 International Labour Organization (ILO) Reports, websites, pamphlets of insurance companies and interviews.

Annex 6

Details of Specific Microinsurance Products of Selected Institutions

A. Life insurance: comparing public sector and community managed products

Parameters	Public Sector	Community Managed
Policy	Jana Shree Bima Yojana	Gangai Vattara Kalanjia Mutuals
Insurance Company	Life Insurance Corporation	
Age	18 - 60 years	Up to 65 years
Eligible group	Specified occupational groups	All self-help group members and spouses / Limited cover for spouses
Premium	INR 200 per member INR 100 is paid by government	** INR 132 for members only INR 200 for including spouse
Natural Death cover	INR 20,000	INR 20,000 to member INR 10,000 to spouse
Accidental death cover	INR 50,000	INR 50,000 to member INR 20,000 to spouse
Permanent (total) disability due to accident	INR 50,000	INR 50,000 to member INR 20,000 to spouse
Permanent (partial) disability due to accident	INR 25,000	INR 25,000 to member INR 10,000 to spouse
Other benefits	Student scholarships to 2 children per family (9 - 12) at INR 300 per child per quarter	If earning member of the family is admitted to hospital, wage loss compensation of INR 75 per day for a maximum of 7 days

** Unlike most microinsurance products, this is priced on actuarial calculations.

B. Cattle insurance: comparing standard cattle insurance with special cattle insurance package offered through qualified non-governmental organizations

Parameters	Standard Package	Special Package
Policy	United India Insurance	Royal Sundaram
Insurer	United India Insurance	DHAN Foundation
Premium	4 percent of value of the animal for private clients 2.25 percent for animals financed under subsidized loan programs	2.25 percent of value of the animal
Certification of animal	Veterinary doctor	Non-governmental organization staff

Documentation for death claim	1. Photo of the deceased animal 2. Death certificate 3. Post mortem report from veterinarian	1. Photo of the deceased animal 2. Death certificate from veterinarian

C. Health insurance: products by New India Assurance Company Limited

This health insurance product is offered to self-help groups in Palmyrah Workers Development Society, Development Association for Training and Technology Application, Network for Education and Empowerment of Rural Artisans (NEERA).

Terms and conditions

- Floating hospitalisation cover includes 42 diseases, and has a ceiling of INR 20,000.
- Accidental death cover to the insured and spouse of INR 50,000.
- Permanent Total Disability (PTD) due to accident of INR 50,000.
- Partial permanent disability due to accident, i.e. loss of a hand, a leg, or an eye of INR 25,000.
- Age limit up to 65 years.
- Maximum of 7 family members can be covered.
- In case of insured members accidental death or permanent total disability, one daughter below the age of 18 will get INR 5,000 to cover marriage expenses. This amount will be provided after she has reached the age of 18.
- The premium will be calculated based on the age of the eldest in the family. The premium, includes service tax of 10.2 percent, is calculated according to the matrix below:

Family members	Premium payable in rupees including service tax Maximum age of family members			
	Up to 35 years	36 – 45	46 – 55	56 - 65
1 member	287	309	430	488
2 members	315	340	472	537
3 members	342	367	513	583
4 members	368	395	552	630
5 members	393	423	593	676
6 members	419	451	633	720
7 members	443	479	672	766

Exclusions

- Hospital reimbursement does not cover expenses incurred for the first 30 days from the time of the commencement of the policy.
- Pre-existing diseases not covered.
- Operations not covered during the first year.
- Eye check ups, dental surgery and childbirth not covered.
- Insurance company needs to be informed 24 hours prior to admission in hospital.
- Claim to be filed within 7 days of discharge from hospital.

D. 'Shakti' life insurance policy offered by State Bank of India

Shakti extends life cover to self-help group members. A special feature of the policy is that the entire life insurance premium is returned to the client in case he survives for the ten year period. Shakti was originally launched in Orissa in October 2003 and later extended to all other states.

