2 Review of Literature

2.1 About Insurance
2.2 About Microinsurance
2.3 Why study Microinsurance?
2.4 Influence of the Marketing Mix decisions of the firm
2.1 About Insurance

2.1.1 Basic Concepts
Before we study Microinsurance, let us first understand what Insurance is. Albrecht (1992) sees the insurance product as a transfer of information and conditional payments from the insurance company to the customer and, at the same time, a transfer of risks and a monetary premium vice versa, as shown in the following figure 2.1:

![Insurance as a Transfer of Risk and Information](image)

The insurance company sells specific information regarding the insured object to the customer. The information consists of the guarantee to pay a monetary equivalent for the object insured in case a defined event (accident, fire, etc.) occurs. The customer pays a certain premium and transfers the risk of having a monetary disadvantage due to potential damage to the insurance company.¹

Security is a fundamental need of all human beings and need for insurance arises from this basic need. Black and Skipper (1994) say that the study of human history and civilization reveals a universal desire for security. According to them, the quest for security has been one of the most potent motivating forces in their material and cultural growth. They say that the early societies relied on family and tribe cohesiveness for their security. With the

economic progress, however, this security source weakens. Insurance, thus is a universal response to societies’ quest for security.

Insurance, as is known today, did not exist in ancient or medieval times, although practices having important elements of insurance existed. From the standpoint of the individual, the most important element of insurance is a total or partial relief from the potential burden of financial loss, commonly known as transfer of risk.²

What would consumers do, if they did not take up insurance? According to Data Monitor (November 2009), “Consumers can adopt risk management strategies such as ‘Self-Insurance’ whereby an eligible risk is retained, but a calculated amount of money is set aside to compensate for the potential future loss. However savings are not a sure way to guarantee protection in the same way that insurance can, thus reducing the benefit of this option”.³

In today’s world, Insurance is the best ‘bet’ against any future insecurity. Ponreka and Rao (2009) claim that Insurance is the best form of fortification against risk that has been formulated by man. Since its emergence, insurance has become unavoidable to every aspect of human life from health disorders to building properties, from household articles to multimillion - dollar projects.⁴

There cannot be two opinions about the necessity of insurance in the world we live in today. A UNDP report (2007) says that a well developed insurance sector has both micro 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 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.⁵

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2.1.2 A Brief History of Insurance in India

The concept of insurance in India is not new and it has been in existence for almost two centuries. According to Dr P.K. Gupta (2004), "The first Indian Life Insurance Company – The Oriental Life Insurance Company was established in Kolkata in 1818 followed by Bombay Life Assurance Company in 1823."

But, Insurance in India has had a chequered history. Though the sector quickly grew to 250 companies, it was plagued by unethical practices by some companies when the government decided to regulate the sector. The Indian Life Assurance Act, 1912 and later The Indian Insurance Companies Act 1938 were the first measures to regulate the insurance industry. Dr. Gupta (2004) says that "the regulations were further consolidated in 1938 by the Insurance Act, 1938. The act was further amended in 1950 resulting in far reaching changes in the insurance sector."

Post independence, the insurance industry saw a drastic change. According to Dr Gupta, "by 1956, 154 Indian insurers, 16 foreign insurers and 75 provident societies were carrying on life insurance business in India. Life insurance business was concentrated in urban areas and confined to the higher strata of the society (Gupta, 2004). On January 19, 1956, the management of life insurance business of 245 Indian and foreign insurers and provident societies then operating in India was taken over by the Central Government and Life Insurance Corporation (LIC) was formed as a statutory body."

The monopoly of LIC continued till 1999 when the government passed the Insurance Regulatory and Development Authority bill on the recommendation of the Malhotra Committee. IRDA's mandate is to carry out a developmental role for insurance regulation in response to the Indian society's socio-economic and political aspirations. IRDA has an overwhelming task — to establish and promote fair competition, promote sustainable growth of the sector and finally support national economic growth. It has also to look in to the availability and affordability of insurance services. The passing of the IRDA bill changed the landscape of insurance sector in the country. Private
players were once again allowed to operate and compete directly with the state run LIC.\textsuperscript{6}

**Some of the important milestones in the life insurance business in India are:**

1818: Oriental Life Insurance Company, the first life insurance company on Indian soil started functioning.
1870: Bombay Mutual Life Assurance Society, the first Indian life insurance company started its business.
1912: The Indian Life Assurance Companies Act enacted as the first statute to regulate the life insurance business.
1928: The Indian Insurance Companies Act enacted to enable the government to collect statistical information about both life and non-life insurance businesses.
1938: Earlier legislation consolidated and amended to by the Insurance Act with the objective of protecting the interests of the insuring public.
1956: 245 Indian and foreign insurers and provident societies are taken over by the central government and nationalised. LIC formed by an Act of Parliament, viz. LIC Act, 1956, with a capital contribution of Rs. 5 crore from the Government of India.

The General insurance business in India, on the other hand, can trace its roots to the Triton Insurance Company Ltd., the first general insurance company established in the year 1850 in Calcutta by the British.

**Some of the important milestones in the general insurance business in India are:**

1907: The Indian Mercantile Insurance Ltd. set up, the first company to transact all classes of general insurance business.
1957: General Insurance Council, a wing of the Insurance Association of India, frames a code of conduct for ensuring fair conduct and sound business practices.
1968: The Insurance Act amended to regulate investments and set minimum solvency margins and the Tariff Advisory Committee set up.


Figure 2.1

TOP TEN COUNTRIES IN NONLIFE AND LIFE INSURANCE IN EMERGING MARKETS, 2007

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<tr>
<td>1</td>
<td>China</td>
<td>$33,810</td>
<td>17.0%</td>
<td>China</td>
<td>$56,673</td>
<td>26.4%</td>
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<td>2</td>
<td>Russia</td>
<td>28,973</td>
<td>14.6</td>
<td>India</td>
<td>51,322</td>
<td>23.0</td>
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<tr>
<td>3</td>
<td>Brazil</td>
<td>20,501</td>
<td>10.3</td>
<td>South Africa</td>
<td>34,430</td>
<td>15.5</td>
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<tr>
<td>4</td>
<td>Mexico</td>
<td>9,763</td>
<td>4.9</td>
<td>Brazil</td>
<td>18,533</td>
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<td>South Africa</td>
<td>8,345</td>
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<td>Poland</td>
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<td>7</td>
<td>India</td>
<td>7,402</td>
<td>3.7</td>
<td>Malaysia</td>
<td>5,573</td>
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<td>8</td>
<td>Turkey</td>
<td>7,201</td>
<td>3.6</td>
<td>Indonesia</td>
<td>4,728</td>
<td>2.1</td>
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<tr>
<td>9</td>
<td>Venezuela</td>
<td>6,977</td>
<td>3.5</td>
<td>Thailand</td>
<td>4,521</td>
<td>2.0</td>
</tr>
<tr>
<td>10</td>
<td>Argentina</td>
<td>4,471</td>
<td>2.2</td>
<td>Chile</td>
<td>3,792</td>
<td>1.7</td>
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<td></td>
<td>Total, Top 10</td>
<td>$129,619</td>
<td>68.0%</td>
<td>Total, Top 10</td>
<td>$197,177</td>
<td>88.6%</td>
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Source: Swiss RE in Sigma No 5/2008

The huge Indian market combined with the entrepreneurial spirit of the private players and the regulatory regime of the IRDA has made insurance as a 'sunshine' sector in the Indian economy. According to Data Monitor (2009), The Indian insurance market grew by 8.2% in 2008 to reach a gross premium income of $57 billion. In 2013, the Indian insurance market is forecast to have a gross premium income of $103.2 billion, an increase of 81.2% since 2008. Life insurance dominated the Indian insurance market in 2008, generating 87.3% of the market's overall gross premium income and Non-life insurance

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generated 12.7% of the market's gross premium income. India accounts for 6.7% of the Asia-Pacific insurance market's gross premium income.8

The market situation of insurance in India as explained in the same report says that “Overall the threat of substitutes to the Indian insurance market is weak. The Indian insurance market is heavily concentrated. Despite liberalization, the market is dominated heavily by the former state owned Life Insurance Corporation of India Additionally the presence of international incumbents as well as the sheer number of companies operating within the market, increases the level of rivalry. The entry barriers, though not insignificant, are lower than exit barriers.”9

While insurance seems to be on a major ‘bull run’ in India, it is still a privilege of the upper and middle classes, particularly in the urban areas. The rural and the lower income people are ironically left behind in this business of providing security. Subir Ghosh (2008), while explaining the concept of rural insurance says that rural insurance helps to safeguard rural income against probable danger involved in rural activities. Insurance business is spreading mainly in urban areas. But in rural areas, income generating activities like agricultural operations, livestock productions etc. for survival of human being are very much dependent on various unpredictable factors or risks like flood, drought, storm, earthquake etc. Therefore rural activities need protection and should come under insurance coverage. In this context, the concerned government either should provide protection to the rural people directly or should encourage private or foreign insurers to bring the rural population under the insurance coverage in safeguarding their income.10

The concept of insurance for the poor may seem to be the solution for all the ills of the poor population; it has to be applied very cautiously. Not every one categorized as poor can be the immediate target for insurance. The ‘poorest of the poor’ have little to lose in their life. Even the UNDP report (2007)

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suggests that while the utility of insurance for the poor is evident, market based insurance may not be immediately applicable for all categories of Bottom of the Pyramid (BOP) population. Its potential is likely to be greater for those with income streams and assets to protect, at least in early days of market development.  

Thus we see how insurance has evolved in India and the gaps in the form of rural insurance or insurance for the poor that the industry needs to fill. These gaps are basically the social obligations of the insurance industry. The IRDA, as discussed earlier has done a fantastic job of developing this sector in the country. The IRDA has taken concrete steps in ensuring that the insurance companies fulfill their social obligations. These are sought to be done through compulsory regulation and promotion of microinsurance. In the next section we shall look at the concept of microinsurance.

If insurance plays such a role in the society, then it is important to learn how it works. Listed below are the basic principles of insurance which every insurance company follows. This is important for our study as many SHG’s and NGO’s who want to get into this business should know them to be successful in their endeavor.

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2.1.3 Principles of Insurance

According to insure.org\textsuperscript{12} and Rochester Investment Consulting Pvt. Ltd\textsuperscript{13}, commercially insurable risks typically share seven common characteristics.

1. **A large number of homogeneous exposure units.** The vast majority of insurance policies are provided for individual members of very large classes. The existence of a large number of homogeneous exposure units allows insurers to benefit from the so-called “law of large numbers,” which in effect states that as the number of exposure units increases, the actual results are increasingly likely to become close to expected results.

2. **Definite Loss.** The event that gives rise to the loss that is subject to insurance should, at least in principle, take place at a known time, in a known place, and from a known cause. The classic example is death of an insured on a life insurance policy. Fire, automobile accidents, and worker injuries may all easily meet this criterion. Ideally, the time, place and cause of a loss should be clear enough that a reasonable person, with sufficient information, could objectively verify all three elements.

3. **Accidental Loss.** The event that constitutes the trigger of a claim should be fortuitous, or at least outside the control of the beneficiary of the insurance. The loss should be ‘pure,’ in the sense that it results from an event for which there is only the opportunity for cost. Events that contain speculative elements, such as ordinary business risks, are generally not considered insurable.

4. **Large Loss.** The size of the loss must be meaningful from the perspective of the insured. Insurance premiums need to cover both the expected cost of losses, plus the cost of issuing and administering the policy, adjusting losses, and supplying the capital needed to reasonably assure that the insurer will be able to pay claims. For small losses these latter costs may be several times the size of the expected cost of losses. There is little point in paying such costs unless the protection offered has real value to a buyer.

\textsuperscript{12} http://insure.org.in/articles/74739/Insurability
\textsuperscript{13} www.rochester.com
5. **Affordable Premium.** If the likelihood of an insured event is so high, or the cost of the event so large, that the resulting premium is large relative to the amount of protection offered, it is not likely that anyone will buy insurance, even if on offer. Further, as the accounting profession formally recognizes in financial accounting standards, the premium cannot be so large that there is not a reasonable chance of a significant loss to the insurer. If there is no such chance of loss, the transaction may have the form of insurance, but not the substance.

6. **Calculable Loss.** There are two elements that must be at least estimable, if not formally calculable: the probability of loss, and the attendant cost. Probability of loss is generally an empirical exercise, while cost has more to do with the ability of a reasonable person in possession of a copy of the insurance policy and a proof of loss associated with a claim presented under that policy to make a reasonably definite and objective evaluation of the amount of the loss recoverable as a result of the claim.

7. **Limited risk of catastrophically large losses.** The essential risk is often aggregation. If the same event can cause losses to numerous policyholders of the same insurer, the ability of that insurer to issue policies becomes constrained, not by factors surrounding the individual characteristics of a given policyholder, but by the factors surrounding the sum of all policyholders so exposed. Typically, insurers prefer to limit their exposure to a loss from a single event to some small portion of their capital base. Where the loss can be aggregated, or an individual policy could produce exceptionally large claims, the capital constraint will restrict an insurers appetite for additional policyholders. The classic example is earthquake insurance, where the ability of an underwriter to issue a new policy depends on the number and size of the policies that it has already underwritten. In extreme cases, the aggregation can affect the entire industry, since the combined capital of insurers and reinsurers can be small compared to the needs of potential policyholders in areas exposed to aggregation risk.
2.2 About Microinsurance

2.2.1 Basic Concepts
As seen in the earlier section, insurance is a pro-active action to deal with any unforeseen eventuality. The insured person does not wait for the event to happen and then find out ways and means to deal with the situation. “Insurance is an ex ante risk management tool through which individuals and businesses hedge potential financial losses in exchange for fixed premium payments”.

While microinsurance is defined as “a set of market based insurance products and processes designed to address both life and non-life risks faced by the people at the bottom of the socio-economic pyramid (BoP)”. 

The key words here are: ‘Market based’ and ‘Bottom of the Pyramid’. In effect, Microinsurance is like any other financial product which depends on the vagaries of the market where the market is the ‘Bottom of the Pyramid’. Thus we see that the difference between insurance and microinsurance is the customer segment that the company chooses to target. “The difference between microinsurance and regular insurance is that microinsurance is available to those who have social or business affiliations with much smaller groups”.

Though insurance is an age old business, microinsurance is a recent phenomenon. Markus Loewe (2006) has described Micro-insurance as “a rather new concept, which emanated just a few years ago”. The concept evolved as a result of efforts from the self help groups and efforts of insurance companies and micro finance institutions.

Markus Loewe (2006) sees microinsurance emanating almost simultaneously from two different sources in practice: a bottom-up and a top-down approach. The bottom-approach is that of the self help groups and NGO’s. The top-

down approach is the one followed by insurance companies and microfinance institutions. In the former approach, many self-help groups were considering what their members could do to support one another more effectively in their risk management efforts. In the later approach, Microfinance institutions, on the other hand, were reflecting how they could (i) broaden their product portfolio, (ii) tap additional sources of finance for their credit lines and, at the same time, (iii) protect themselves against loan repayment failure stemming from the occurrence of risks on the side of their clients. They found out that micro-insurance can be instrumental for all these three goals.”

Thus came in to existence a very potent tool for the social and economic development of the dispossessed. But microinsurance is more of a broad concept or philosophy than a specific insurance scheme. Consequently, its definition too remains very broad. The definition(s) of microinsurance talks about who are the beneficiaries and what it does without detailing the specific premium limits or coverage amount. Christina Blanchard-Horan and Michael J. McCord (2007) explain the concept of Microinsurance as “Microinsurance, in general, is the protection of low-income people against specific perils in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved. Low-income people can use microinsurance, where it is available, as one of several tools to manage risks.”

The Insurance Information Institute traces the origin of microinsurance to the microfinance projects revolutionized by Bangladeshi Nobel Prize-winning banker and economist Muhammad Yunus, which helped millions of low-income individuals in Asia and Africa to set up businesses and buy houses”. More on the relationship between microinsurance and microfinance is covered in section 2.6

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18 Insurance Information Institute
Microinsurance has the ability to change the economic condition of millions of people. While insurance companies target only those who can pay easily, Microinsurance targets those who need it the most, i.e. those at the bottom of the pyramid. The population at this segment is just about making ends meet. Micro insurance is a risk protection made particularly for the Bottom of the Pyramid.

According to Chandhok (2009), Micro insurance is a vital tool to eliminate poverty, as the logic behind it is that it helps to climb the economic ladder. It is designed specifically for the poor in developing countries, who are either self employed or employed in small firms and do not have access to insurance products. The people BPL (below poverty line) need financial tools to protect themselves and their families against perils like illness, death, weather etc.¹⁹

The Insurance Information Institute explains the fundamental behind microinsurance, “A number of insurance companies are seeking to tap markets in developing countries through "microinsurance" projects, which provide low cost insurance to individuals generally not covered by traditional insurance or government programs. Microinsurance products tend to be much less costly than traditional products, and thus, extend protection to a much wider market.”²⁰

Ahuja (2005) explains microinsurance as “Micro-insurance is relatively a new term referring to insurance services that are specifically aimed for the poor, delivered through a nodal agency (as in the case of micro-credit), which involves modest premium and coverage amount. Micro-insurance is also referred to as community based insurance.

The ILO (International Labour Organization) Report (2000) defines micro-insurance schemes as those set up by self-employed and informal economy workers to meet their priority social protection needs. Generally, these

²⁰ Insurance Information Institute
schemes work on the principle of cooperation or mutual help, through pooling the resources for the larger benefit of the society.  

