

Microfinance Bulletin

Mozambique Microfinance Facility

A Brief Introduction to Microinsurance

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Microinsurance is insurance for the poor. Of the three billion people who live on less than US\$2 a day, fewer than 10 million currently have access to insurance. Insurance companies have traditionally assumed that the poor are not interested in buying insurance and that they would not make profitable clients.

Microinsurance is not charity. The growth of the microfinance (small loans, savings and remittances) industry since the mid-1970s has shown that there is a strong demand for financial services in low income groups. The development of microinsurance can be seen as a natural evolution of the microfinance sector.

The most common microinsurance product is credit life insurance (loan principal and interest is paid on the death of the borrower, often also includes a benefit payment

for funeral expenses). The health microinsurance market is growing and the property (protection of household assets) microinsurance sector, though small, is also expand-



ing. Other products include disability coverage (for loans) and crop insurance.

One difference between traditional insurance and microinsurance is that the amounts involved (premiums and benefits) are much smaller in microinsurance. Another key difference is that microinsurance products need to be made easier to understand than traditional products because the poor are not familiar with insurance concepts.

In Section II we highlight

some best practices in the field of microinsurance; Section III examines three case studies - one involves credit life insurance, another involves multiple insurance products

and the third deals with health insurance. Finally, Section IV briefly discusses the issue of Islamic insurance.

II. Best Practices

Microinsurance is still a fairly new field and it is too early to draw many conclusions. But the following observations can be made:

1. *Most—but not all—successful microinsurance programs use the partner-agent model*

Insurance is a different busi-

ness from other microfinance services. Simply adding insurance as another product has caused problems for microfinance institutions (MFIs). In the partner-agent model the MFI (agent) works with a regulated insurer (partner). The MFI collects premiums from the client and passes it on (less commission) to the insurer. The MFI also pays any claims that are made by the client and is reimbursed by the insurance company.

This model is effective as the MFI acts as a distribution channel making it possible for the insurer to reach a market that would be very difficult to serve on its own. The MFI's clients are able to access insurance coverage that is priced and managed by professionals.

2. In the partner-agent model the MFI must fight for the interests of its clients

The insurance company typically has little knowledge of the economic needs of the poor. The poor typically know little about insurance. It is vital that the MFI ensures that the insurance products being developed fit the needs of its clients and are easy to understand, that the claims process is efficient and that clients are educated about insurance.



3. The MFI must understand that different insurance products are different

Credit life insurance is a relatively simple product and some MFIs have successfully offered this product without partnering with an insurance company.

Health insurance is far more complex. From a review of the literature, it appears that there are very few success stories of health microinsurance where the schemes are viable based on the income received from policyholders and users. The question then is how to design a sustainable health care delivery model (including insurance) that serves the poor over the long term.

4. Government regulation is important

Government regulations should encourage or even mandate participation of formal insurance sector. For example, private insurers in India are compelled to sell a percentage of their policies to disadvantaged persons. This requirement has generated massive pressure on insurers to sell microinsurance and has stimulated some significant innovations.

III. Selected Case Studies

Case Study 1—Zambia (Credit life and funeral cover insurance)

Madison Insurance Zambia is one of only two regulated private insurers in Zambia that reach the low income market in partnership with MFIs. Madison works with four MFIs: PULSE, PRIDE Zambia, FINCA Zambia and CETZAM Opportunity Microfinance. They all offer similar insurance products - mandatory credit life and funeral cover - with minor variations. Over 100,000 people are covered and the program is a profitable one both for Madison and the MFIs.

Lessons learned in case study 1

CETZAM and PULSE both deduct premium payments from the loan amounts along



with other loan fees. As a result, clients perceive insurance as a cost for acquiring a loan - in fact, a much higher cost than it actually is. Focus group discussion showed that most clients have little understanding of insurance features and benefits.

Before insurance was introduced, potential borrowers were more likely to be screened for HIV/AIDS; now there is less concern about screening as long as members appear physically healthy. Microinsurance is therefore facilitating access to loans by HIV patients who are not yet in a critical condition.

Case Study 2—India (Life, health, livestock and hut insurance)

Shepherd (Self Help Promotion for Health and Rural Development) is a relatively small MFI offering a wide range of insurance products (life, health, livestock and hut (house) fire) in partnership with different insurers with

the intention of providing its customers (all women) with comprehensive social protection. Insurance is not linked to loans. Over 10,000 people are covered by life policies, about 5,000 have health policies and more than 200 livestock policies are currently in-force. The insurers have indicated that they just want to break even with their microinsurance policies and set premiums accordingly.

Lessons learned in case study 2

Claims processing is a potential weak link in the partner-agent model: processing can take months, claims can be rejected for reasons that are not clear to the client and there may be problems cashing payouts because the beneficiary is a minor or does not have a savings account.

For women to benefit from life insurance, the coverage should be on the lives of their husbands; however, adverse selection problems can emerge if this is done without

screening or age restrictions.

Case Study 3—Bangladesh (Health insurance)

BRAC's Micro Health Insurance for Poor Rural Women in Bangladesh (BRAC MHIB) program is open to all poor families living in its two areas of operation. BRAC MHIB provides free treatment to the poor and destitute (non-members pay a fee) and covers over 40,000 people. The program is not viable without a subsidy.

Grameen Kalyan's health scheme is open to all Grameen Bank borrowers and their families as well as to poor villagers living within 8km of a GK health centre. GK does not provide any free health care service. GK covers about 300,000 people, has an operating loss but a net surplus after investment income.

Lessons learned in case study 3

Large membership is desirable in any health microinsurance scheme. It brings economy of

scale and covers the administrative overheads of large branch networks.

Poor people do not normally have a concept of risk pooling and are skeptical of a scheme in which payments come first with no immediate return. They are normally reluctant to part with funds before a health problem arises.

The strategy to serve the community at large and to charge higher rates to the less poor allowing for cross-subsidisation has some merit and should be explored in more detail.

IV. Islamic Insurance (Takaful)

Insurance penetration in many Islamic countries is low. This is because conventional insurance contains elements contradictory to Islamic principles, namely uncertainty (gharar), gambling (maisir) and interest (riba). Takaful is the form of insurance deemed permissible for Muslims under Sharia (Islamic) Law. The first takaful insurer, the Islamic Insurance Company of Sudan, was established in 1979; there are now about 50 takaful companies around the world, mostly in Arab countries. Malaysia is the only country with a specific takaful law.

The fundamental philosophy of takaful is the same as that of the cooperative with added restrictions on investments and more flexibility on capital formation. The first ever seminar bringing together the cooperative/mutual insurance movement and the takaful movement was held in Tunisia in May 2004.



Insurance

Endnotes & References

¹ The Microinsurance Resource Center section of <http://www.microfinancegateway.org>

Section II is drawn from *Preliminary Donor Guidelines for Supporting Microinsurance* (October 2003) and the case studies that appear in this section.

The three case studies in Section III are summaries of Case Study No. 10 (May 2005), Case Study No. 15 (September 2005) and Case Study No. 13 (September 2005).

Section IV is based on material in *Insurance and Poverty Alleviation* by Sabbir Patel (January 2002) which can be accessed in the Development section of the International Cooperative and Mutual Insurance Federation (ICMIF) website, <http://www.icmif.org>

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