An exclusive product for self-help groups

This is a group insurance scheme. Any self-help group that has been in existence for more than one year,maintains a savings account with a bank, and has been approved for bank credit, is eligible to join the group insurance scheme. Every member of the self-help group between the age of 18 and 50 years is covered under the scheme.

The scheme offers life insurance of INR 25,000 to cover death due to any reason. Premium is INR 400, payable annually as a lump sum in advance. The premium is the same for all age groups in the self-help group, irrespective of age. Insurance cover will be available to self-help group members as long as they remain in the self-help group and pay the premium. If the insured is alive after a period of 10 years and has been making regular premium payments, he or she receives the entire refund of INR 4,000. Those who pay the premium for less than 10 years are refunded as per a graded scale.

E. Insurance products offered by Bharitya Samruddhi Investments and Consulting Services Limited (BASIX).

Bharitya Samruddhi Investments and Consulting Services Limited (BASIX) has developed long-term partnerships with insurance companies, helping develop appropriate products and processes through interactions and feedback with the clients. The present range of products is described below:

- Since April 2005 BASIX has offered 'Gramin Arogya Raksha', a voluntary health insurance product to its members. It provides cover in case of hospitalization for more than 24 hours and disability due to personal accident. In case of the former, hospitalization expenses are reimbursed at INR300 per day for 5 days. In case of disability due to personal accident, it provides a cover of INR25,000 and a one-time payment of INR10,000 in case of critical illness to the insured. The premium rate is INR137 per member, per annum. Pre-existing diseases are excluded, and a waiting period of 90 days is applicable for the first year.

- 'Jana Suraksha,' a pure term insurance product, 'Amar Suraksha,' term insurance with premium payable at the end, and 'Anmol Suraksha,' term insurance with guaranteed return at the end, are retail products of AVIVA life insurance company. BASIX voluntarily distributes these products to its clients.

- Livestock cover is offered to clients through a partnership with the Royal Sundaram Insurance Company. The Area Executive for monitoring and risk management undertakes a monthly 'Livestock Quality Survey', and covers 15 livestock per unit on a random basis and 3 units per month.

- A pilot Rainfall Insurance Scheme in partnership with Industrial Credit Investment Corporation of India Limited (ICICI) Lombard is in place. This product has been well received in the market, following which three other companies have followed the example of ICICI and started offering this product. This scheme, though originally conceived for farmers, is attracting other clients such as brick kiln owners.

- BASIX has helped Aviva Life Insurance evolve a new product 'Gramin Suraksha'. This is awaiting approval of the Insurance Regulatory and Development Authority (IRDA). The policy term is 5 years. Clients get an additional six months grace period to make the second year premium payment, giving them a lot of flexibility.

F. Health insurance: Parivar Suraksha Bima offered by Healing Fields Foundation – a project of the United States Agency for International Development (USAID).

Healing Fields Foundation (HFF), based in Hyderabad, is a non-profit organization working to make healthcare affordable and accessible to the people of India. After 2 years of research and

background work HFF, in association with Housing Development Finance Corporation (HDFC) Chubb General Insurance Company Limited, has launched a health insurance product 'Parivar Suraksha Bima' for self-help group members. HFF is partnering with non-governmental organizations for administrating this product.

Parivar Suraksha Bima is a unique health insurance product designed especially for the benefit of self-help group women and their families. Though a single product, it has multiple benefits.