Jacquier Christian et al (2006) see microinsurance as one instrument which can be used to extend social protection to the excluded. They say that it is particularly relevant in situations where governments lack the resources and capacity to provide social protection. Even in situations where the resources are available, if governments support microinsurance as a social protection mechanism, like in Columbia, it may be a more efficient means of social protection than services provided entirely by the government.

Mosleh (2005) clarifies the entire concept of microinsurance as follows:

**Microinsurance is**

- Community risk pooling
- Protecting the poor from shocks of life & death
- Business opportunity for insurance companies.

**Microinsurance is not:**

- Charity
- Savings & Credit risk prevention
- A small insurance company
- Just another product offered by MFIs
- A “magic bullet” and a cure for all problems of the poor people

Thus, microinsurance is a win-win proposition that benefits all the stakeholders like:

- The excluded population
- The insurance companies
- The government
- The society as a whole

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\(^{23}\) Mosleh,UA. “Going Beyong Microcredit, Microinsurance”, *Building Sustainable Microfinance in RBEC*, Community of Practice Workshop, Almaty, Kazakhstan, 9 – 11 November, 2005
Microinsurance caters to life insurance and Health insurance needs of the rural and weaker section of the society. Health microinsurance is of particular interest as without a health insurance, the poor are pushed into the cycle of poverty. Describing the characteristics of Health Microinsurance, Christina Blanchard-Horan and Michael J. McCord (2007) say that Health microinsurance is the application of microinsurance principles to health care financing for the poor. Health microinsurance is not simply downscaled products from the wealthier markets but it is the development of new products that respond to the specific needs of the low-income market in terms of: coverage, delivery mechanisms, premium setting (because the low-income markets experience different risks than the wealthy market).

Health microinsurance schemes offer a way for low-income and economically vulnerable people to pay for protection and to manage risk against health crises. Schemes involve insurance products that are designed for a low-income market. In this way, health microinsurance as an alternative health financing mechanism attempts to improve quality of healthcare by improving access and reducing vulnerability to healthcare crisis.

Health microinsurance is relatively new alternative health financing concept. However, it is a growing phenomenon that began in the 1970s and has grown to penetrate systems in at least 26 countries on three continents. Results from an analysis of an ILO working paper, Health Micro-insurance: A Compendium, indicated that HMI schemes were developing as early as 1975. The authors, Blanchard-Horan and McCord (2007) identify the first community insurance scheme as developing in one community of Bangladesh. From 1975 until approximately 1993, the number of schemes in Bangladesh increased at the rate of one to two new schemes every one to two years. The mid-80s saw a surge in the development of community-based health microinsurance schemes in Asia, including a rather large program developed in 1987 in the Philippines in 1987.  

Health insurance seems to be the flavor of the month and one sees many organizations trying to jump into the bandwagon without understanding the real implications. Many of them seem to think that health insurance is panacea for all evils in the health system. One forgets that health insurance is just a health financing mechanism. It has some specific roles. One should not expect miracles by changing over to a health insurance system.25

Community-based health microinsurance schemes began developing in Africa in the late 1980s to late-1990s. In the mid-1990s, Latin America saw a rise in the number of community-based schemes serving low-income communities. Today there are schemes in 10 Latin American countries, according to the 2000 ILO report. Even though the number of health microinsurance schemes has doubled in the past decade, they were only marginally considered as alternatives financing strategies until the past 10 years. In fact, as early as 1996, discussions about alternative strategies for improving healthcare services included only limited references to health microinsurance schemes.26

The importance of microinsurance is thus well understood, but that is not sufficient to implement it on a mass scale. There are challenges that need to be addressed before we can see it reaching the intended masses. Primarily, one ought to take note of the priorities of the different stakeholders. The core issue is the gap in perspectives between the insured and the insurers.

For the rural poor, a product should fulfill needs and be affordable. When both 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. They also need to be 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.

25 Devdasan,N. Community Health Insurances in India, Lessons Learnt, Friends of Women World Banking, India, 2005, Page 89,90
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.27

It would be worthwhile to study some cases where microinsurance schemes were in force. Dr. N Devdasan, reviewed the following ten community health insurance schemes by NGOs:

- ACCORD (Action for Community Organisation, Rehabilitation and Development)
- DHAN (Development of Humane Action)
- SEWA (Self Employed Women’s Association)
- BAIF (Bhartiya Agro Industries Foundation)
- YESHASVINI
- RAHA (Raigarh Ambikapur Health Association)
- SHH (Students Health Home)
- MGIMS (Mahatma Gandhi Institute of Medical Science)
- KARUNA
- VHS (Voluntary Health Services)

According to Devdasan, “When one reviews the ten schemes, one notes that the predominant reason for introducing health insurance is to improve access to health care by removing the financial barriers. Some organizations (especially the recently started CHIs) also felt that health care costs were high and were impoverishing the communities. So they started the CHIs to protect the patients from these catastrophic health expenditures. Some of the older CHIs started health insurance as a measure to increase solidarity among their community, to enhance the feeling of ‘oneness’ and mutual support during disaster. And finally, some of the CHIs hoped to use health insurance as a tool to increase the involvement of the community in their own health care.”

They felt that when people contribute, they will have more stakes in improving the system and will participate in decision making.  

Most of the CHIs have used existing community organizations to implement the health insurance schemes, be it self-help groups, unions or cooperatives. This is an effective and efficient way to develop a CHI and the potential is enormous e.g. hospitals/NGOs could piggyback insurance programmes on existing local trade unions, cooperatives, self-help groups or NGO groups.

The success of rural insurance business in India centers around innovative product design, increasing penetration, finding effective and lower-cost distribution channels, education, access and affordability. These requirements may appear daunting, but new approaches are likely to pay dividends to insurers in the long run as the rural economy benefits from the growth being witnessed in the rest of India.

For microinsurance to achieve its potential, and overcome its limitations, it requires a dynamic, three pronged approach:

(i) Bottom-up initiatives: To stimulate the grassroots development of microinsurance, it is necessary to sensitize the general public, policymakers, donors and development agencies, as well as social partners and other social protection actors, about how microinsurance works and its potential contribution to social protection.

(ii) The development of Linkages with government interventions, other microinsurance schemes, healthcare and other service providers, social security institutions, social assistance programmes, etc. can strengthen the sustainability of the schemes as well as enhance their effectiveness.

28 Devdasan, N. Community Health Insurances in India, Lessons Learnt, Friends of Women World Banking, India, 2005, Page 89

29 Devdasan, N. Community Health Insurances in India, Lessons Learnt, Friends of Women World Banking, India, 2005, Page 91

(iii) Top-down efforts: To fulfill its social protection potential, microinsurance must be seen by policymakers and other stakeholders within the broader context of coherent national social protection systems or strategies.  

For microinsurance to provide more people with better services over the long term, current and future risk carriers and delivery channels will need to consider their beliefs, attitudes, values and structure. Given the current dearth of good practices, there appears to be significant room for improvement in this area.

Churchill and Leftley (2006), stress on a solid organization that will ensure success of microinsurance in the market. Accordingly, It should have its own presence in the insurance companies and distribution channels so that people are committed to making it work better. In other words, it should not be relegated to a small department in the organization with little scope or empowerment. Not only should it have a strong presence, it should have top management commitment else everything will remain on paper. Churchill and Leftley (2006) also says that “A greater emphasis must be placed on staff training” and “Compensation and incentives that reward client retention are likely to be more appropriate for microinsurance than incentives strongly linked to sales”.  

Challenges in implementation

One of the main reasons for microinsurance collapse is for lack of sufficient clients. The main sources of market failure are distrust, lack of information, lack of know-how, high transaction costs, lack of financial intermediaries, high drop-out rates, lack of competition and lack of sustainability.  

Alex Weber gives solution to each of these potential factors for Insurance Market Failure. According to him, distrust should be nullified by cooperating with local stakeholders such as village chiefs, public administration, hospitals

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and other local providers, or by teaming up with well known health care providers or organizations such as cooperatives or micro credit institutions. Lack of information has to be dealt with by indulging in social marketing by circulating folders in local dialects or using explanatory drawings instead of written texts, or cooperating with radio and television. Lack of know how can be overcome by taking technical advice from international organizations and donors. Weber further suggests that high transaction cost can be brought down by cooperating with local stakeholders. Lack of cash can be a major issue but there have been few experiments where contribution is accepted in kind instead of cash. Lack of financial intermediaries can be overcome by tying with the banks but high dropout rates are a serious concern. Once again, Weber suggests that involvement of local stakeholders reduces anonymity for the insured there by raising social cost of canceling membership. Competition between health insurers is a way of exercising social control over management. Finally, to overcome sustainability strategies to reduce administrative costs should be adopted like collections by volunteers and getting into a reinsurance agreement.  

2.2.2 Microfinance and Microinsurance

Bhattacharya, et al (2008) have explained how microfinance works. In addressing the problems of rural credit, two aspects deserve close attention: (a) easy access to loans for the poor (both for production and consumption purposes) and (b) financial viability of the lending institutions.

To achieve both these ends simultaneously the idea of social collateral is popularized through the group lending programs. The poor individual, by definition, lacks any asset that can serve as collateral with the lending institutions. However, the poor rural people live in a strong community framework governed by social pressure where the denial of social support would endanger their sheer existence. Under this strong social bondage the use of peer pressure (Stiglitz 1990) may play a positive role in fostering repayment incentives in group-lending programs. This pressure itself acts as a collateral and, unlike financial collateral, this one is not an appropriable asset in the event of default; it is just a device for making default more costly to the borrowers (Besley and Coate 1995). If instead of any particular individual, the loan is granted to a group, then the group as a whole is held responsible for the repayment of the loan and that creates incentives for individual group members to screen and monitor the other group members and to enforce repayment. 35

Siegel, et al (2001 ) demonstrate how the success of Microfinance can be replicated for microinsurance. “MI programs can learn from the experience of MF programs. Credit/finance and insurance markets face similar problems of information asymmetries and other sources of market failure so schemes that address problems such as moral hazard, adverse selection and high transactions costs might be effective for both. MFI innovations such as group lending and mutual enforcement have helped overcome these failures by using social dynamics. In addition, some of the targeting and screening mechanisms used by MFIs to target poor households and identify "good clients" can be applied to MI. Links between MFIs and MI extend to

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institutional and regulatory issues, issues of financial and economic sustainability, and potential for social inclusion and exclusion embodied in MF/MI design.” 36

Dror and Armstrong (2006) too have suggested links between microfinance and microinsurance.”The phenomenon of insuring by or through MIUs is relatively new but by no means negligible. The attraction to deal with MIUs finds its origin in the thought that, just as micro finance enabled poor people to gain access to capital, micro insurance might provide the platform to make health insurance work for the poor. The term “micro insurance” can be found in the literature for the first time in 1999, but other terms have also been used before and since, including community-based health financing schemes, mutual health insurance schemes, etc. In the last few years there has been new published research on the strength of MIUs in gaining clients’ trust, based on the social capital of the group.”

They further add that, “Several inventories of MIUs suggest that they have developed mainly in West Africa, in India, Philippines, and Bangladesh, although quite a few MIUs operate also in other South Asian countries (e.g., Nepal) and elsewhere. Overall outreach is now counted in the millions of insureds. Much of the literature looks at MIUs as health systems: for example, what impact do MIUs have on access to healthcare, or how well do these bodies perform in terms of equality of access among members, their contribution to capturing additional resources for healthcare, on expressed willingness to join and willingness to pay for such health insurance.” 37

Microfinance and microinsurance are very synergistic activities. “MFIs mobilize savings, providing households with fungible financial reserves that can be used to smooth consumption”.

As incomes grow, households are better equipped to manage risk through precautionary savings, asset diversification, and short-term borrowing.


However, in many cases, regulatory restrictions that prevent MFIs from providing savings and thereby restrict the use of savings as a means of risk management. This is one reason that there has been interest by MFIs to consider insurance as an alternative risk management instrument. MFIs are also interested in insurance because microfinance schemes - as often structured - can increase vulnerability of clients via risks of loan default, especially when it ties households into rigid repayment schedules. Risky events can threaten timely loan repayment. Households, rather than suffer social sanctions from default, tend to resort to "bad" coping practices that increase their vulnerability to future losses. Provision of insurance might strengthen and broaden participation in MFI schemes by vulnerable households by increasing their creditworthiness. 38

Siegel (2001) et al establishes the link between Microinsurance and Microfinance. A strong link exists between MF and MI schemes, as the former have piloted many of the latter. Additionally, some MFI's (Micro Finance Institutions) have perceived a demand for increased risk management product that can protect both their clients' and their own interests. The reason for existence of microinsurance was to “Reduce the negative impact of risky events on client's ability to repay loans and serve as a collateral substitute, thereby helping existing clients and expanding coverage to riskier clients”.

Microinsurance also emerged as an additional revenue stream for microfinance institutions. They had a captive audience and all they had to do was cross-sell them the insurance product. Microinsurance provided an additional financial service and source of revenue for the MFI, and therefore (it) improved the financial sustainability of the MFI.

Donors and NGOS are also interested in MI because they want to strengthen existing MFIs, and build upon the perceived successes of MF programs. Also, donors and NGOs have had an important role in facilitating and funding many MFIs. Examples of an MFI providing an insurance product that meets its own and its clients needs simultaneously are "life insurance" and "property insurance", which when offered, are usually mandatory conditions for

receiving loans (Brown and Churchill, 2000). Life insurance is offered by some MFIs, but is often really loan insurance in the event of death, since it guarantees that if the client dies his or her outstanding debts will be repaid, with or without any survivor benefits. In some cases MFIs offer property insurance, but it usually only repays the outstanding balance of a loan used to purchase the insured asset - and not the replacement value or any income losses. In both of these cases, the MI benefits both the client and the MFI, although it might be argued that the MFI is the main beneficiary - since households might still be left vulnerable with respect to their future income earning and risk management potential. A possible problem with linking microinsurance to microfinance loans occurs if a borrower decides not to borrow during a certain period. What happens to their insurance coverage?

Microinsurance is potentially a much more complicated financial instrument than microfinance. Brown (2000) notes: "More so than credit or savings, offering insurance is an inherently risky business (pardon the pun). In order for an insurance scheme to be sustainable, its managers have to be able to predict the future – setting prices for insurance products requires calculations of how many clients will die in the next year (life insurance) or the value of assets lost, stolen or destroyed (property insurance or the cost of annual medical treatment (health insurance) - and be reasonably accurate on a consistent basis. If these predictions prove to be inaccurate, unexpectedly high insurance claims can quickly decapitalize an institution." Microinsurance is also more prone to corruption and mismanagement because of the nature of insurance – where premiums are collected and held in reserve for future payments. In fact, the history of MFIs offering microinsurance has not been promising (Brown and McCord, 2000)." 39

Product focus-Microinsurance (2007) clearly shows how microfinance works and how microinsurance got a boost from it. "Mexico’s biggest microfinance company has over 573,000 accounts, according to a December 14, 2006 Business Week (New York) story. "There is a ready market for microfinance products in Mexico," says the magazine. A large Mexican retailer that

participates actively in the Mexican microfinance market has made over US$1.8-billion in small loans to regular customers. The success of the loan business has not been lost on Mexican insurers who have traditionally sold costly policies to upper income segment Mexican consumers. Some of the better know names are actively considering offering very small insurance policies using micro credit. One insurance executive quoted in the Business Week story told the magazine, "To date we have found that credit is the most important vehicle (to sell microinsurance) because it is the principal need of the people in these segments." Life insurance has commonly been the lead product, but elsewhere in Latin America other innovative microinsurance products are under development. 40

Chandhok (2009) has found out the relationship between Microfinance Institutions and Microinsurance. In India, the BPL (below poverty line) population is more than 400 million people with per capita income below $2 per day at PPP (purchasing power parity) rates. This segment is not covered by insurance of any kind. So, the Governments, insurance companies, MFIs, SHGs, banks, health institutions and Co-operatives can play an important role in propagating insurance to this section of society. MFIs occupy a unique position in providing micro insurance, as they have extensive networks and are already offering financial services to poor clients. In some cases, MFIs link with formal insurance companies and act as agents. MFIs also form joint ventures with formal insurers.

Some MFIs team up with professional insurance providers, who have technical expertise in this area. Micro insurance through its various delivery models can be implemented to popularize insurance and eradicate poverty. In developing countries, it is a tool which is designed for the lower income groups. Micro insurance gives protection to the poor against various risks like life, illness, death, health, disability, property and agriculture. Through micro insurance, poverty can be eradicated, which leads to development in the country. 41

40 Product focus—Microinsurance, MARKET: LATIN AMERICA, MARCH 2007
This research is an effort to understand the market for microinsurance in detail so that the insurance companies can cater to them and the poor will be able to access products that they genuinely need. It will thus benefit the society at large in ensuring an inclusive growth.

What is "Micro" about Microfinance and Microinsurance?

Dror and Jacquier, 1999; Juetting, 1999; Brown, et. al, 2000 clarify that "micro" refers to the type or size of transaction. The terms finance (e.g., credit, savings) or insurance refer to the type of financial instrument. Microfinance (MF) and microinsurance (MI) instruments are designed for low-income households who transact relatively small amounts of financial services. They usually can not directly access formal finance or insurance instruments because of high transactions costs, along with problems of moral hazard and adverse selection, lack of collateral, etc. MF and MI are attempts to aggregate the "micro" clients into a group or association and to simplify the design of the instruments in order to lower transaction costs and other problems using a combination of formal and informal finance and insurance arrangements (see Dror and Jacquier, 1999; Juetting, 1999; Brown, et. al, 2000). 42

Loewe (2006), further states that “the pre fix “micro-” does not hint at low numbers of participants or a limited area covered by the schemes. Just as in the case of micro-credit products, it rather indicates that the contribution rates are affordable for low-income earners, that benefits are there fore limited as well, and that the scheme meets the specific needs of the target group as to the benefit package, the enrolment conditions and the transaction formalities.” 43

Shetty and Veerashekharappa (2009) quoting Dror clarify that micro refers to the small size of a group or volume of transactions and also to the locus of operations at the lowest level of social organizations, just above the family. 44
2.2.3 Who is under the purview of Microinsurance?

Sourav Biswas and Ratna Devi (2008) argue that the poor have always been the victim of circumstances and no amount of state sponsored programs ends up as a benefit to them. Almost everywhere in the world, health services have benefited the rich much more than the poor. Even in programs that were exclusively designed for addressing the health needs of the poor—such as family planning and child nutrition—the better off groups have usually captured the majority of the benefits than the target segments. The poor have always been the losers mainly due to the lack of knowledge and information, lack of awareness about their rights and lack of power. 45

Keeping this in mind, the IRDA, at the time of opening up of the insurance sector to private players, ensured that the poor did not remain out of the purview of insurance. Schedule I of the IRDA Act has amended the Indian Insurance Act 1938 and added Section 32 B, which instructs every insurer to undertake a certain percentage of life and general insurance business in the rural and social sectors, as specified by the authority. (Figure 2.3)

Section 32 C of the Act clarifies that to discharge the obligations under 32 B, the insurers should provide life and general insurance policies to persons residing in rural areas, workers in unorganized and informal sectors, economically vulnerable or backward classes of society or other categories as may be prescribed.

As per the IRDA (2005b), rural sector means places or areas classified as “rural” by the latest decennial Census of India.

Social sector includes unorganized sector, informal sector, economically vulnerable or backward classes and other categories of persons in rural as well as urban areas.

According to this regulation, “Unorganized sector includes self-employed workers such as agricultural laborers, bidi workers, brick kiln workers, carpenters, cobblers, construction workers, fishermen, ‘hamals’, handicraft

 artisans, handloom and khadi workers, lady tailors, leather and tannery workers, papad makers, powerloom workers, physically handicapped self-employed persons, primary milk producers, rickshaw pullers, ‘safai karamcharis’, salt growers, sericulture workers, sugarcane cutters, tendu leaf collectors, toddy tappers, vegetable vendors, washerwomen, working women in hills, or such other categories of persons” [IRDA 2005b].

2.2.4 Micro Insurance around the World
Historically one learns that other countries especially those with predominantly social health insurance (Germany, Belgium, Netherlands, Japan), all started with small ‘sickness funds’ that grew over time and merged with each other to form the current “Mutual Funds” or health insurance companies. Today these are shining examples of equitable and comprehensive health insurance programmes globally. Thus history and international experience is on the side of community health insurance. 46

Siegel et al in their discussion paper for the World Bank say “Some of the best know of such programs include the Grameen Bank in Bangladesh, the Bank Rakyat of Indonesia, and BancoSol in Bolivia (Morduch, 1999; Morduch and Sharma, 2001). Numerous community banks have also emerged, particularly in Latin America. These programs strengthen households' risk management by providing credit to finance new economic activities and adopt new technologies to help raise incomes, and use group dynamics to improve access and lower the costs of this credit”. 47

American International Group Inc. (AIG) was one of the first companies to offer microinsurance and began selling policies in Uganda in 1997. Swiss Re, Munich Re and Zurich Financial Services have also entered the microinsurance arena. A 2008 study by Swiss Re reports that microinsurance is gaining popularity in Latin America, Africa and Asia. 48

46 (191) Dr. N Devdasan, Community Health Insurances in India, Lessons Learnt, Friends of Women World Banking, India, 2005, Page 88
48 Insurance Information Institute
Chandhok (2009) has extensively studied microinsurance around the world. According to her “Micro insurance is driven by microfinance institutions (MFIs), NGOs, Health institutions, Agricultural and Health Co-operatives. MFIs occupy a unique position to provide micro insurance, as they have extensive networks and are already offering financial services to poor clients. In some cases, MFIs link with formal insurance companies and act as agents for the formal insurer, although the insurer retains all the risks. MFIs also form joint ventures with formal insurers and share both risk and management. Some MFIs have good networks among the poor, but they are not technically proficient to provide insurance services. So, they team up with professional insurance providers, who have technical expertise in the area. While MFIs are the organizations through which resources are distributed to BOP, the insurers reach the poor and cover their risks through micro insurance.

Developing countries like India, Uganda, Kenya, Tanzania and Bangladesh have ventured into the field of micro insurance with the help of MFIs, banks, NGOs, donors, health institutions and Cooperatives, focusing on areas like life & endowment cover, accident cover and comprehensive health care. 49

She further goes on to enumerate such exercises in various parts of the world. Note that all such activities are part of the developing countries. In Uganda, the focus of organizations involved in micro insurance has been on group personal accident, comprehensive health care and in-patient care.

• Microcare (comprehensive health care)
• AIG Uganda (group personal accident)
• CIDR (in-patient care)
• Nsambya Hospital Healthcare Programme
• Kitovu Patients Prepayment Scheme (comprehensive health care)

In Kenya, the focus has been on comprehensive health care.

• Mediplus (formal health management organization)
• Community Health Plan (comprehensive health care)

In Tanzania, micro insurance services offered are out-patient health care, medications and comprehensive health care.

- UMASIDA (out-patient health care)
- Poverty Africa (comprehensive health care)
- Community Health Programme (medications & out-patient care)

In Bangladesh and the Philippines, the emphasis has been on life and endowment cover.

- Delta Life insurance company

Philippines:

- CARD Mutual Benefit Association (life and endowment)

In Cambodia, the focus has been on acute and in-patient care.

- CIDR (limited acute and in-patient care)

In India, the focus has been on life, in-patient health care and property.

- SEWA (Small Enterprise Women’s Association) (life, in-patient health care and property),
- LIC, India

In 2006, the then President of India, Dr. APJ Abdul Kalam had launched a Special Scheme for covering the risks of the rural poor through micro insurance by the LIC of India. The CNRI (confederation of NGO’s) was vested with the responsibility of collecting the insurance premia. The Scheme introduced was named ‘Jeevan Madhur. It has been implemented in various states like TN, Kerala, Maharashtra, A.P, Gujarat and U.P. The other details of this Scheme are as follows:

- Value of insurance covered so far: Rs 110 Cr
- No. of people covered initially: 80,000
- Individual amount assured: Rs 5,000 to Rs 30,000
- Mode of payment of premium: weekly or fortnightly • Policy period: 5 years to 15 years  

2.2.5 Current Status & Situation Analysis

There are 205.9 million households in the country in 2004-05, of which 30 percent (61.4 million) lived in urban areas and the rest (144.5 million) in rural areas. The average household in India has an annual income of Rs 65,041

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and an expenditure of Rs. 48,902, leaving it with a surplus of Rs. 16,139 to save and invest. Urban incomes are around 85% higher than rural ones. Incomes of the households are a function of factors like occupation, education and landholdings. The survey found one-fourth of the Indian families (51 million households equivalent to 262 million persons) to be financially vulnerable. In other words incomes of around 25 percent of Indian households are below their total expenditure and these households are unable to meet their needs through the financial resources at their disposal. Approximately three fourths of such households is located in rural India.  

The IRDA annual report 2004-05 sums up the growth of Insurance sector in India. The appraisal of insurance market in the report says that the insurance sector was opened up in the year 1999 facilitating the entry of private players into the industry. With an annual growth rate of 24.31 per cent and the largest number of life insurance policies in force, the potential of the Indian insurance industry is huge. The year 1999 saw a revolution in the Indian insurance sector, as major structural changes took place with the ending of government monopoly and the passage of the Insurance Regulatory and Development Authority (IRDA) Bill, lifting entry restrictions for private players and allowing foreign players to enter the market with some limits on direct foreign ownership. Life insurance penetration in India was less than 1 per cent till 1990-91. During the ‘90s, it was between 1 and 2 per cent and from 2001 it was over 2 per cent. In 2003-04 it was 2.4 per cent. The impetus for increase is due to the active role played by IRDA in licensing private players and taking positive steps in increasing the insurance awareness among the people.

The report further goes on to compare penetration of Insurance in India with that of the world and how the insurance companies are spreading their wings in the wide Indian market. According to the report, “The penetration rates of health and other non-life insurances in India is also well below the international level. These facts indicate immense growth potential of the insurance sector. Since opening up of the insurance sector in 1999, foreign

Investments of Rs. 8.7 billion have poured into the Indian market and 21 private companies have been granted licenses. Innovative products, smart marketing, and aggressive distribution have enabled fledgling private insurance companies to sign up Indian customers faster than anyone expected. Life insurance is viewed as a tax saving device. People are now turning to the private sectors that are providing them with new products and variety for their choice.\textsuperscript{52}

With large population and untapped market, insurance is a big opportunity in India. The insurance business (measured in the context of first year premium) registered an impressive growth of 94.96 per cent in 2006-07, surpassing the growth of 47.94 per cent achieved in 2005-06. This has resulted in increasing insurance penetration in the country. Insurance penetration or premium volume as a ratio of GDP, for the year 2006 stood at 4.10 per cent for life insurance and 0.60 per cent for non-life insurance. The level of penetration, particularly in life insurance, tends to rise as income levels increase. India, with its huge middle class households, has exhibited growth potential for the insurance industry. Saturation of markets in many developed economies has made the Indian market even more attractive for global insurance majors. The insurance market in India has witnessed dynamic changes including presence of a number of insurers in both life and non-life segment.\textsuperscript{53}

\begin{figure}[h]
\centering
\begin{tabular}{|l|l|}
\hline
\textbf{Key market indicators} & \\
\hline
Life and non-life market in India & Rs 181971.61 crores (US$ 41.74 billion) \\
(Total Premium) & \\
\hline
Global Insurance Market & US$ 3723 billion \\
(as on 31\textsuperscript{st} December 2006) & Inflation adjusted growth: 5.0\% \\
\hline
Growth in premium underwritten in India & Life: 47.38\% \\
and abroad in 2006-07 & Non-Life: 21.51\% \\
\hline
Geographical restriction for new players & None \\
Equity restriction & Foreign promoter can hold up to 26\% of the equity \\
Registration restriction & Composite registration not available \\
\hline
(Source: IRDA Annual Report 2006-2007) & \\
\end{tabular}
\caption{Figure 2.2}
\end{figure}

\textsuperscript{52} IRDA, "Appraisal of insurance market", \textit{IRDA annual report 2004-05}, New Delhi, 2005,
For micro-insurance facilities to be available to the poor, the IRDA has divided the poor block of people under the two broad categories which are: a) RURAL SECTOR, b) SOCIAL SECTOR. And there are the obligations set by the IRDA to be fulfilled in both of these sectors. These obligations are listed in figure 2.3 below:

Figure 2.3

Rural and Social Sector obligations of Private Insurance companies

<table>
<thead>
<tr>
<th>Obligations</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural sector,</td>
<td>(a) every insurer, who begins to carry on insurance business after the commencement of the Insurance Regulatory and Development Authority Act, 1999 (41 of 1999), shall, for the purposes of sections 32B and 32C of the Act, ensure that he undertakes the following obligations, during the first five financial years, pertaining to the persons in—</td>
</tr>
<tr>
<td>(i) in respect of a life insurer,</td>
<td>(I) seven per cent in the first financial year; (II) nine per cent in the second financial year; (III) Twelve per cent in the third financial year; (IV) Fourteen per cent in the fourth financial year; (V) Sixteen per cent in the fifth year;</td>
</tr>
<tr>
<td>of total policies written direct in that year;</td>
<td></td>
</tr>
<tr>
<td>(ii) in respect of a general insurer,</td>
<td>(I) two per cent in the first financial year; (II) three per cent in the second financial year;</td>
</tr>
<tr>
<td>of total gross premium income written direct in that year.</td>
<td></td>
</tr>
<tr>
<td>Social sector,</td>
<td>(b) in respect of all insurers,</td>
</tr>
<tr>
<td>(I) five thousand lives in the first financial year;</td>
<td></td>
</tr>
<tr>
<td>(II) seven thousand five hundred lives in the second financial year;</td>
<td></td>
</tr>
<tr>
<td>(III) ten thousand lives in the third financial year;</td>
<td></td>
</tr>
<tr>
<td>(IV) fifteen thousand lives in the fourth financial year;</td>
<td></td>
</tr>
<tr>
<td>(V) twenty thousand lives in the fifth year;</td>
<td></td>
</tr>
</tbody>
</table>

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54 The Gazette Of India, Extraordinary, Part III– Section 4, Published By Authority, Insurance Regulatory And Development Authority, Notification, New Delhi, 16th October , 2002
The rural obligations are in terms of certain minimum percentage of total policies written by life insurance companies and, for general insurance companies, these obligations are in terms of percentage of total gross premium collected. The social obligations are in terms of number of individuals to be covered by both life and non-life insurers in certain identified sections of the society.

In order to fulfill all these requirements of IRDA all the insurance companies have designed products especially for the poorer sections, rural sections sand also for the low income group. These insurance companies in collaboration with the nodal agencies have been able to cater to the low-income segment of the economy. These nodal agencies which organize the poor, impart training, and work for the welfare of the low-income people play an important role both in generating both the demand for insurance as well as the supply of cost effective insurance.55.

According to Sorab Sadri (2009), “Customer is being short changed by the life insurance executives (paid employees). This is because for them incentives and bonuses have a higher value premium than ethical conduct of business. What is worse is that senior management in the industry seems oblivious of this fact. This paints a bleak picture of the industry and exposes the underbelly of peripheral capitalism of a retarded variety.” 56

Universal coverage, secure access to adequate healthcare for all at an affordable price, is the ultimate objective of SHI. Through analysis of the experience in eight countries with developed SHI (Social Health Insurance) schemes, this paper has shed light on what are important facilitating factors for the speed of the transition period. A number of factors were judged crucial in facilitating this transition: the level of income, the structure of the economy, the distribution of population, the country’s ability to administer SHI, and the level of solidarity in the society. It is essential that the policymakers take these


factors into account and try to use them as policy levers. Improving administrative capacity and fostering a sufficient level of solidarity are among those factors that can be impacted upon more directly via government stewardship. Thus while experience demonstrates that SHI development in a particular country to a large extent depends on that country’s own specific socio-economic and political context, experience also shows how the transition to universal coverage is dependent on the government’s stewardship of the health system.\textsuperscript{57}

CBHI (Community Based Health Insurance), which is more appropriate insurance arrangement for the poor, could take different forms and each of these forms may be suitable depending on the characteristics of the target population, their health profile, and health risks to which the community is exposed. Indeed, for a country as diverse as India there can be no pan India model and all different forms need to be explored. The scheme announced in the last budget and recently launched by the prime minister, seems promising provided the insurers find it attractive enough to partake in. The liberalization of the insurance market has made this less likely, as competition in the market place will turn the focus of companies to the most profitable lines of business. However, a regulatory requirement to this effect may then be a possible way out. The proposed scheme being a group insurance scheme is not meant to cover the entire BPL population and it also excludes outpatient care. As experience accumulates, the scheme can be fine-tuned and expanded to cover the entire low-income population. However, increased public health spending and reforming of public health facilities is a must for the success of these community-based health initiatives.\textsuperscript{58}

\textsuperscript{57} Carrin, G. and James, C, Social health insurance: Key factors affecting the transition towards universal coverage \textit{International Social Security Review}, Vol 58, 1/2005), World Health Organization,2005.

\textsuperscript{58} Mahendran, T “Health Insurance for the poor”, Health Insurance Sector in India, 2008, pp 113-114
2.3 Why study Microinsurance?

2.3.1 Microinsurance: An instrument of Social Protection

According to Churchill (2006) in the Microinsurance compendium, Workers in the informal economy and their families live and work in risky environments, vulnerable to numerous perils, including illness, accidental death and disability, loss of property due to theft or fire, agricultural losses, and disasters of both the natural and man-made varieties. The poor are more vulnerable to many of these risks than the rest of the population, and yet they are the least able to cope when a crisis does occur. Poverty and vulnerability reinforce each other in an escalating downward spiral. Not only does exposure to these risks result in substantial financial losses, but vulnerable households also suffer from the ongoing uncertainty about whether and when a loss might occur. Because of this perpetual apprehension, the poor are less likely to take advantage of income-generating opportunities that might reduce poverty. 59

Dror (2007) has gone into the root cause of social needs of the poor with respect to health security. Since the poor do not have any financial security, they are directly exposed to extreme conditions when ill health strikes them. The poor have got none or very little savings. When a member of the family gets unwell then the family has to either sell off whatever little assets they have or depend upon loan sharks to finance the treatment of the member. This further adds to the misery of the poor family. They now have to deal with the illness & the added financial burden. The problem is more severe when one considers the kind of environment that they live in, like dangerous terrain, exposure to elements of nature, overcrowded households & unhygienic conditions. All these make them more susceptible to illness. The poor are also the first & the worst victims of natural disasters. Their life is a big challenge of never ending fight with diseases, taking them further into financial burden. In such circumstances, how are they ever expected to come out of the circle of poverty?