Premium

- Members pay INR363 per annum to cover entire family of five. INR285 for Health Insurance, INR35 for Personal Accident Benefit, INR 33 for Service Tax, and INR 10 to HFF as registration fee.
- Eligible age of the members is between 18 and 65 years.
- Insurance product covers 5 members of a family, i.e. member, husband and three unmarried children below 21 years.
- Access to treatment at a high-quality nursing home or hospital up to INR20,000.
- Loss of wage compensation of INR50 per day for a maximum of 15 days, i.e. from the fourth to the eighteenth day of hospitalization.
- Only 25 percent hospitalization cost has to be paid by the client and the remaining 75 percent is paid by the insurance company.
- In case of accidental death or permanent disability of either client or spouse, a total insured sum of INR25,000 is awarded to members.
- For partial disability, the self-help group member is awarded half the amount of INR 12,500 from the total insured amount.
- In case of death of the client, along with the total insured amount INR25,000 an additional INR5,000 is paid to each unmarried girl children below 21 years towards marriage and INR5,000 is paid to each child getting educated (maximum 3 children).

Enrolment and identification

- Once the premium is paid, the client is enrolled in the insurance plan.
- The non-governmental organization has to arrange the family photograph, including husband, wife and two or three children, carrying details of self-help group members name, identity number and the name of the non-governmental organizations. These photographs have to then be sent to HFF.
- HFF then issues a photo identity card.
- The client is provided with a list of hospitals where they can access services.
- At the time of hospitalization, the member has to show the Photo identity card to HFF facilitator at the hospital and the facilitator takes care of the insured.

Service delivery

- Hospital authorities claim 25 percent of the bill from clients at the time of discharge.
- The hospital charges clients according to pre-negotiated rates with HFF - Diagnostic Related Group model to avoid any confusion about billing from the client or hospital.
- The HFF facilitator at the hospital deals with documentation and all issues faced by the patient.
- In case of any payment problems, the HFF facilitator liaises with the office and the concerned non-governmental organization.

As on November 2005, this health insurance product has 13,835 clients. HFF is working in Anantapur, Nellore, Prakasam, Nalgonda, Rangareddy, and East Godavari districts of Andhra Pradesh.

Annex 7

IRDA Microinsurance Regulations

INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY (MICROINSURANCE)REGULATIONS, 2005

Official Gazette - November 10, 2005

OBJECT

In exercise of the powers conferred by Section 114A of the Insurance Act,1938 (of 1938) read with Section 26 of the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999), the Authority, in consultation with the Insurance Advisory Committee, hereby makes the following regulations, namely:

1. Short title and commencement

(1) These regulations may be called the Insurance and Development Authority (Microinsurance) Regulations, 2005

(2) They shall come into force from the date of their publication in the Official Gazette.

2. Definitions

In these regulations, unless the context requires otherwise:

a) "Act" means the Insurance Act, 1938 (4 of 1938)

b) "Authority" means the Insurance Regulatory and Development Authority established under sub-section (1) of section 3 of the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999)

c) "Family" means a unit comprising of husband, wife, dependant parents and a maximum of three children. Provided that where the number of children is more then three, for construing the composition of family as aforesaid, the first three children shall be included provided further that an insurer may, within the aforesaid parameters laid down for the composition of the family, define "family" as per the requirements of the individual or group

d) "General microinsurance product" means any health insurance contract, any contract covering the belongings, such as, hut, livestock or tools or instruments or any personal accident contract, either on individual or group basis, as per terms stated in Schedule-I appended to these regulations

e) "Life microinsurance product" means any term insurance contract with or without return of premium, any endowment insurance contract or health insurance contract, with or without an accident benefit rider, either on individual or group basis, as per terms stated in Schedule-II appended to these regulations

f) "Microinsurance agent" means: (i) a Non-Government Organisation (NGO), or (ii) a Self Help Group (SHG), or (iii) a Microfinance Institution (MFI), who is appointed by an insurer to act as a micro insurance agent for distribution of microinsurance products

Explanation: For the purposes of these regulations:

(I) Non-Government Organisation (NGO) means a non-profit organization registered as a society under any law, and has been working at least for three years with marginalized groups, with proven track record, clearly stated aims and objectives, transparency and accountability as outlined in its memorandum, rule, by-laws or regulations as the case may be, and demonstrates involvement of committed people