The response of the not-so-poor in such circumstances is to insure them against any such unforeseen event. They invest a fixed amount, called premium with the insurer & expect a return from the insurer in the unfortunate circumstance that something might happen to him. The insurer happily accepts the premium from a large number of customers as it is sure that not everyone will face such an ‘unfortunate circumstance’. This broad principle of insurance governs the financial security of the not-so-poor classes. They are happy to pay a small amount today to fight a future ill health or disease. The insurance industry world over thrives on this. People, who are insured, buy a future safety net & are thus not vulnerable to financial insecurity.

Dror (2007) also brings out the true need for Insurance for the poor, that in India today, out-of-pocket spending by households for healthcare represents about 73% of total health expenditure (WHO, 2006); another estimate puts that rate at more than 80% (Devadasan, Ranson, Van Damme, Acharya, & Criel, 2005). This high rate exposes many households to unexpected and unaffordable healthcare costs for which insurance can be an attractive and cheaper alternative (Ray, Pandav, Anand, Kapoor, & Dwivedi, 2002). However, at present only about 3% of India’s population, mostly in the formal sector, benefit from some form of health insurance and the role of grassroots community-based schemes is prominent in the informal economy relative to the alternatives offered by the public sector or by commercial insurers.  

Figure 2.4

<table>
<thead>
<tr>
<th></th>
<th>Life</th>
<th>Non-Life</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>4.0</td>
<td>0.6</td>
<td>4.7</td>
</tr>
<tr>
<td>Asia</td>
<td>4.6</td>
<td>1.6</td>
<td>6.2</td>
</tr>
<tr>
<td>World</td>
<td>4.4</td>
<td>3.1</td>
<td>7.5</td>
</tr>
</tbody>
</table>

Source: Swiss Re Pravartak, Journal of Insurance and Risk Management, Jan 2009

Furthermore, community-based health insurance schemes in India cover a partial benefit package that reflects the assumption that premiums are the main source of financing. If the poor are to pay for insurance, the package

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must be attractive in two regards: it must meet clients’ perceived needs and be affordable to them (Radwan, 2005; Wiesmann & Jütting, 2000). Since affiliation to grassroots schemes is voluntary, and considering that willingness to join such schemes may increase when prospective clients are satisfied with the benefit package and identify with it (De Allegri et al., 2006; Fleck, 1994; Schone & Cooper, 2001), it is important to develop a tool to assess prospective clients’ priorities.  

Social Gains as with privatization in any industry, the benefits are not restricted to the customer alone, but extend to society at large, by generating employment opportunities for thousands. One of the most promising outcomes of this trend is that a job as an insurance advisor has become a practical career option for thousands of people who would otherwise not work – mothers, retirees, even those with just basic educational qualifications! Success levels are determined by the amount of effort one puts in, and the advantages are several – flexible hours, continuous learning and training, little or no financial investment, the pride of working with some of the most respected names in the financial industry, and last but not least, an income stream that can continue for many years.

Microinsurance can break the “cycle of poverty” by providing low-income households, farmers and business access post disaster liquidity, thus securing their livelihoods and providing reconstruction. Following the United Nations International year of Microcredit 2005, there is a growing interest in microfinance solutions to help alleviate poverty in developing countries. Using micro credit and, to a lesser extent, microinsurance to indemnify against losses caused by severe or catastrophic natural disaster is only just emerging.

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61 Dror, DM. et al., “Health insurance benefit packages prioritized by low-income clients in India: Three criteria to estimate effectiveness of choice”, Social Science & Medicine 64, 2007 884–896
Mahendran (2008), claims that “According to the World Health Organization, greater than 80 per cent of total expenditure on health in India is private and most of this flows directly from households to the private-for-profit healthcare sector. Most studies of health care spending have found that out-of-pocket spending in India is actually progressive, or equity neutral; as a proportion of nonfood expenditure, richer Indians spend marginally more than poorer Indians on health care. However, because the poor lack the resources to pay for health care, they are far more likely to avoid going for care, or to become indebted or impoverished trying to pay for it. On average, the poorest quintile of Indians is 2.6 times more likely than the richest to forgo medical treatment when ill [Peters, Yazbeck et al 2002]. Aside from cases where people believed that their illness was not serious, the main reason for not seeking care was cost.”

The UNDP report on building security for the poor (2007) categorizes poverty reduction into (1) income generating schemes and (2) protecting these incomes through effective risk management. The report says that “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”. The report describes Microinsurance as an important constituent of a broader overall poverty reduction strategy. The first Millennium Development Goal of the United Nations aims to eradicate extreme poverty and hunger, while goal three aims at gender equality and the empowerment of women: microinsurance contributes to both.

Justino (2007) explains that “A large fraction of the world population lives under extreme conditions of poverty and deprivation. These are typically people found in remote areas, with difficult access to markets and institutions, uneducated, with poor health, employed in jobs with little security and with inadequate access to productive assets. Such characteristics make the poor vulnerable to shocks caused by life cycle changes, economic reforms and

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64 Mahendran, T “Health Insurance for the poor”, Health Insurance Sector in India, 2008, pp 115

other types of events such as illness or bad weather conditions. The vulnerability of the poor to socioeconomic shocks can be reduced by policies that protect their livelihoods, increase their human capital and assist them in times of crises. However, despite the need for social security policies, it is not immediately clear that developing countries are able to implement programs of social security”.

Justino (2007) further explores the need to provide protection mechanism for the poor. “The introduction of social security programs in developing countries is a difficult task given the fragility of their capital and insurance markets and large budget restrictions. Furthermore, developing economies are typically characterised by traditional labour structures, where informal sector and unregulated employment prevails, and large levels of poverty. These characteristics would require social programmes to achieve a magnitude that few governments in developing countries are able or willing to implement. In addition, governments in those countries have, in general, less capacity to collect taxes, implement complex policy programmes or correct market failures, due to their lower levels of income, education and infrastructure. These problems have led researchers and policy advisers to argue that poverty eradication and socio-economic security of the poor should rather be achieved through sustained economic growth that will raise the level of living of the whole population (Bruno et al., 1995; Dollar and Kraay, 2000). However, although economic growth is an important factor in the promotion of better standards of living, it is not empirically clear that economic growth per se brings about social development and increased equality. In fact, pockets of poverty can persist due to the inability of some population groups to participate in the growth process (Gaiha and Kulkarni, 1998). Protection mechanisms are therefore needed in order to guarantee the safeguard of vulnerable elements of the population against life contingencies and socio-economic uncertainties. 66

In a study carried out by the Microinsurance Academy by Iddo Dror (2007) in different places in India, the overwhelming reason cited for not joining a local

insurance scheme across all locations was lack of trust. The numbers were fairly consistent across locations, ranging from 39% in Maharashtra (both Rural & Urban) to 43% in Karnataka. This inquiry from India adds some field evidence to the study of social capital in the context of microinsurance. It offers a few new insights notably that the lack of social capital can lead to low insurance uptake. Generally speaking the research shows that there are some unexpected findings that justify further study in order to enable practitioners and policy makers to understand the social dynamics underlying the design and implementation of microinsurance schemes.

Health insurance is emerging as an important financing tool in meeting the healthcare needs of the poor. Neither market mediated nor government provided insurance is an appropriate way of reaching the poor. Community based health insurance is a more suitable arrangement for providing insurance to the poor. The development of private health insurance in the country has both potential risks and benefits in the access of the poor to health services. Appropriate regulatory changes can minimize the risks and turn potential benefits into concrete gains for the poor. However, currently, even the private health insurance market lack development for want of proper regulatory decisions both on the supply of health services and on the demand for health insurance.

As an independent risk-management arrangement, microinsurance is not sufficient to protect poor people against risk. An integrated strategy of social protection should be conceived in collaboration with the government, the private sector, health professionals, social partners and other civil society organizations. Microinsurance can be most successful if it complements other risk-management instruments on the basis of a comprehensive risk assessment.


68 Mahendran, T “Health Insurance for the poor”, Health Insurance Sector in India, 2008, pp 113-114
Although the operations of microinsurance schemes are largely the same regardless of their objectives, microinsurance schemes in the context of social protection should be assessed and monitored differently from microinsurance schemes for assets, livestock or housing, for example. The social protection schemes have to be inclusive of high-risk or destitute member, and ideally access public subsidies to compensate for the higher claims or lower contributions. If they access public subsidies, they also have to be accountable for them, ensuring that those funds are used efficiently and for the intended purposes.

The decision to implement or support microinsurance schemes is not only driven by risk analysis, but also by political considerations: priority contingencies to cover, populations to be targeted, the relevance of this mechanism as compared to others, and the possibility to link it to other mechanisms and other social protection components. The objective is to improve efficiency, increase coverage and progressively create more coherent and equitable systems of social protection. 69 Devadasan and Nagpal (2007), sighting the reason for growth of microinsurance state that “Today, in the light of the governments not being able to provide adequate health services, coupled with the escalating costs in the private health sector, globally the poor have been denied access to health care. And when they do access, the costs are so prohibitive, that the family is pushed into poverty. Peters et al show that 25 – 40% of all (not just the poor) hospitalized patients have to borrow money to meet the medical costs in India. This is one of the main reasons why micro-health insurance has been growing as a movement. Many poor families in Africa, SE Asia and now India are being protected by such schemes. In India, the first such scheme was started in 1955 in Kolkata, the Student’s Health Home. There was a gradual increase in the number of schemes, but this has shown a phenomenal increase in the past five years. Currently, as per ILO estimates, there are more than 85 such schemes, covering at least 8 million people.” 70

Rao (2007) says that “The term Microinsurance is akin to regular insurance as it is made available and sold, except that the target market for the potential insured is low-income people. Mainstream commercial insurers tend to ignore this target group as they aim more to cater to those in the formal economy, who have predictable incomes, assets, cash flows and understand the importance of buying insurance as a risk management tool. Those working in the informal and unorganized economy have low and irregular incomes and cash flows, live in more risky environments and do not understand how insurance operates as risk management tool. They are therefore, more financially vulnerable to perils either man-made or natural”. 71

Alex George, (2007) gives a fair amount of idea about the scope of Insurance in India. As per the study, Private expenditure constitutes 78.7 per cent of health expenditure in India. As high as 98.5 per cent of this is out of pocket expenditure [WHO 2005; World Bank 2005]. Health insurance coverage in India is variously estimated by researchers to be between 3 per cent and 10 per cent of the population, consisting mainly of employees in the organized sector and their families [Rao 2005; Devadasan et al 2005; Gupta and Trivedi 2005]. On the contrary workers in the informal sector of the economy, constituting 93.3 per cent of the workforce [Gupta and Trivedi 2005] and their families and an overwhelming part of the population do not have any coverage, except a few schemes of non-governmental organizations (NGOs).72

Monique Cohen and Jennefer Sebstad (2003) looked at the ways to reduce vulnerability through microinsurance in Africa. According to them “While everyone stands to benefit from formal insurance, few people currently see it as an option. It is viewed as a province of the rich who are in a better position to take precautionary measures to avert illness and to protect against property loss. The poor live life in a reactive mode, moving from crisis to”


crisis. For many poorer households, risk management strategies usually involve reacting to a shock ex post. The lucky ones have access to informal insurance. Even this is limited in effectiveness when seen against the cost of meeting the immediate expenses associated with a shock, feeding the family and keeping children in school.

Coping strategies that involve taking on more debt make the escape from poverty seem ever more distant. The very poor often fall out of informal group based systems if they cannot keep up with reciprocal obligations and depend almost entirely on inadequate self-insurance mechanisms. Some are lucky but many remain in debt, in a permanent race to stay one step ahead of the next shock.  

Cohen and Sebstad (2006) trace the financial pressures that the poor have to go through. This book says that “Risk is ever present in the lives of the poor. Faced with shocks, poor people draw on their financial, physical, social and human assets to meet the resulting expenses. In the absence of precautionary or ex ante risk-management instruments, most are forced to rely on a range of options after the fact or ex post. When a crisis occurs, a common coping strategy is to borrow from the moneylender or microfinance institution; others might ask friends and relatives to help. Few have access to formal insurance services.

Poor people struggle endlessly to improve their lives. It is a slow and gradual process marked by tentative advances. Continually bombarded with financial pressures, low-income households find that shocks can easily erode their hard-earned gains.”

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The result is that their trajectory out of poverty follows a zigzag route: advances reflect times of asset building and income growth; declines are the result of shocks and economic stresses that often push expenditure beyond current income. Vulnerability is closely associated with poverty and can be described as the ability of individuals and households to deal with risk. Risk comes in many forms, for example illness, death of a loved one, fire or theft. These shocks occur frequently and create pressures on household cash flow that exacerbate the ever-present stress of meeting regular expenses, such as food, rent and school fees.  

The World Bank report talks about how desperate the poor are to get financial security in the event they fall sick. Although the type of risks faced by the poor such as that of death, illness, injury and accident, are no different from those

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faced by others, they are more vulnerable to such risks because of their economic circumstance. In the context of health contingency, for example, a World Bank study (Peters et al. 2002), reports that about one-fourth of hospitalized Indians fall below the poverty line as a result of their stay in hospitals. The same study reports that more than 40 percent of hospitalized patients take loans or sell assets to pay for hospitalization.  

RNK Prasad (2007), in his study on promoting Microinsurance through Capacity Development, argues that, Key risks such as illness, death, natural catastrophes, loss of property etc., confront the rich and poor alike, but their economic impact on the low income population is much greater and can rapidly erode their hard earned incomes and push them back into poverty. And for over 70% of Indian population living in villages, these shocks are known to be frequent resulting in depleted household resources, loss of income and assets, increased indebtedness and quite often untreated health problems. While commercial insurers have managed to reach several million households in the urban areas their outreach, as far as rural and marginalized population go, has been very limited for a variety of reasons. Microinsurance is a valuable vehicle to reduce the vulnerability of the poor and protect them against specific insurable risks. Microinsurance is a specialized risk protection solution for the low income market in relation to its cost, terms, and coverage and delivery mechanisms.  

According to Michael McCord (2007), most low-income people in developing countries are self-employed or employed in small firms; they have had little to no access to insurance products that fit their needs. The appropriate delivery channels, types of coverage, product simplicity, premiums, and premium collection methods that this market requires have not been available. (45)  

The World Bank conducted a study on Access to Insurance for the poor. This report also reiterates the views expressed by many authors on Microinsurance. It also lays stress on market based solutions for the poor to access the insurance and suggests not relying on public funds alone. The

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report states that unpredictable events, such as illness, loss of livestock, death or accidental disability, bring devastating consequences to poor households, particularly in developing countries. Worse, entire communities face upheaval from droughts, hurricanes, and earthquakes. Such risks call for some kind of safety net or other social protection mechanism. While public funds will always be necessary to help the most indigent, market-based solutions are an efficient and fiscally attractive option to meet the risk management demands of poor households and small enterprises. 79

Dr S P Gupta report on India Vision 2020 (2002) lays lots of emphasis on health care for the entire population. It stresses the point that “The health of a nation is a product of many factors and forces that combine and interact. Economic growth, per capita income, employment, literacy, education, age at marriage, birth rates, availability of information regarding health care and nutrition, access to safe drinking water, public and private health care infrastructure, access to preventive health and medical care, and health insurance are among the contributing factors. Measured in terms of infant mortality rates, maternal mortality, life expectancy and nutrition, the health of the Indian population has improved dramatically over the past 50 years. Yet, despite these achievements, wide disparities exist between different income groups, between rural and urban communities, between different states and even districts within states, and a big gap from the level attained by the high middle income and advanced developed country.”

The report by Dr Gupta (2002) touches upon major threats to the people of the country from various illnesses and the role that insurance can play to tackle those threats. The infant mortality rate among the poorest quintet of the population is 2.5 times higher than that among the richest. Maternal mortality remains very high. More than one lakh women die each year due to pregnancy-related complications. Communicable diseases such as malaria, kalaazar, tuberculosis and HIV infection remain the major causes of illness in India. During the next five to ten years, existing programmes are likely to eliminate polio and leprosy and

substantially reduce the prevalence of kalaazar and filariasis. However, TB, malaria and AIDS will continue to remain major public health problems. India has about 1.5 million identified cases of TB that are responsible for more than 3,00,000 deaths annually. Assessing the impact of HIV epidemic is more difficult; according to an estimate, there are about 4 million persons infected with HIV. Health insurance can play an invaluable role in improving the overall health care system.

The insurable population in India has been assessed at 250 million and this number will increase rapidly in the coming two decades. This should be supplemented by innovative insurance products and programmes by panchayats with reinsurance backup by companies and government to extend coverage to much larger sections of the population.  

Kaveri Gill (2009) while evaluating the National Rural Health Mission (NRHM) shows the commitment of the government to ensure universal health goals for all. The Commission on Macroeconomics and Health of the World Health Organization (2001) argues that ‘health is a creator and pre-requisite of development’, with an extension in the coverage of health services and improved health care the key not only to better health outcomes and reductions in poverty, but also increased productivity, and hence growth, in poorer countries. While the instrumental value of health might appeal to economists and be taken as a ground for action on its own (Bloom and Canning 2008), the intrinsic value of health for health’s sake cannot be ignored. Health inequity i.e. unfair, unjust and avoidable causes of ill health, resulting in inequalities in the health functioning of individuals, social groups, and national populations, raises fundamental social justice questions (Sen 2002). The moral motivation and social contract obligation to direct health policy in a certain equitable way thus becomes paramount under the rights-based approach, particularly in poorer countries seeking to decide on the most appropriate distribution of limited resources (Venkatapuram and Marmot 2009). Regardless of whether one is moved by the efficiency or the equity

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argument, the desirability of the goal of achieving better population health status is undisputed.

As a part of its socially progressive Common Minimum Programme, the UPA Government launched the National Rural Health Mission (NRHM) in 2005. Major objectives of NRHM include the following: to raise public spending on health, with improvements in community financing and risk pooling; to provide access to primary healthcare services for the rural poor, with universal access for women and children; to see a concomitant reduction in IMR / MMR / TFR; to prevent and control communicable and non-communicable diseases; and to revitalize local health traditions.  

The World Bank Report on Access to Insurance for the Poor also suggests a solution to the goals of universal health. It claims that "Microinsurance is one such instrument for social protection. Of the estimated four billion people worldwide who live on less than $2 a day, fewer than 10 million currently have access to formal insurance from a regulated financial institution. Current work in the area of microinsurance is largely focused on delivering insurance to the poor by partnering with microfinance institutions. This approach is not sufficient, as millions of poor people in rural and other areas live far from a microfinance institution. Formal financial institutions, such as commercial banks and insurance companies, and other institutions, like community-based organizations, can also deliver and service insurance products effectively and profitably. Microinsurance-style products have a long history of providing social insurance in industrial countries, but their reach in the developing world remains limited."

A workshop report on Microinsurance in Rajasthan, lays emphasis on Microinsurance as a full fledged business as the experiments with Self Help Groups cannot be taken on a mass scale. "It has been well documented and accepted that micro-insurance is a key service in the financial needs package


of the people at the bottom of the pyramid (BOP). There exists an enormous demand for social protection among India’s poor. But, though there are around 18 lakh SHGs in India linked with banks under the NABARD initiative, we do not see these groups maturing into enterprising units. Most of the loans taken for enterprising activities take the shape of consumption loans because there aren’t any plans to mitigate unforeseen risks, in which case most of the loan amounts get exhausted. Unless mechanisms are in place to mitigate market and natural risks, these gaps and quality issues would continue to worry.

Micro-insurance cannot be highlighted enough keeping in view the vicious circle of debt trap the poor fall into because of their thin asset base and recurring misfortunes. Risk mitigation is one of the most important areas, therefore, for micro-insurance and for the economy. Micro-insurance is vital to overcome these and other obstacles and to provide insurance to the poor so that they are not sucked deeper into poverty when struck by catastrophe (not only catastrophe, but even in case of small setbacks, poor tend to fall in poverty trap).  

Arup Chatterjee (2009) points out that Microinsurance will lead to a much more inclusive growth. According to him, "Microinsurance has the potential to become an agent of economic and social change that improves risk management structures decreasing some of the causes of poverty. Understanding some of these linkages by policymakers, supervisors, donors, and potential investors will not only contribute towards strengthening of insurance regulatory regimes but also for the development of a more inclusive insurance industry and economic growth and development in developing countries."  

Rajeev Ahuja (2003), says that a group insurance scheme is a powerful way of insuring a number of poor people in one shot. The role of a nodal agency is crucial as it helps in lowering transaction costs by managing the scheme, 

83 Workshop Report, "Micro-Insurance in Rajasthan Issues, Experiences and Challenges" Workshop Report, conducted by Center for Microfinance, prepared and documented by Juhi Shah, pp 9,10  
building trust among its members, bringing about behavioural changes, checking against the adverse selection and moral hazard problems, tailoring the product to the needs of the group, and claims verification. Spreading the idea of insurance among the poor, illiterate or semi-literate community is not easy. It requires a great deal of sustained effort. Once people join an insurance scheme, the issue of retaining them becomes crucial, particularly those who do not receive any benefits. An insurance company cannot be expected to perform all these tasks, and if it does so it only jacks up the premium. Only an organization that is rooted in a community can carry out these tasks. Hence the role of an NGO or some other nodal agency is absolutely crucial in micro-insurance.\(^{85}\)

Rajeev Ahuja (2004) differentiates between a regular insurance and microinsurance. He says: In essence the principle behind regular insurance & microinsurance is same; i.e. there is a risk distribution of a few people over a huge population. Microinsurance also works on similar lines. The difference between the two lies in:

**Target Audience**
While regular insurance is targeted at the middle & upper end of the society, Microinsurance focuses on the BOP market.

**Premiums**
Regular insurance has high administrative & customer service cost built in to it. Premiums are collected annually, six monthly or quarterly. Microinsurance is a low premium business where collection of premium is very erratic.

**Intermediaries**
Conventional insurance is sold by the company to the end customer through its own representatives or trained agents. For Microinsurance, huge geography and lack of local knowledge act as barriers to reach the individual customer. Insurance companies find it much more convenient to deal with a representative body of the customers as intermediary. This body takes on a very strong role in reaching the product to the market & collecting premiums.

2.3.2 Untapped Market Potential

A study by UNDP (2007) makes it evident that microinsurance is poised for a take off in India. “Given the current heightened interest from different stakeholders, combined with the concrete impetus provided by November 2005 directives of IRDA, concrete, complimentary catalytic support will enable all the stakeholders to play a more pro active role. The current gaps, the size of the market potential and the areas for concrete support have been identified.

From the insurance company viewpoint, microinsurance is yet to be a proven business proposition, hence investment from their side has been sporadic and limited to tie-ups with some facilitating agencies. However, most companies are eyeing microinsurance as a real business opportunity of the near future. Efforts from 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. 86

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 micro-credit 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.\textsuperscript{87}

\textbf{Willingness to Pay}

The growing number of demand studies is beginning to provide a credible base of information which can be used to estimate market demand and help design appropriate products in selected countries. This is enabling service providers to move away from simply downsizing existing insurance products originally aimed at the middle class to developing products and services that work for the “bottom of the pyramid”.\textsuperscript{88}

In the context of the discussion on extending the reach of micro-insurance scheme, which hold promise for reducing health related shocks facing poor households, it is essential to make a distinction between those who can afford health insurance and those who cannot. Lack of demand for insurance need not necessarily be the result of affordability per se, and thereby justifying the need of government subsidy, but may be the result of other institutional rigidities such as borrowing or credit constraint.\textsuperscript{89}

David M Dror (2006) collected field evidence in seven locations where micro health insurance units operate, using a bidding game to assess willingness to pay (WTP). The evidence shows that most people are willing to pay more than 1 per cent of their income for health insurance. 50 per cent of the sampled population (15,668 persons in 3,204 households) stated a willingness-to-pay level of 1.35 per cent of annual household income for a health insurance package; and 75 per cent of the sampled population agreed to pay about 1 per cent of annual household income. Median household income in this sampled population was Rs 41,400 per year (median income per person Rs 9,000). Consequently, this study shows that the majority of the

\textsuperscript{88} Cohen, M. and Sebstad, J. “The Demand For Microinsurance”, \textit{Protecting the Poor A Microinsurance Compendium}, edited by Craig Churchill, 2006, ILO, pp 44
sampled populations were willing to pay about Rs 559 per household per year (value date mid-2005).  

David Mark Dror, et al (2006) studied the willingness of the target segment to pay for the insurance. This study of WTP (Willingness to Pay) provides field evidence that rural and BoP (Bottom of the Pyramid) population segments in India would agree to pay for health insurance at least 1.35% of median HH (Household) income per household per year, or at least 1.8% of median non-health HH expenditure per HH per year.

The nominal levels of WTP identified through this study are much higher than has been known hitherto; we submit that nominal WTP levels stated in this article are conservative estimates, bearing in mind that small HHs are willing to pay up to INR 230 per person per year, and large HHs, while willing to pay a decreasing amount per person, nevertheless, agree to pay about INR 150 per person when household size counts six persons and above.

A policy objective of extending health insurance that includes raising revenues for healthcare financing would gain from shifting the subscription unit from single individuals to entire HHs en-bloc. In this study, the questions posed and the replies received about WTP refer to the entire HH rather than to single individuals. And with nominal WTP values that increase with HH size, it stands to reason that respondents prefer to insure the entire HH, and this must also be the aim of the insurer. The likely effect of subscribing entire HHs en-bloc, in addition to raising more resources, would be that the cost of the pure risk should drop because the risk of adverse selection should diminish.

In most other studies of WTP, it has been established that WTP is positively correlated with income. In fact, this is one of the criteria to evaluate methods for WTP estimation. Consequently, we deduce that poorer people are willing to pay a higher percentage of their income as health insurance premiums. We found a positive association of WTP with education, but this relation also vanishes when WTP is expressed as percentage of income. HH size is found to be the most dominant determinant influencing WTP levels; but when we look at WTP per HH member, it decreases with HH

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90 Dror, DM. “Health Insurance for the Poor: Myths and Realities”, *Economic and Political Weekly*, November 2006, Pp 4541-4544
size but only down to a limiting value”. This strongly suggests that respondents understand that the level of coverage is linked to the level of the premium, and that reasonable coverage commands a certain level below which the payment cannot drop. In addition, persons insured by MIUs accepted higher WTP levels than uninsured, even though respondents were not given the option to choose the composition of the benefit package. 91

David M. Dror, et al (2008) studied the need for hospitalization and within that category, which of them had the worst financial impact. “Our study showed that the main financial burden of illness among the surveyed poor population was due to the combined cost of drugs and primary care, more so than due to the cost of hospitalizations. However, when they occur, hospitalizations can have a devastating financial impact”. Hospitalization is usually considered as the prime source of catastrophic financial exposure. Our data confirmed that when hospitalization was required it was indeed the most costly component on average, and this was true in all three morbidity types (acute, chronic or accident). “Yet we also observed that severe illnesses that required hospitalizations were also associated with higher costs for other benefit types (e.g., tests, drugs, etc.).” This combined effect could explain the high impact of hospitalization on the cost of illness Drugs were the second most expensive item in all types of morbidity. In fact, drugs were used much more frequently than hospitalizations. Therefore, it was not surprising that on an aggregated basis, drugs accounted for 49 per cent of total costs whereas hospitalizations accounted for only 11 per cent of total. 92

David M Dror (2008) has proved that Micro health insurance units provides a much better delivery than the commercial route adopted by companies. Micro health insurance units (MIUs) can offer a better fit to the priorities of the clients by applying social rules and administrative practices that differ from

the commercial routines. For one, MIUs can reduce adverse selection by inclusion rather than by exclusion: instead of excluding certain persons, there are examples in India and elsewhere that communities have decided on obligatory affiliation of entire groups into the insurance, regardless of age or pre-existing conditions. This inclusiveness rule enhanced the diversification of the risks that MIUs underwrite, and thus reduced their risk exposure. Also, whereas the commercial practice is to determine the premium of each person according to individual risks (estimated by age and sex), MIUs can decide on other ways of determining the premium, e.g. they can apply the same rate to all members of the group (“community rating”). There are examples of very successful application of such rules by villages. 93

Pilot Survey Conducted in Kancheepuram District, Tamilnadu, India by Gunita Arun Chandhok (2009) shows some surprising results. According to this survey:

• The study reveals that majority (43.8%) of respondents are in the age group 41-50 years. This implies that people become conscious of health during this age group and start realizing the importance of an insurance cover.
• The study also shows that majority(66.3%) of respondents are males. This shows that males take most decisions pertaining to financial matters among the poor.
• Majority of respondents (79.5%) are aware and understand the importance of health insurance.
• Majority of the individuals have the capacity to pay premiums towards health insurance. They have the capacity to pay ranging from Rs 75- Rs 90 per annum per head. This indicates that there is enormous scope for the insurance companies to innovate health insurance products which should be affordable by the poor. An appropriate premium has to be devised which suit the pocket of the poor. This can be done by offering micro insurance products to this sector of society. 94


Willingness to pay surveys are generally related to the quality of health services and choice of health care providers. These factors are inextricably linked to the design and development of benefit packages that form the basis of contingent valuation surveys. These factors also play a role in determining contribution rates.

Willingness-to-pay responses are positively related to household income. If the contingent valuation methodology is used to determine contribution rates for microinsurance, survey responses must come from a cross-section of the population within a community to capture variation in amounts individuals are willing to pay. This information may be used to develop a range of benefit packages, from a basic minimum package affordable to the poorest households to a more comprehensive package that wealthier households could afford. Ability to pay may be a better predictor than willingness to pay of probability of enrollment, as well as continuity and sustainability of repayment.

According to Juan Luis Martinez and María Carbonell (2007), “The poor pay, and they pay well. They repay credit under terms and conditions with ratios that would be the envy of many finance entities. They buy products following the same guidelines and demands as the high-income consumer; they make cross-purchases; and once they have grown in strength as people, becoming fully integrated into the formal system of the market with the same rights and obligations as the rest, they respond by giving their loyalty”. 96

Potential Market for Life Insurance

Shukla (2007) in his study ‘How India Earns, Spends and Saves’ clearly indicates that there is a definite scope to increase the volume of savings in life insurance, given the current distribution of income amongst the households and their employment structure. A substantial proportion of households in all


income, occupation and education groups are uninsured. A significant fraction of the uninsured households might not be aware of the benefits of life insurance or might not know insurance agents who presumably tend to concentrate their efforts in spreading insurance among the upper income group. For instance 39 million rural households and 18 million urban households are aware of life insurance but do not own any policy and are confident about their households’ financial stability. This customer segment represents a key potential target segment for life insurance marketers. These households have the potential to increase the market for life insurance by Rs 258 billion – the market potential in rural areas is Rs 139 billion while the corresponding figure for urban areas is Rs 119 billion.

Alternatively, there are 11 million rural households and 10 million urban ones that could be a lucrative target for life insurance marketer. These segments are aware of life insurance and are confident about their financial security, but do not own any policy. They earn more than the median income of insured households. In monetary terms, at the (average) current premium, this household segment could yield additional Rs 105 billion – Rs 36 billion each in rural as well as urban areas – as an immediate market that needs to be captured by life insurance companies.

Based on the above calculations the market (including both rural and urban) could generate an additional premium between Rs 105 billion to Rs 258 billion according to Rajesh Shukla as of 2007.\footnote{Bodla and Verma (2007) have shown the changes that have taken place in the rural India. According to them, “The rural market is booming beyond expectation. This has been primarily attributed to the increase in purchasing capacity of farmers now enjoying an increasing marketable surplus of farm produce. In addition, an estimated induction of Rs. 140 bn in the rural sector, through government’s rural development plans in the ninth plan and about Rs. 450 bn in the tenth plan, is also believed to have significantly contributed to

\footnote{Shukla, R. “How India Ears, Spends and Saves”, Results from the Max New York Life – NCAER India Financial Protection Survey, 2007}
the rapid growth in demand. The high incomes combined with low cost of living in the villages has resulted in more money." 98

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$ 1,384.55 to 1,872.61 million), which is only expected to grow as microinsurance is better understood. In case of life, the potential is estimated to be between INR 15,393 to 20,141 million (US$ 342.07 to 447.58 million); in case of non-life, between INR 46911.70 to 64,126.55 million (US$ 1,042.48 to 1,425.03 million). 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 US$1-2 a day. This is expected to increase as demand grows and a wider range of risks are recognized as insurable. 99

Sharma (2009) dwells upon the huge role of technology in delivering healthcare services to the unreachable. He too stresses the role of insurance in making healthcare affordable for the poor. By 2020, Indians in the remotest village should be able to get advice over broadband from specialists in metros or even foreign hospitals. Already, there are some small projects that combine mobile telephony, broadband connectivity and satellite links to shrink distances. Pranay Lal, Technical Advisor (Policy), International Union Against Tuberculosis & Lung Disease, says: “Over the past year or so, technology, particularly SMS text messaging and community radio services, has been used to alert people to stick to their treatments regimens and to avoid drop outs.” Insurance, too, is slowly increasing its coverage. Dr Rana Mehta, Vice President (Healthcare) at consultants Technopak Advisors, says: “Community Health Insurance schemes are slowly penetrating the rural markets with more than 25 schemes, covering over 10 million lives all over India.” A McKinsey & Co. report, India Pharma 2015, released in 2007, noted: “We expect insurance coverage to double from current levels to cover around 20 per cent of the population by 2015.” According to Gurumani (2009) CEO, SKS Microfinance, universal coverage through health insurance will gather more

momentum if health insurance is backed by a cashless health service delivery infrastructure—a paradigm shift that’s in its early days. Still, while technology combined with insurance can improve access and affordability, the process can be aided further by playing the volume game—large volumes that lower unit costs. 100

Arvind Virmani (2006), looks at the development pattern across various segments and proves that the India growth story has been equitable and not lop-sided. A reasonably standardised large sample consumption survey has been carried out every five years by the National Sample Survey Organisation since 1972-73 (the earlier surveys are not strictly comparable). Based on these surveys a consistent series for the consumption distribution can be constructed. This is shown in Table below. If we ignore the 1977-78 data for the moment, we find a noteworthy result. The rural income distribution has improved progressively (but very gradually) from 1972-73 to 1999-2000 and this can be seen at every level. Thus for instance the share of the poorest 10%, which was 3.7% in 1972-73 increased to 3.8% by 1983, to 4.3% in 1987-8 to 1993-4 and to 4.4% in 1999- 2000. The same pattern is found at every level of cummulation (Technically there is “Stochastic Dominance,”). Thus the new situation is Pareto superior to the earlier one, reducing the importance of measure such as the ‘Gini’ coefficient.