(II) Self Help Groups (SHG) means any informal group consisting of ten to twenty or more persons and has been working at least for three

years with marginalized groups, with proven track record, clearly stated aims and objectives, transparency and accountability as outlined in its memorandum, rules, by-laws or regulations, as the case may be, and demonstrates involvement of committed people

(III) Microfinance Institutions (MFI) means any institution or entity or association registered under any law for the registration of societies or co-operative societies, as the case may be, inter alia, for sanctioning loan/finance to its members

g) "Microinsurance policy" means an insurance policy sold under a plan which has been specifically approved by the Authority as a micro insurance product

h) "Microinsurance product" includes a general microinsurance product or life insurance product, proposal form and all marketing materials in respect thereof

i) All words and expressions used herein and not defined but defined in the Insurance Act, 1938 (4 of 1938), or in the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999) or in any Rules or Regulations there under shall have the meanings respectively assigned to them in those Acts or Rules or Regulations

3. Tie-up between life insurer and non-life insurer

1. An insurer carrying on life insurance business may offer life microinsurance products as also general microinsurance products, as provided herein

Provided that where an insurer carrying on life insurance business offers any general microinsurance products, he shall have a tie-up with an insurer carrying on general insurance business for this purpose, and subject to the provisions of section 64VB of the Act, the premium attributable to the general microinsurance product may be collected from the prospect (proposer) by the insurer carrying on life insurance business, either directly or through any of the distributing entities of microinsurance products as specified in regulation 4, and made over to the insurer carrying on general insurance business

Provided further that in the event of any claim in regard to general microinsurance products, the insurer carrying on life insurance business or the distributing entities of microinsurance products, as the case may be, as may be specified in the tie-up referred to in the first proviso, shall forward the claim to the insurer carrying on general insurance business and offer all assistance for the expeditious disposal of the claim

2. An insurer carrying on general insurance business may offer general micro- insurance products as also life microinsurance products, as provided herein

Provided that where an insurer carrying on general insurance business offers any life microinsurance products, he shall have a tie up with an insurer carrying on life insurance business for this purpose, and subject to the provisions of section 64VB of the Act, the premium attributable to the life microinsurance product may be collected from the prospect (proposer) by the insurer carrying on general insurance business, either directly or through any of the distributing entities of microinsurance products as specified in regulation 4, and made over to the insurer carrying on life insurance business

Provided further that in the event of any claim in regard to life micro insurance products, the insurer carrying on general insurance business or the distributing entities of microinsurance products, as the case may be, as may be specified in the tie-up referred to in the first proviso, shall forward the claim to the insurer carrying on life insurance business and offer all assistance for the expeditious disposal of the claim

4. Distribution of microinsurance products

In addition to an insurance agent or corporate agent or broker licensed under the Act, read with the regulations concerned made by the Authority for licensing of individual or corporate agents, or insurance brokers, as the case may be, microinsurance products may be distributed to the micro insurance agents

Provided that a microinsurance agent shall not distribute any product other than a microinsurance product

5. Appointment of microinsurance agents

1) An insurance agent shall be appointed by an insurer by entering into a deed of agreement, which shall clearly specify the terms and conditions of such appointment, including the duties and responsibilities of both the microinsurance agent and the insurer

Provided that before entering in to such agreement, the same shall be approved by the head office of the insurer

2) A microinsurance agent shall not work for more than one insurer carrying on life insurance business and one insurer carrying on general insurance business

3) The deed of agreement referred to in sub-regulation (1) shall specifically authorize the microinsurance agent to perform one or more of the following additional functions, namely:

   a) Collection of proposal forms
   b) Collection of self declaration from the pro poser that he/she is in good health
   c) Collection and remittance of premium
   d) Distribution of policy documents
   e) Maintenance of registers of all those insured and their dependants covered under the mi croinsurance scheme, together with details of name, sex, age, address, nominees and thumb impression/signature of the policy holder
   f) Assistance in the settlement of claims
   g) Ensuring nomination to be made by the in sured
   h) Any policy administration service