Another way to look at the result is from the perspective of the eighties and nineties. In this case 1977-78 constitutes the situation prior to the start of the eighties. Therefore ignoring 1972-73 we again find that the consumption distribution has improved continuously (though very gradually) during the eighties and the nineties. Each rural consumption distribution during the eighties stochastically dominates the previous distribution based on large sample surveys. In common parlance citizens at every level of income have shared in the fruits of growth since 1980-81. 101

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100 Sharma, EK. “Hi-Tech, Yet Affordable”, Business Today, Syndications Today, (Division of Living Media India Ltd) December 2007, pp 124


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A white paper by Evaluerserve on Bottom of the Pyramid Marketing (2008) goes on to define the Bottom of the Pyramid segment, which essentially is the same as the target audience for Microinsurance. The benefits of economic liberalization initiated in 1991 have started to trickle down to the bottom of the economic pyramid. The percentage of population with an annual disposable income of less than INR 90,000 decreased from 93 percent in 1985 to 54 percent by 2005, reflecting that 103 million people moved from low poverty levels, not only in urban centres, but also in rural areas.

In the Indian context, the BOP can be defined as a section of people who have moved above the poverty line and live in rural or semi-urban areas. About 110 million people inhabiting these rural and semi-urban areas can be defined as BOP consumers.  

Arvind Virmani (2006) explores the root cause of the failure of social indicators in the country. According to him, India’s poverty ratio of around 22% in 1999-2000 is in line with those observed in countries at similar levels of per capita income. The ratio is relatively high because we are relatively poor/low income i.e. with low average income. 90% of the countries in the world have higher per capita (average) income than India. The number of poor is very high because our population is very large, the second highest in the world. Contrary to hints, illusions and allegations, the large number of poor has nothing to do with income distribution. Our income distribution as measured by the Gini co-efficient is better than 3/4th the countries of the World. The consumption share of the poorest 10% of the population is the 6th best in the world.

Where we have failed as a nation is in improving our basic social indicators like literacy and mortality rates. Much of the failure is a legacy of the three decades of Indian socialism (till 1979-80). The rate of improvement of most indicators has accelerated during the market period (starting 1980-81). The gap between our level and that of global benchmarks is still wide and our global ranking on most of these social parameters remains very poor. This is the result of government failure. Government overstretch, misplaced priorities and deteriorating quality (corruption) has resulted in a failure to fulfil the traditional, accepted functions of government like public safety & security, universal literacy and primary education, public health education (superstition & quackery), provision of drinkable water, sanitation drains & sewage facilities, public health (infectious & epidemic diseases), building roads and creating & disseminating agricultural technology. Consequently the improvement in social indicators has not kept pace with economic growth and poverty decline and has led to increasing interstate disparities in growth and poverty.  

The White paper by Evalueserve on Bottom of the Pyramid Marketing brings to our notice, the size of the BOP market, its changing spending pattern and the need for marketers to respond to this change. The white paper recommends that “At present, BOP consumers spend 42 percent of their income on food and beverage, tobacco, transportation and housing. However, by 2025, the spending on food, beverage and tobacco is estimated to decline to 25 percent as disposable income increases. Meanwhile, spending on transportation, healthcare, personal products and services, recreation and education are likely to increase steadily. The changing spending pattern has necessitated a change in marketing strategies to unlock the full potential of the Indian market. The size of the BOP market is expected to expand at a faster rate than that of the top of the pyramid. The BOP strategy needs to focus not only on lowering price points for existing products and services, but also on creating and

offering customized products to address the unmet needs of BOP consumers.” 104

Anabil Bhattacharya (2008) says that the rural scenario in India today, provides a greater opportunity than the urban markets. If we take into account the increasing rural-urban connectivity, we find the basic nature of rural economy and the rural market has undergone fundamental transformation. To quote NCAER “The mobility towards higher income group has, in fact, been much higher in the rural areas than urban.” This provides greater opportunity for marketing in rural areas. The changing behaviours and attitudes of the rural income groups regarding savings and financial institutions indicate tremendous growth in opportunity. There is lot of institutionalization of savings. Opportunities in the rural market are vast.105

Figure 2.7 106

The Potential Market for Microinsurance in India

<table>
<thead>
<tr>
<th>Insurance Segment</th>
<th>Market Size (Potential) (Rs Million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Segment</td>
<td>15393 – 20141</td>
</tr>
<tr>
<td>Non-Life Segment</td>
<td>46911.70 – 64126.55</td>
</tr>
<tr>
<td>Total (Life and Non-Life)</td>
<td>62304.70 – 84267.55</td>
</tr>
</tbody>
</table>

Anabil Bhattacharya (2008) further shows that this change along with government policies will further lead to higher insurance penetration. The rural areas of India during the 21st Century are not what they used to be at the time of independence. Sustained investments in irrigation & power and modern methods of connectivity & communication have brought prosperity and affluence to a sizable population. It makes sound business sense to study these markets and fully tap the vast potential that exists today.


Moreover, phase two of detariffing process would help the insurers to develop products more suited for the rural folk, farmers, and agro-based industries.  

Arvind Virmani (2007) in his paper on Sudoku of Growth, Poverty and Malnutrition, shows that the distance between the urban and rural India is slowly but surely reducing. According to his findings, over the 11 year period from 1993-4 to 2004-5, the proportion of poor below the poverty line and the absolute number of poor have declined. The poverty ratio has declined by 23% from 36% of population to 27.5% while the number of poor has declined by 6% to 301.7 million (Table below). The other noteworthy feature is the convergence of rural and urban poverty rates from a gap of 4.9% points in 1993-4 to 0.8% points in 2004-5. This suggests that the rural and urban areas are getting better integrated in terms of movement of workers, goods and services and the price differentials that drive them.  

The market for microinsurance is large. All stakeholders, insurance companies, their agents and policyholders have much to gain from this market being served well. However, getting everyone working together will take time. In the absence of a strong insurance culture among low-income households, client demand in many places is still evolving. Where insurance has worked well for low-income households – where the coverage is appropriate, accessible, affordable and well understood – it has been met with considerable and growing success. It reduces risk and vulnerability in the lives of poor people, allowing them to move from reactive to proactive behavior and thus plan for the future. With more financial control, poor people have more options. Research on client demand can continue to play a key role in the development of successful microinsurance products.  

Microinsurance is poised for a take off in India. The current heightened interest from different stakeholders, the stimulus provided by the November

2005 directives of the IRDA, and complimentary catalytic support, will enable the development of this latent market. 110

### 2.3.3 The Need for Discussion on Micro Insurance

Sourav Biswas and Ratna Devi (2008) have laid out the benefits of micro health insurance to all the stakeholders. Both the promoter and the partner are benefited from a micro health insurance scheme, along with the poor.

**Promoter Institution Benefits**

The potential benefits of partnering the NGO include:

- **Limited Initial Capital Investment and Low Variable Costs**: By partnering, the promoter does not need to spend time or money developing the actuarial, underwriting, and claims management expertise of its staff. This reduces both the upfront and the ongoing costs for the promoter. Some investment will be required to provide staff training on marketing and sales.

- **Rapid Product Launch and Scale Up**: Product launch and scale up can take place quickly because both the sides already have in place most of the resources and staff needed to develop and offer the product.

- **Compliance with Legal and Regulatory Requirements**: Although regulatory requirements for licensed insurers differ around the world, the NGO acting as an agent is generally not subject to regulatory requirements such as reserve or capital requirements, investment restrictions and other policy provisions.

**Partner Benefits**

The insurance company partnering with the NGO also benefits from this relationship:

- **Access to New Markets**: The insurance provider gains access to a new market and new customers that had previously been overlooked or avoided because of the high cost of reaching these customers. Over time, this new

market may become receptive to other, more sophisticated insurance products.

**Access to Clientele with Strong Financial Records:** Insurers working with NGOs benefit from access to a stable client base that has an existing relationship. By entering the market on their own, most insurers would not have this ability to identify new customers.

**Lower Transaction Costs for Serving a New Market:** Because the insurer relies on the promoter to identify and serve new clients, transaction costs would be higher if the insurer seeks to enter this market alone. 111

Community Health Insurance is emerging as an alternative form of financing health care. Conservative estimates indicate that about 3.5 million Indians are covered by community health insurance. In the Indian context of one billion population, this may look small (0.35%), but as totally only 30 million Indians are insured, this is a sizeable percentage. Considering the fact that it is more equitable (as compared to out-of-pocket expenditure), this form of health financing should be encouraged. 112

On reasons for laying stress on Microinsurance, Gunita (2009), says that:
- Most Indians do not save adequately during their early lifetimes. They need to be educated that saving for future through insurance is a basic necessity of life and it also provides financial security.
- With increasing life expectancies, most of the people lack adequate financial resources to support themselves during their old age.
- The traditional and informal methods of income security, such as the joint family system is breaking up, making it all the more difficult to cope with increasing costs.
- The Government has not played an effective role in popularizing micro insurance products.
- An ILO (International Labor Organization) study in 2004 revealed that the overall market for micro insurance would be Rs 250 billion by 2008.

112 Devdasan,N. Community Health Insurances in India, Lessons Leamt, *Friends of Women World Banking*, India, 2005, Page 88
• According to Munich Re Foundation Chairman Thomas Lester, "India is a key country in microinsurance with a market of over 200 million for micro insurance products." 113

Maria and Sidhu (2009) have also stressed the need for microinsurance by the poor. Microinsurance is a crucial part of the financial services needed by the poor in developing countries, and includes life, health, agricultural and property insurance. Unpredictable events, such as illness, accidental death or disability can bring devastating consequences to poor households, particularly in developing countries. Worse, entire communities face upheaval from catastrophes such as droughts, tsunamis, hurricanes and earthquakes in areas without protections from the government and private sector that are readily available in developed countries. Microinsurance can help the poor—and the tenuous markets in developing countries—recover if one of these events occurs.

Developing countries offer insurers and reinsurers enormous economic potential. They hold an estimated 86% of the world's population, and they are developing middle classes with disposable income. Microinsurance is often provided in developing countries by nongovernmental organizations, including development organizations, trade unions and microfinance institutions. "Mutuals" are professionally managed, regulated, member-owned insurers, often owned by credit unions or cooperatives. They tend to be closer to the poor and therefore to the market for microinsurance. 114

A study of policies sold by private players in the last 4 years (see table & graph below) shows a very high skew towards urban centers. The rural share of the market has not crossed 18%, even though 70% of the population lives there. This major gap in market potential & servicing has to be narrowed down & narrowed down profitably for all the stakeholders.

114 Orecchio, M and Sidhu, V, Best's Review, August 2009 Pg 89
(1) Need & Significance for the Insurance Industry

Bodla and Verma, while discussing gaps left by LIC in insurance penetration state that “LIC has made a steady and firm penetration into rural India. It has registered an annual growth of 18% for policies taken in last three years, which is much higher when compared to 3.86% in small towns and cities. Though the lion’s share of LIC’s present business lies in rural India, they are not very successful in the areas of realistic pricing, product promotion and reaching to the rural customer. Hence, insurance players will be keenly interested in understanding the rural customers, and their buying behavior related to life insurance policies.”

Juan Luis Martinez and María Carbonell (2007) have studied the short term approach of the insurance companies in taking their products to the low income consumers. According to them, Low-resource consumers have traditionally been “invisible” to the business world since its efforts have been focused on the upper part of the income pyramid. Low-income consumers have been considered “accidental consumers”; and, when product marketing has met with success among them, most companies have been unable to explain it, since it was unintentional. Perhaps a degree of marketing myopia

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115 Global Industry Monitors, Cygnus (Sept 2006), India Stat
has prevented the business world from seeing reality and made it difficult to identify new opportunities to create value and do business in unexplored parts of the globe.

This myopia is partly due to a fear of innovation but also due to the lack of comprehension of the needs of the poor. Many companies are working overtime trying to get a fraction of a per cent increase in market share in a developed country, but those same companies are taking a dangerous stance if they fail to address a large potential market: people who earn less than $2,000 a year. Many companies still assume that those with little income only allocate their spending to basic needs, thus making it impossible to do business profitably in BoP regions.  

There is a pressing need for government & Insurance companies to penetrate this market. This study will explore how the rural customer views Insurance, what are his priorities, what is the generic competition to Insurance & the overall buying behavior of the customer. It will offer solutions for marketers to target it successfully.

This study will have very high significance for the entire Insurance industry as companies will be able to Position themselves better in the minds of the rural customer. The study will bring out the real needs of the customer, which will help Insurance companies to cater distinctly for this huge market. They can design their products for this specific segment & not offer a standardized product to all & sundry.

(2) Need & Significance for the poor

Msuya et al (2007), while studying the health insurance schemes in rural Tanzania (2007), have analyzed that formal health insurance schemes cover only a marginal proportion of the population in low-income countries. Due to economic constraints, lack of good governance and institutional weaknesses,

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formal social protection for the vulnerable segments of the population is widely absent. Hence, it is one of the most important challenges today to increase the access to health care in low income countries. This study has analyzed the role of community-based health insurance schemes in rural Tanzania in contributing to this objective.

We find that members of a community health fund are more likely to seek formal medical care when they are ill than non-members. Hence, community based health insurance can help to turn latent demand into effective demand. Beside an improved access, we also find that members rely less on risk coping mechanisms that have a negative mid-to long-term impact such as selling of assets, taking children out of school, etc.

The results show that members paid considerably less out-of-pocket at health care facilities than non-members. This means that in an area where most people are deprived from access to health care of good quality, the introduction of CHF’s schemes can make a substantial difference. Access to curative health care is improved while at the same time members of the CHF are financially better protected against health shocks. This has a potential positive effect on the ability of households to smooth their consumption, on labor supply and labor productivity and the health status of the insured persons.  

According to Ahuja and Narang (2005), Currently, majority of the poor in India make out-of-pocket payments in the event of hospitalisation, and such spending is sporadic and not necessarily welfare improving. For example, during the harvest season a small illness receives higher funds than a serious illness if it comes during non-harvest time, when availability of funds is limited. Health insurance is a mechanism that provides health protection when people actually need it, and thereby, enables people to spend wisely and judiciously.

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Rural India comprises of over 650 000 villages with over half of them having a population of less than 5000. For a long time a need has been felt for having insurance products, which can be afforded by the rural and urban poor. Rural insurance will also ensure employment for the rural population. Indian villages will need thousands of agents who will work as distribution channels for the insurance companies. The IRDA has relaxed qualification & training criteria for those who want to become insurance agents in the rural market. IRDA rules also allow for very high commissions to rural agents.

(3) Need for the Economy
Janet and Manmohan (2005) have explored the economic contribution of insurance companies. According to them, “Insurance companies are important financial intermediaries in both mature and emerging markets. In most mature market countries (with the exception of the United States and Canada), and in most parts of Asia and Central Europe, insurance companies are the largest institutional investors in terms of asset under management (AUM). In the United States, Canada and in most Latin American countries the largest institutional investors are pension funds.” 120

The economic imperative of a well functioning insurance market cannot be over emphasized for economic development and growth. It promotes financial stability, acting as a lubricant for trade and commerce and mobilizing savings. Insurance the world-over has been an important medium of channelizing the household savings for long term infrastructure development projects which fuel overall economic growth and well being. Infrastructure in or context means, not only power, roads, ports, communication etc; but in its more comprehensive sense of education – particularly for the girl child, primary health-care, housing, universal supply of potable water and appropriate sewage and waste management systems. Admittedly, this requires huge

amounts of long-term savings, which can be harnessed through insurance and pension products.  

Tapen Sinha shows the relationship between insurance and capital markets. Accordingly, by nature of its business, insurance is closely related to saving and investing. Life insurance, funded pension systems and (to a lesser extent) non-life insurance, will accumulate huge amounts of capital over time which can be invested productively in the economy. In developed countries (re)insurers often own more than 25% of the capital markets. The mutual dependence of insurance and capital markets can play a powerful role in channeling funds and investment expertise to support the development of the Indian economy.  

2.3.4 The rationale behind the study

By and large the literature on demand side is still thin. A few micro-level studies that have tried to estimate demand for health insurance based on the willingness-and ability- to-pay for health insurance have come out with positive findings.  

Much of the existing literature on micro-insurance focuses attention on supply and institutional issues (Siegel et al. 2001). The limited understanding of households’ needs, preferences, and expectations will have to be deepened, if future experiments in micro-insurance are to be “demand-driven.”

G V Rao (2007), in an article in the IRDA journal, has laid lot of stress on understanding the needs of the rural and poor masses for microinsurance. As per Rao, “Inculcating a habit among the rural masses to insure the assets, the

122 Sinha, T., “The Indian insurance industry: challenges and prospects”, Swiss Re,  
lives and the health of their families has remained an elusive goal, notwithstanding the recent introduction of specialist insurance regulation that is very insurer friendly. The task of mobilizing the efforts of insurance units to make this goal partly achievable has yet remained a non-starter.”

Rao, further goes on to add the most important aspects that need to be studied to make microinsurance a success. According to him, one needs to understand “What misconceptions of the mental models and physical infirmities have been the hindrances to make even the smallest progress? Each segmented market, including the Need to understand rural markets. The value and belief systems of the rural people that are targeted for sale of micro-insurance products have to be understood and analyzed. One would also have to evaluate how their needs of insurance are currently being met and from what sources and how much they are costing them now? What kind of price-value proposition of insurers would make them consider a switch? How could the principle of insurance, wherein premiums are paid upfront for a promise of future financial delivery of an insurer, be sold as an acceptable proposition?”