4) The microinsurance agent or the insurer shall have the option to terminate the agreement referred to in sub-regulation (1) after giving a notice of three months by the party intended to terminate the contract

Provided that no such notice shall be necessary, where the termination is on account of any misconduct or indiscipline or fraud committed by the microinsurance agent

6. Employment of specified persons by microinsurance agents

A microinsurance agent shall employ specified persons with the prior approval of the insurer for the purpose of discharging all or any of the functions stated in sub-regulations (3) of regulation 5

Provided that corporate agents and insurance brokers procuring microinsurance business shall continue to be governed by the Insurance Regulatory and Development Authority (Licensing of Corporate Agents) Regulations, 2002, and Insurance Regulatory and Development Authority (Insurance Brokers) Regulations, 2002, as the case may be

7. Code of conduct of microinsurance agents

1) Every microinsurance agent and specified person employed by him shall abide by the code of conduct as laid down in Regulation 8 of the Insurance Regulatory and Development Authority (Licensing of Insurance Agents) Regulations, 2002, and the relevant provisions of Insurance Regulatory and Development Authority (Insurance Advertisements and Disclosure) Regulations, 2000

   Provided that the insurer shall ensure compliance of the code of conduct, advertisements and disclosure norms by every micro insurance agent

2) Any violation by a microinsurance agent of the code of conduct and/or advertisement or disclosure norms as aforesaid shall lead to termination of his appointment, in addition to penal consequences for breach of code of conduct and/or advertisement or disclosure norms pursuant to the provisions of sub-regulation (1)

8. Filing of micro insurance product design

1) Every insurer shall be subject to the "File and use" procedure with respect to filing of microinsurance products with the Authority
2) Every microinsurance product which is cleared by the Authority for the purpose of microinsurance shall prominently carry the caption "Microinsurance product"

9. Issuance of microinsurance policy contracts

1) Every insurer shall issue insurance contracts to the individual microinsurance policyholders in the vernacular language which is simple and easily understood by the policyholders

   Provided that where issuance of policy contracts in the vernacular language is not possible, the insurer shall as far as possible issue a detailed write-up about the policy details in the vernacular language

2) Every insurer shall issue insurance contract to the group micro insurance policyholder in an unalterable from along with a schedule showing the details of individuals covered under the group, and also issue a separate certificate, to each such individual evidencing proof of insurance, containing details of validity period of cover, name of the nominee, and addresses of the underwriting office and the servicing office, where both offices are not the same

10. Underwriting

No insurer shall authorize any microinsurance agent or any other outsider to underwrite any insurance proposal for the purpose of granting insurance cover

11. Capacity building

Every insurer shall impart at least twenty-four hours of training at its expense through its designated officer(s) in the local vernacular language to all microinsurance agents and their specified persons in the area of insurance selling, policyholder servicing and claims administration

12. Remuneration/commission

1) A microinsurance agent may be paid, remuneration for all the functions rendered as outlined in regulation 5 and including commission, by an insurer, and that the same shall not exceed the limits as stated below:

   (a) For Life Insurance Business
   Single premium policies - Ten per cent of the single premium
   Non single premium policies - Twenty per cent of the premium for all the years of the premium paying term

   (b) For General Insurance Business - Fifteen per cent of the premium

2) Where the agreement between the microinsurance agent and insurer is terminated for any reason whatsoever, no future commission/ remuneration shall be payable

3) For group insurance products, the insurer may decide the commission subject to the overall limit as specified in sub-regulation (1)

13. Overall compliance

Every insurer shall ensure that all transactions in connection with micro insurance business are in accordance with the provisions of the Act, the Insurance Regulatory and Development Act (41 of 1999), and the rules and regulations made there under

14. Submission of information

Every insurer shall furnish information in respect of microinsurance business in such form and manner and containing such particulars, as may be required by the Authority from time to time

15. Obligations to Rural and Social Sectors

1) All microinsurance policies may be reckoned for the purpose of fulfillment of social obligations by an insurer pursuant to the provisions of the Act and the regulations made there under

2) Where a microinsurance policy is issued in a rural area and falls under the definition of social sector, such policy may be reckoned for both under rural and social obligations separately

16. Handling of complaints/ grievances

1) It shall be the responsibility of the insurer to handle and dispose of complaints against a microinsurance agent with speed and promptitude

2) Every insurer shall send a quarterly report to the Authority regarding the handling of complaints/ grievances against the microinsurance agents and where in a particular quarter, there are no complaints/grievances, a "Nil" report shall be sent

17. Inspection by Authority

The Authority may cause inspection of the office and records of any micro insurance agent, at any time, if it is deemed necessary

18. Removal of difficulties

Where any doubt or difficulty arises in giving effect to the provisions any of these regulations, the same may be deferred to the Authority, whose decision thereon shall be binding on the parties concerned

SCHEDULE I
(See regulation 2(d))

	Type of Cover	Min. Am Cover	Max. Am. Cover	Min Term of Cover	Max Term of Cover	Min Age Of Entry	Max Age Of Entry
1	Dwellings or contents, or livestock or tools or other named assets / or crop insurance	Rs 5,000	Rs 30,000	1 year	1 year	NA	NA
2	Health insurance (individual)	Rs 5,000	Rs 30,000	1 year	1 year	Insurer's discretion	
3	Health insurance (family) – (option to avail limit for indiv/float on family)	Rs 10,000	Rs 30,000	1 year	1 year	Insurer's discretion	
4	Personal accident (per life/ earning member of the family	Rs 10,000	Rs 50,000	1 year	1 year	5	70

Note : The minimum number of members comprising a group shall be at least twenty for group insurance

SCHEDULE II
(See regulation 2(e))

	Type of Cover	Min. Am Cover	Max. Am. Cover	Min Term of Cover	Max Term of Cover	Min Age Of Entry	Max Age Of Entry
1	Term insurance with or without return or premium	Rs 5,000	Rs 50,000	5 years	15 years	18	60
2	Endowment insurance	Rs 5,000	Rs 30,000	5 year	15 years	18	60
3	Health insurance (individual)	Rs 5,000	Rs 30,000	1 year	7 years	Insurer's discretion	
4	Health insurance (family)	Rs 10,000	Rs 30,000	1 year	7 years	Insurer's discretion	
5	Accident benefit as rider	Rs 10,000	Rs 50,000	5 years	15 years	18	60

Note 1: Group insurance products may be renewable on a yearly basis
Note 2: The minimum number of members comprising a group shall be at least twenty for group insurance

Reducing poverty requires not just the generation of income among the poor, but also the protection of these incomes. Microinsurance offers innovative new ways to combat poverty in India through helping the rural poor systematically manage financial risks to their livelihoods and lives, this powerful study shows. And the microinsurance industry is poised to take off, just as microcredit did a decade ago: 90 percent of the Indian population – some 950 million people – are not covered by insurance and represent an untapped market of nearly US$2 billion. This enormous "missing market" is ready for customized life and non-life insurance, but first, serious mismatches between the needs of the insured and the insurers must be overcome, pitting priorities against profits. The study strategically points to the numerous emerging opportunities for energizing the rural insurance market, building on robust economic growth, increasing numbers of rural entrepreneurs and recent insurance regulations. Conclusions are based on new evidence from three states in India – each with a population the size of some countries – which also has policy relevance across the Asia-Pacific region and beyond. The study presents concrete recommendations for insurers, authorities and community-based organizations alike in order to realize the potential of this latent market. In so doing, it opens the way for a "win-win" situation from catalyzing microinsurance, combining the double bottom line of commercial viability with social benefits, clearly demonstrating the potential for a public-private partnership.

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