The workshop report on Microinsurance in Rajasthan makes it adequately clear that there is a market for microinsurance but the product cannot be a poor country cousin of what is available for the regular market segment. The report says that:

*The poor have buying power...*

It is a myth that the poor cannot pay or are not willing to pay. In reality, they are willing to pay a lot. This can be demonstrated by the survey conducted by Dror on 5,930 households in 2005. It was found that illness and hospitalization were common and a major share of the household earnings went on healthcare expenses. All these households could understand the importance of insurance and 60-70 per cent of the sampled households were ready to at least one-two per cent of their annual household income for their health insurance.

*... but want a customised product*

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The poor are willing to pay a lot if the product is designed as per their needs and priorities. They are savvy and they want return for their investment. The poor are not deprived of funds. They are deprived of choices. The solution, then, is to design the products that they want. 126

Michael J McCord has summed up the entire process of customizing the product for the target market. This will happen only when we understand the decision making process of the consumer. McCord has proposed this decision making model which will help companies design products as per the needs of the consumer. This decision model (figure 2.9) evaluates every step in the decision making process of the insurance by the poor. It takes into account the target market and their

- Perceptions about insurance (Do they perceive insurance in a positive light or not?)
- Understanding the concept of insurance (Do they realize the principles of insurance?)
- Product/Demand match (Is the product being offered, same as what is being demanded?)
- Easy access (to buying of insurance)
- Cost of coverage (i.e. premium, how much do they pay for covering themselves?)
- Available income (Money in hand at that specific time is a deciding factor)
- Cost/frequency of event.

McCord suggests that all these factors have an effect on the decision making for insurance. This decision making leads to purchase or no purchase of insurance. According to him, “The ultimate purchase decision for microinsurance products has many components—not just cost. In product development, all the issues in the microinsurance purchase decision diagram at left must be considered. The first two relate to developing appreciation for insurance within the market. The rest are issues that must be addressed directly in the construction of the product.” 127

126 Workshop Report, "Micro-Insurance in Rajasthan Issues, Experiences and Challenges" Workshop Report, conducted by Center for Microfinance, prepared and documented by Juhi Shah, pp 9,10

Decision Model for purchase of Microinsurance as Suggested by Michael J McCord is reproduced in figure 2.9 below.

Figure 2.9

Decision Model for Microinsurance

Perceptions of Insurance
Understanding Insurance Concepts
Product/Demand Match
Easy Access
Cost of Coverage
Available Income
Cost/Frequency of event

McCord provides reasons for why a research should be done to understand demand. The match of product characteristics with the demand concerns of the market is critical in any successful product. The level of ease of access will determine success or failure of a microinsurance product. Access must be seen broadly in microinsurance as making every aspect of the product easy—from policy simplicity to clear and manageable claims procedures. Demand research provides guidance in the creation of accessible products. The cost

of the premiums, available household income, and the potential policyholder’s perception of the cost and frequency, and thus their risk, of the occurrence of the insured event all must be considered in developing a balance between what the product will cover and what it will cost. All these factors are key inputs to the purchase decision, and not just the cost.\footnote{McCord, MJ. “Product Development–Making Microinsurance Products Successful”, \textit{Microinsurance NOTE 4}, USAID, April 2007, pp 1-9}

\textit{These concluding remarks by McCord provides the rationale behind this study, wherein the purpose is to understand the decision making process of the microinsurance customer.}

Iddo Dror (2007), Director of Operations of the Micro Insurance Academy\footnote{MIA is a New Delhi-based charitable trust dedicated to evidence-based studies, training and advisory services for microinsurance units serving the poor.}, tries to explain the gap in his study of Social Capital and Insurance ownership. “A recent review of social capital and economic development in micro health insurance units (MIUs) suggested that trust and community networks at the local level (proxies for social capital) have a significant impact on effectiveness of activities within MIUs. However, the authors of that study pointed to the dearth of field evidence of measured social capital and cases where the effects on MIUs were assessed scientifically, citing only two studies that do so. Using data from a 2005 household survey in four locations in India, the study group examined whether there is an association between insurance status and indicators of social capital, and whether this association is a general phenomenon or rather, dependant on attributes of the community or of the local MIU.”

This inquiry from India (the study carried out by Iddo Dror) adds some field evidence to the study of social capital in the context of microinsurance. It offers a few new insights notably that the lack of social capital can lead to low insurance uptake. \textbf{Generally speaking the research shows that there are some unexpected findings that justify further study in order to enable practitioners and policy makers to understand the social dynamics}
underlying the design and implementation of microinsurance schemes.

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Though attempts have been made to understand Microinsurance from Demand side, there is a big gap in available literature. The present study will try to fill this gap and understand Microinsurance from the buyer’s point of view. As suggested by Iddo Dror, the social dynamics underlying the buying process needs to be studied so that design and implementation of Microinsurance schemes can be much more effective. The present study will take the social capital concept to much more detail than trust and internal networks as propounded by Iddo Dror. It will try to answer questions raised by G V Rao like how their needs of insurance are currently being met and from what sources and how much they are costing them now. What kind of price-value proposition of insurers would make them consider a switch? How could the principle of insurance, wherein premiums are paid upfront for a promise of future financial delivery of an insurer, be sold as an acceptable proposition? etc.

This study will try to explore the behavior of the consumer as buyer or non-buyer of Microinsurance in the social context. It will answer the question of how to customize the product for this section of the society.

Schiffman and Kanuk (2002) have illustrated in their book the need to understand consumer behavior. “The field of consumer behavior is rooted in a marketing strategy that evolved in the late 1950s, when some marketers began to realize that they could sell more goods, more easily, if they produced only those goods they had already determined that consumers would buy. Instead of trying to persuade customers to buy what the firm had already produced, marketing-oriented firms found that it was a lot easier to produce only products they had first confirmed, through research, that consumer wanted. Consumer needs and wants became the firm’s primary focus. This consumer oriented marketing philosophy came to be known as the marketing concept.

The key assumption underlying the marketing concept is that, to be successful, a company must determine the needs and wants of specific target markets and deliver the desired satisfactions better than the competition. The marketing concept is based on the premise that a marketer should make what it can sell, instead of trying to sell what it has made.  

\[1^{32}\]

\[\text{Schiffman, Kanuk, Consumer Behavior, Pearson Education Asia, 2002, page 5}\]
2.4  

Marketing Influences

Phillip Kotler (2001), in his book, Marketing Management, says that the aim of marketing is to meet and satisfy target customers’ needs and wants. The field of consumer behavior studies how individuals, groups, and organizations select, buy, use and dispose of goods, services, ideas or experiences to satisfy their needs and desires. He further adds on to say “that understanding consumer behavior and knowing customers is never simple. Customers may say one thing but do another. They may not be in touch with their deeper motivations. They may respond to influences that change their mind at the last minute.” “Studying customers”, according to him “provides clues for developing new products, product features, prices, channels, messages, and other marketing mix elements.”

He also describes Insurance products as ‘Unsought Goods’. “These are consumer goods that the consumer does not know about or knows about but does not normally think of buying. Examples of known, but unsought products are Life Insurance and Encyclopedias. By their very nature, unsought goods require a lot of advertising, personal selling and other marketing efforts. Some of the most advanced Personal Selling methods have developed out of the challenge of selling unsought goods.”

Naren Joshi (2005), writing in India Insurance Report Series –I, states that “The rural market in India, constituting 742 million people, is by far the largest potential market in the world. The average annual rural household income of Rs. 56,630 (as per NCAER, IMDR 2002) coupled with changing rural aspirations in consumption patterns and lifestyles unfolds tremendous opportunities for rural marketing. However, some of the issues that seem to be hindering the large-scale advent in the rural market are as under:

- Lack of understanding of the rural customer
- Inadequate data on rural markets
- Reaching products/services to 6.4 lakh villages.

- Poor infrastructure.
- Relatively low levels of literacy.
- Inadequate reach of mass media.

The insurance sector, per se, has not made much headway in the rural area, which constitutes 70% of our population. It is common perception and belief amongst the insurance companies, particularly in private sector, that it is expensive to do business in rural areas. Most of the companies are focusing only on meeting the regulatory requirements from rural areas; they do not recognize commercially profitable rural business opportunities, waiting to be exploited. ¹³⁴

M C Garg and Anju Verma (2010) explains how every insurance company is trying to implement a Marketing program. The Government of India made history on October 24, 2000 by once again bringing back insurance business to private companies, which had earlier been abolished 34 years ago. The opening of the insurance sector was facilitated through the Insurance Regulatory and Development Authority (IRDA). Today, organizations are competing in complex business environments characterized by continuous change in economic, social, politico-legal and regulatory factors. The insurance sector, along with other elements of marketing, as well as financial infrastructure, have been touched and influenced by the process of liberalization and globalization in India. The customer is the king in the market. Life insurance companies deal in intangible products. With the entry of private players, the competition is becoming intense. In order to satisfy the customer, every company is trying to implement a Marketing Mix (MM) program. ¹³⁵

Javeri (2005), in India Insurance Report Series – I states that “The rural sector is a perfect case for mass marketing. Competition in rural areas tends to be “kinder and gentler” than in urban areas, which can easily be termed cutthroat. And the generally smaller policy amounts in rural areas would be


more than offset by the higher volume potential in these areas in contrast with urban areas. Identifying the right agents to harness the full potential of the vibrant and dynamic rural markets will be imperative. Rural insurance should be looked upon as an opportunity and not an obligation. A smaller bundle of innovative products in sync with rural needs and perception and an efficient delivery system are the two aspects that have to be developed in order to penetrate the rural markets”. 136

Evalueserve (2008) classifies the population into the following economic classes with percentage of population in each class (figure 2.10)

Bottom of the Pyramid Marketing (2008) divides the population into 5 levels as shown in figure 2.10 above. The percentage population at each level is as follows:

Upper: 11 percent
Upper Middle: 17 percent
Middle: 19 percent
Lower: 24 percent
Lower Lower: 29 percent

Bodla and Verma (2007) while working on “Life Insurance Policies in Rural Areas: Understanding Buying Behavior have found that around 70% of the respondents have monthly income below Rs. 8,000.  

Rajeev Shukla (2007) says that “the awareness about insurance is quite high in India. Around 78% households are aware of Insurance products. However, ownership of insurance products is low – only 24 percent households in the country own a life insurance cover. Those households owning a life insurance tend to be more prosperous, more educated, and own more consumer durables than those that do not own life insurance. It is the salaried class that tends to buy the most life insurance, followed by the businessmen. Predictably it is the married who tend to buy life insurance more. At the all-India level, for all households, while the average sum assured of a life insurance policy in the country is Rs. 27,951, the average premium paid is Rs. 1227 and this represents 4 percent of the household disposable income. If, however, the insured households alone are considered, their average premium payments work out to Rs 5,007 and sum assured of Rs 114,450”.

UNDP (2007) paper lists 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


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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.

(4) Difficulty in distribution, is one of the most cited reasons for absence of rural insurance. The high cost of penetrating rural markets, combined with under utilization of available distribution channels, hinder growth of rural 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.  

Wipf et al (2006), while describing the Product design of Microinsurance state the following points that must be kept in mind for successful implementation:

- Microinsurance product design must strike a balance between broad inclusion, appropriate benefits, low premium rates and sustainability (or targeted profitability).
- Products have to be customized to clients’ needs and preference.
- Affordability and product design features have to be considered together.
- Microinsurance is relatively easy if the target market is well-organized in group; significant challenges are faced when trying to serve unorganized individuals.
- Group coverage is generally more appropriate for microinsurance because it minimizes administrative costs, which should lead to lower premiums.

Mandatory coverage has significant advantages, while its disadvantages can be curbed through marketing and education efforts, and some choice in benefit packages.

Short-term insurance is generally more appropriate for the low-income market.

The heterogeneous low-income market prefers a variety of premium payment frequencies and mechanisms.

It is advisable to limit benefits to the most important insurable risks.

The spreading of life insurance benefits over a period of time might be advantageous to both parties as long as transaction costs can be minimized.

If policyholders cannot easily claim for a benefit, then the policy is not very beneficial.

Deductibles, co-payments and benefit limits are important claims controls for health insurance schemes.

Product design features like waiting periods and benefit schedules allow microinsurance schemes to include high-risk persons without incurring additional screening costs. 141

A whitepaper on Bottom of the Pyramid marketing by Evalueserve, (2008) concludes that it is vital to understand consumer buying pattern and preferences in the rural markets. “The attractive yet virtually untapped rural market is plagued with low per capita disposable incomes, large number of daily wage earners, dependence on monsoon, seasonal consumption, poor roads, power problems and inaccessibility to conventional advertising media. These perennial issues have so far discouraged several companies to explore the BOP market. Further, lack of knowledge on consumer buying pattern and preferences in these markets have also played a pivotal role.” 142

Prahlad argues that what is needed to be successful in this market is a ‘change of mindset’ According to him, (fig 2.11 below) the leap of faith from


“the poor is a problem” to ‘the poor is a market’ is the beginning of success in marketing to them.

Webb et al (2009), in ‘Investigating the Key Criteria, for Micro Loan Provider Selection: The Case of the Poor in Kedungjati, Indonesia’, have found out that “The potential of micro loan products to reduce poverty has received wide approval. Indeed, the highest acclaim, perhaps, is the winning of a Nobel Peace Prize in 2006 by a Bangladeshi economist, Muhammad Yunus of Grameen Bank, for his significant contribution to the development of the microfinance sector.

But they further report that “In spite of the above reported success, critics have nonetheless questioned the effectiveness of micro loan product implementation. Datta (2004), for example, argues that while micro loan products have contributed positively to the well-being of the poor, they have failed to reach the poorest of the poor. Prahalad (2005) refers to these poor as ‘Bottom of the Pyramid’ (BOP) customers. This paper (‘Investigating the Key Criteria, for Micro Loan Provider Selection: The Case of the Poor in Kedungjati, Indonesia’) argues that one factor that is contributing to failure is...
Micro Finance Institutions (MFIs), which lack basic marketing information about the BOP market.

As we saw in the above chapter, the target segment for Microinsurance is same as that of Microfinance, we can conclude from the study by Dave Webb, Nunik Kristiani and Doina Olaru that basic marketing information is not sufficiently available to Insurers.

“Results of a study by Webb et al (2009), have highlighted the importance of marketing stimuli in micro loan provider selection with institutional characteristics representing the strongest predictors. Consequently, it is clear that relevant industry marketers should make sure that the reputation of MFIs is strong and positive in the minds of BOP customers. This can be achieved by paying particular attention to the development of appropriate communication strategies that emphasize and reinforce an organization’s positive ‘image’ along the lines of the institutional characteristics highlighted by this study. We note at this point that the institutional characteristics discussed earlier can logically be referred to as ‘image’ factors. 143

Gerry Nkombo Muuka and Mutinta Milimo Choongo (2009), in ‘Listening to voices in poverty from Zambia, state that “Too often, the poor are ignored at the planning stages of social programs that are ostensibly designed to help them, while the needs and desires of “upstream” donors take precedence (Lagace, 2002). The place for social marketing, of poverty reduction, is to ensure that an "exchange of goods and services" paradigm is replaced by a little more of an "intervention” paradigm. For that to happen, somebody needs to listen to people on the ground, the poor, when they speak in their own words. Someone has to mediate between "donors" and commercial organizations on the one hand, and the poor on the other. What initiatives have the potential to alter life balances in favor of the poor? Marketing

professionals can lend their own voices to this process, in a multi-pronged strategy for poverty reduction, in Zambia and beyond.¹⁴⁴

Thus, it becomes imperative that the success of Microinsurance as a tool for poverty reduction should involve the very people for whom the business is targeted. This study tries to understand the market from customers’ point of view so that commercial organizations, donors and government can devise product, price, place and promotion strategies accordingly.

From the firm’s point of view, its marketing efforts are a direct attempt to reach inform and persuade consumers to buy and use its products. The marketing strategies of product, price, place and promotion (4 P’s) are used to achieve this end.

To carve out these strategies, marketers need to understand the needs and wants of the customers.

¹⁴⁴ Muuka, GN. and Choongo, MM. “If only the chronically poor could talk: listening to voices in poverty from Zambia”, International Journal of Nonprofit and Voluntary Sector Marketing 14: 155-160 (2009) Published online 2 December 2008 in Wiley InterScience, 2009
Product Decisions

Phillip Kotler (2001) defines Product as anything that can be offered to a market for attention, acquisition, use or consumption and that might satisfy a want or a need. This definition includes not just physical products but services.

According to Indian Institute of Banking and Finance, as a financial services example, an insurance policy could be viewed as:

- A written promise from an insurance company to pay a defined amount to the policyholder in the event of specific occurrences.
- (or)
- A range of services provided by the financial institution such as toll-free hotline, newsletters, additional financial advice etc
- (or)
- A feeling of security and peace of mind on the part of the consumer

Sourav Biswas and Ratna Devi (2008) have brought out the need and stages in making a demand oriented product. “Although Micro Health Insurance (MHI) is meant for people who live below or just above the poverty line, those who cannot afford the traditional health insurance schemes, it is not giving the desired results. These schemes are not sustainable in the long run due to several limitations in the product design. To overrun this problem a feasibility study including the data collection and analysis phase, scheme design phase, and a phase to prepare for implementation of the scheme is required. Designing a client demand oriented product is a must for the successful implementation of the scheme, and stages such as client requirement analysis, prototype design, pricing, final product design, staff training and pilot test are to be considered. The performance of the scheme can be measured through a set of indicators—growth ratio, coverage ratio and liquidity ratio.”

145 Managing and Marketing of Financial Services, Indian Institute of Banking and Finance, Taxman Publication, Page 64

Thus we see that the same product can be viewed from different dimensions while performing the same core function.

Service goods are immaterial. The customers cannot test the quality of the good to be purchased in advance. Thus, a certain degree of confidence is required in the product to be bought from the service company. This is especially true for insurance products. The product sold by the insurance company is the guarantee to pay a monetary equivalent for the object insured in case a defined event (accident, fire, etc.) occurs. This guarantee is not only immaterial, but the customer can only experience the quality of the product if the insured event actually happens. 147

With the notification of IRDA (Micro-insurance) Regulations 2005 by the Authority, there has been a steady growth in the design of products catering to the needs of the poor. The flexibilities provided in the Regulations allow the insurers for composite covers or package products. The insurance companies are now offering already approved general products as Micro-insurance products with the approval of the Authority, if the sum assured for the product is within the range prescribed for Micro-insurance. 148

Ponreka Maria D and Surya Rao (2009) compare the performance of LIC and that of private players with respect to service quality. The public and private players need not compete each other in life insurance market. They have to create their own niche market. This is possible only under non price competition especially consistent development of their service quality and delivery of the customized service. The mean and standard deviation of LIC data revealed that LIC is good at Reliability, Assurance and Empathy features than at Tangibles, Responsiveness features of the life insurance service. These features are based on the standard SERVQUAL dimensions. Through factor analysis, the factors identified with new names which influence the quality of service rendered by the LIC in Madurai district are Individualized

148 IRDA Annual Report 2008-09
attention. Performance, Tangibles, Trustworthiness and Courtesy. While this research provides some important initial insight into role of service quality factors in life insurance market, there is still an opportunity to extend these findings to gain on more comprehensive understanding of service quality. 149

Microinsurance is low premium – low claims product. It is targeted at those who have no means to protect themselves. The product design demands lowest possible price to the end customer. Regular insurance product is very complicated to understand & contains many exclusions & riders. Microinsurance is simple to read with bare minimum exclusions & riders.

In many aspects, problems associated with health insurance are true of other microinsurance products as well. Education and information about insurance are a necessary precondition for satisfied customers. Furthermore, the benefits must correspond to the needs and expectations of the clients. However, while for others microinsurance product lines a consensus seems to exist that high-cost, low-frequency events are especially worth covering, this does not necessarily hold true for health. The poor are very much aware of the burden of low-cost, high-frequency events. But these are difficult for a health insurer to cover. The claim process produces high costs as it is difficult and expensive to obtain the information needed for claims’ verification. For a viable health insurance scheme, it is therefore recommended that the policyholders and the community be involved in the business process, thus mobilizing their social capital. The greater the degree of convergence of the interests of insured and insurer, the more viable the arrangement will be. 150

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150 Redermacher, Dror and Noble, “Challenges and Strategies to Extend Health Insurance to the Poor”, Protecting the Poor A Microinsurance Compendium, edited by Craig Churchill, 2006, ILO, pp 93
Pricing Decisions

Balachandran (Insurance Institute of India) describes pricing mechanism as, “In a contract of insurance, the insurer promises to pay the policyholder a specified sum of money, in the event of a specified happening. The policyholder has to pay a specified amount to the insurer, in consideration of this promise. ‘Premium’ is the name given to this consideration that the policyholder has to pay in order to secure the benefits offered by the insurance contract. It can be looked upon as the price of Insurance Policy”.

These (Microinsurance) products are priced at rates affordable for the intended clients, while being financially viable for sustainability of operations. For BoP population, there are both supply and demand side bottlenecks, resulting in a ‘missing’ market.

Monique Cohen et al (2005) have brought forward the essential question that is it only willingness to pay that decides the price of the product. According to them, “Designing a product which the public can afford to purchase is key to its adoption. Otherwise, design efforts are in vain. The question, however, is not simply one of whether or not a family has the money to buy the product; but also whether there is a willingness to pay in its broader sense. This includes the way in which clients have to pay premiums, the total cost of coverage, and the understanding of the product and trust of those delivering it. Since it is often difficult for the poor to generate large lump sums of cash in a short period, microinsurance institutions have found that if they can break the premium into smaller pieces the product becomes more affordable. Consideration of this as well as the timing of customer income flows will increase willingness to pay for an insurance product.”

A white paper by Evalueserve on Bottom of the Pyramid Marketing (2008) explains the crucial role of pricing in market penetration. “Cavin Care introduced INR 0.50 sachet packs of Chik shampoo at a time when

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151 Balachandran, S. Life Insurance, IC-33, New Syllabus, Insurance Institute of India
penetration of hair care products in rural India was quite low. The strategy was highly successful and Chik shampoo’s market share grew from 5.61 percent in 1999 to 23 percent in 2003. The sachet strategy creates “artificial price differential’ and drives volume sales”. 154

McCord et al (2006) in their study on Premium Collection and minimizing transaction costs and maximizing customer service have brought to the fore the complex issue of collecting the premium. “Premium collection is a daunting aspect of efficient microinsurance efficient microinsurance provision. Some insurers (or their delivery channels ) have found ways to minimize premium collection costs and maximize efficiency. Efficient arrangements mean prompt and full payment without affecting the safety of the premium transfer mechanism or sacrificing customer service advantages. To achieve their financial stability, insurers must make every effort to ensure that premiums are paid on time.

The common premium collection methods respond to client needs to varying degrees. Among the least expensive methods for the insurer is for community groups to collect the premiums from their members and make consolidated payments to the insurer. Collection by insurers of aggregated premiums from MFIs and other groups, which link the premiums to another product or electronically transfer the premiums, can be equally inexpensive. The door – to – door method of collecting premiums from individual policy holders is typically very expensive”.

In this study McCord et al, have listed few premium payment lessons. According to them, “a balance should be maintained between the efficiency of the insurer, and the cash flow of the policyholder. Electronic transfers reduce the costs of all parties involved. They also stress that wherever possible, collect premiums from a specific source of funds at a time when those funds are available like employers salary payment. Frauds (in collections) should be controlled and electronic transfers are an efficient method to do that. Collection frequency and timing required should be further explored through market research. The study also lays emphasis on inculcating an insurance

culture amongst clients by making them understand the collection mechanism and consequently the policy that they are purchasing. Finally, the study suggest that non renewals should be dealt with keeping in mind poor people’s realities.  

Place Decisions
Distribution
Organised distribution systems in India reach out to only small towns of 5,000 or more. It is estimated that at least 20 percent of the population is not effectively linked to the national and regional distribution systems of the organised sector. Strong distribution and communication systems are critical to any effective bottom of the pyramid strategy. A company alone, especially an MNC, cannot create the commercial infrastructure at the bottom of the pyramid. Viable partnerships with local people and community agents who have the social capital to bring people together and build incentives should be emphasized.

India’s telecom revolution has improved connectivity across the country and mobile phone penetration in this segment is increasing. However, poor infrastructure in low-income markets increases operations cost. Thus, the involvement of local population in the distribution not only improves product distribution, but also fuels entrepreneurial aspirations, thereby creating more job opportunities.

Bhattacharya et al have suggested the use of group lending in Microfinance to improve recovery rates. The learning for microinsurance is that groups do work better and should be used to prevent dropouts. For the last two decades development experiences of different countries strongly vouch for the potentials of micro credit and group lending. The root cause of failure of the social banking program is located in the asymmetric information between the lender and the borrower, making the individual lending policy extremely costly and absolutely ineffective. To


overcome this problem, group lending is considered as a definitely safer option. Since the group has much better access to local information it is possible for the group to make a distinction between a risky and a safe borrower. The lender has to design some incentive (threat) scheme for the group to utilize the information in the interest of the bank. Thus, the group will, in effect, act as an agent of the lender. If the group is held responsible for non-performance of any one of the group members, then it would simply raise the cost of default and, because of peer monitoring, the repayment rate would improve.  

The Role of the Insurance Agent

According to section 182 of the Indian Contracts Act, an ‘agent’ is a person employed to do any act for another or to represent another in dealing with a third person. In the insurance industry, the term ‘agent’ is ordinarily applied to a person engaged by the insurer to procure new business. The Insurance Act defines an insurance agent as one who is licensed under Section 42 of that Act and is paid by way of commission or otherwise, in consideration of his soliciting or procuring insurance business relating to the continuance, renewal or revival of policies of insurance. He is for all purposes, an authorized salesman for insurance and needs a license.

Bodla and Verma (2007) suggest that agents are the most important source of information and motivation as rural people just take a policy which the agent suggests to them.  


The number of micro-insurance agents at end March 2009 was 7250; of which 6647 were for the LIC and the remaining represented the private sector companies (figure 2.12).

Figure 2.12
Number of Insurance Agents with Public and Private Players

<table>
<thead>
<tr>
<th>MICRO-INSURANCE AGENTS (LIFE INSURERS)</th>
<th>As on 1st April 2008</th>
<th>Additions</th>
<th>Deletions</th>
<th>As on 31st March 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIC</td>
<td>4166</td>
<td>2482</td>
<td>1</td>
<td>6647</td>
</tr>
<tr>
<td>Private</td>
<td>418</td>
<td>281</td>
<td>96</td>
<td>603</td>
</tr>
<tr>
<td>Total</td>
<td>4584</td>
<td>2763</td>
<td>97</td>
<td>7250</td>
</tr>
</tbody>
</table>

Fifteen life insurers have so far launched 30 micro-insurance products. Of the 30 products, 16 are for individuals and the remaining 14 are for groups. 159

Figure 2.13
Chanel wise Individual New Business Performance of Insurers

We see from this table that out of total number of policies issued in 2008-09, a staggering 79% are sold through individual agents only.

Intermediary organizations also have their own set of issues. There are reasons why existing distribution channels have not considered insurance as

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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.160

**Promotion Decision**

B S Bodla and Sushma Rani Verma (2007) suggest that companies should understand the rural psyche before starting a rural promotion program. A communication that is meant for the urban counterparts will not be understood by the rural audience in the right context. According to them, “We can safely say that until some years ago, the rural market was given a stepmotherly treatment by many companies and specific advertising targeting the consumers was usually a hit-and-miss affair. More often than not, the agenda was taken as a shortcut route by pushing urban communication by merely translating the advertisement copy. Hence, advertising that was rooted in urban sensitivities, didn’t touch the hearts and minds of rural consumers. The role of advertisements is still not up to the mark in motivating rural people to buy insurance policies.

Therefore, the greatest challenge for advertisers and marketers continues to be to understand the mindset of the rural consumers because something that sells in one area, may not find the same support in another.”

“The marketers need to understand the rural psyche. They have to recognize that today rural marketing demands somebody with local knowledge and flavor and who can connect with the local audience. The importance of various non-conventional media is stressed. The attitude of the villagers towards various non-conventional and folk media has been found to be very positive and favorable. Apart from this, since the villagers have less accessibility towards conventional media such as television and radio, the marketers need to look at various non-conventional media as alternatives. In fact, marketers can use a judicious mix of conventional and unconventional media. Further, it is important to be glued to the region-specific requirements and cater to the typical tastes of the regional consumers, both in terms of

product offerings and communication packages. Therefore, marketers who understand rural consumers and fine tune their strategies accordingly, are the ones who will succeed in future.” 161

A Whitepaper by Evalueserve on Bottom of the Pyramid Marketing – ‘Reaching out to 110 million Indians’ (2008) shows what promotional tools can companies use to reach out to the rural audience. “Each region in India has a distinct language, culture and rituals. Further, low literacy levels, coupled with absence of traditional advertising media, have posed a challenge for markets. To overcome these challenges, marketers are increasingly organising promotional activities in local haats and mandis, as well as places of worship, frequented by a majority of BOP consumers. For instance, advertising agency O&M promoted Lifebuoy soap by conveying the message of safe health through Gurudwaras. Similarly, Nokia and LG run vans through villages demonstrating and selling their products. However, ‘Word-of-mouth’ is the best form of advertising. In rural areas, there are some select opinion leaders who hold regular meetings with the community. These meetings are a common platform for all to discuss everyday issues.” 162

Michael Menhart/Carsten Rennhak (2006) quoting Albrecht explain the demand for insurance products using Maslow’s theory of needs hierarchy. A different approach to the demand for insurance products is based on Maslow’s theory of human motivation, according to which there is a hierarchy of needs observable in the goods consumed by the people.

It is quite obvious that the demand for basic insurance products is assumed to be part of the second level of Maslow’s hierarchy, the need for safety. The history of the German insurance sector yields several examples supporting this hypothesis.


In the early years of the insurance industry, in the middle of the 19th century, the purchase of insurance was a privilege of the upper class. However, once the industrialization raised the living standard of major parts of the population, insurances became popular for lower classes as well. On the other hand, immediately after the Second World War, the priority of the population was to satisfy the basic physiological needs. Only after the economy recovered and the basic needs were fulfilled in the beginning of the fifties, the insurance industry experienced a significant upturn.

While the physiological needs of the population can be regarded as being more or less satisfied after the 1950s, this is not necessarily the case for the need for safety. In the last 50 years, almost all classes of insurance in Germany experienced significant growth rates. On the other hand, Geiger (1992) identified that even at the beginning of the nineties 40% of the private households in West Germany did not have a life insurance and 70% in the Eastern parts did not have an accident insurance.

Moreover, the concept of the Maslow's pyramid of needs also helps to explain the further growth of the insurance population after the economic upturn in the fifties and sixties. Once the second level of needs is satisfied, people seek for new goals such as the need for esteem and self actualization. If the people nevertheless do not want to neglect the safety requirements of the second level of needs, they might demand additional insurance coverage.

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Sorab Sadri (2009) has linked insurance with savings and also shown how LIC has made rural business, profitable. “Without a state security cover, people would like savings to be linked with risk coverage and therefore insurance has a very important and a powerful attraction for the people. This is the point which we would like to emphasize that public sector insurance companies and, specially the LIC, have proved that doing business in rural India is profitable business, and therefore, do not confine their activities to the urban India only.” 164

Educating the masses about the benefits of life insurance and a more intensive sales campaign are the only definite means of stepping up household savings in this form in the short as well as long-term. Although greater employment security and growth in income would help promote savings in this form, there is scope for increasing savings even at the current levels of income by educating the masses about the importance of life

insurance. This should not be difficult for the service providers, considering the fact that of late, they have been making efforts to increase life insurance ownership in rural India – a more difficult task than extending the coverage in urban areas. However, making households more insurance-minded will be, comparatively, a more difficult task that may require determined sales efforts spread over a longer period of time.\(^{165}\)

Datamonitor’s Financial Services Consumer Insight survey has shown that consumers in Asia Pacific defy being pigeonholed by saving providers, revealing diverse product tastes, saving methods and plans for the future. Financial services providers must appreciate the unique savings culture of their target market and the variety of preferences if they are to successfully build wallet share.

Household savings rates in India and China are among the highest in the world, according to Datamonitor’s Financial Services Consumer Insight (FSCI) survey. The survey also showed that this trend is set to continue, with over 70% and 63% of consumers in India and China, respectively, intending to increase their savings over the next six months. This is in stark contrast to Japanese consumers, who save as little as 3% of their household income. Furthermore, with only 26% of Japanese consumers looking to increase savings, this attitude looks set to continue.

The survey showed that, globally, consumers have shown increased concerns for their personal finances and yet have not made steps to improve their situation for fear of making the wrong move. This 'head in the sand' behavior is also apparent in Asia Pacific as a whole, even though the global downturn has struck in varying degrees of severity across the region. Australia has been sheltered from the bulk of global financial woes and was one of the first developed counties to step out of the recession. Nevertheless, apathetic consumer behavior is evident in Australia: 57% are concerned about their savings, and yet only 43% intend to increase them over the next six months.

Consumers favor products with ease of access over those with high returns.

\(^{165}\) Shukla, R. “How India Earns, Spends and Saves”, Results from the Max New York Life – NCAER India Financial Protection Survey, 2007
Consumers are now much more interested in saving for the near future than in dealing with longer-term goals and are attempting to build up a short-term buffer to use in case of a dip in income. This is reflected in consumers' choice of savings products which ensure that their money is always close to hand and can fulfill its role as a short-term stockpile.  

### Potential for Growth

Microinsurance in India is growing partly in response to government intervention through insurance regulator and partly due to the real need for protection against risks that the poor face. Ideally, all the low income people should have an insurance cover that provides certain minimum level of benefit in the event of illness, death or injury. An insurance package that provides health, life and accident benefits should be provided to the poor. In offering such benefits, the low-income people must be asked to contribute, depending on their ability, which is a function of income. Insurance to poor should be considered not just a financial product but as a poverty alleviation tool.

Dr. David Dror says ‘one cannot exclude the possibility that insurers and others, insufficiently aware of clients' priorities, seem to misinterpret low demand as reflecting Low willingness to pay, ignoring the unattractive value proposition of the main product and the devastating impact on the demand side of “cherry picking” … one can wonder if those who are interested in making insurance work for the poor in India might be stuck in a vicious cycle, which looks like this:

| POOR PRODUCTS → LOW DEMAND → LOW WILLINGNESS TO PAY → LOWERING OF PREMIUMS → FURTHER WORSENING OF INSURANCE PRODUCT OR SERVICE … |

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Breaking the vicious cycle begins at the cycle’s original weak point: unattractive products and insufficient choice to clients must be reversed. Improving the value proposition and variety of micro-insurance products; and after-sale service is not only fair and desirable, but indispensable for the extension of an insurance market that could reach as vast a size as the number of the underserved poor persons. This is also the key to generating more revenue for insurance. 168