Microinsurance in the Health Sector

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SANIT
Introduction

Of the world’s approximately 6.4 billion people, roughly 1.3 billion are currently living in low to middle income countries where access to health care is restricted due limited financing and/or provision of services. Barriers raised by informal economies and large rural populations have caused many to consider the poor to be uninsurable, however, over the past two decades several measures have been taken in order to transfer the control of the financing and provision of health care services from a national level to a community level. One of the current practices to transfer this control is the establishment of microinsurance, which benefits low-income individuals by pooling their risks in a manner that is affordable to them (Preker, Carrin, Dror, Jakab, Hsiao and Arhin-Tenkorang, 2002).

The Emergence of Microinsurance

Health Care Systems

For the vast majority of history, health care has been characterized by a transaction between two parties, the ill and his or her caregiver; however, in the 19th century health systems began emerging. These systems were characterized by three basic functions: the financing of health care, the production of goods, and the provision of services. As health care systems developed so too did the idea of health care as a right of individuals, an idea that culminated in 1938 when New Zealand established the right of universal coverage for a variety of health care services. Other industrialized nations soon followed suit and by the end of the 1950s most developed nations had health systems in place to protect the well-being of their citizens.

The systems developed by industrialized nations rely on a transfer of resources in order to be effective. First, they move resources from groups with little exposure to health risk to groups with a large exposure to health risk. Second, they transfer wealth from high-income individuals to low-income individuals. Lastly, they re-allocate resources from younger, productive members of society to older non-productive members of society (Dror and Preker, 2002, pg.29-30).

Meanwhile, in low and middle income countries health care systems struggled to develop. Spending on health care increased from 3% of world GDP to 8% of world GDP over the course of the twentieth century, yet in developing nations health care spending has averaged only 4% of GDP at the end of the twentieth century. This means that while 93% of illnesses correspond to the 84% of the world’s poor, only 11% of the world’s spending on health care is coming from low and middle income countries (Dror and Preker, 2002, pg. 22-23).
There are several reasons why these figures are true. To begin, low and middle income communities have more problems mobilizing resources. This is due in part to the scarcity of resources that exist within these communities and in part due to the existence of a large informal economy whose income varies seasonally and whose members do not exist within a particular structure. High income nations have a greater number of individuals working within cities for formal employers, hence the main means of resource mobilization, taxation, is easy to regulate. However, low and middle income nations have much larger rural populations who are often self-employed or informally employed, making tax collection much more cumbersome for governments.

The division between the informal and formal economy plays a role in the problem of unifying funds as well, which is second reason why health care systems have not developed as fully in low and middle income nations. Often health systems provide care through different means depending on whether or not the individual belongs to the formal or the informal sector. As a result funding for health care is spread across several programs instead of being placed in a common fund that all parties can draw from regardless of occupation or location. In addition, tax evasion in the informal sector among the wealthy and middle classes of these developing nations is often high, while distrust among the low-income members of society has been aroused by the poor quality of the services being offered. As a result there are few members of the society who want to put their resources into a common pot, even though the pooling of those resources has the potential to lead to better care for more people.

A final factor in low and middle income nations’ difficulties in establishing satisfactory health care systems are the problems that were encountered with resource allocation. Policy decisions about resource allocation can raise conflicts such as whether money should be spent in poor, rural areas with little political influence or in more wealthy areas where the population also has a greater say in government. These conflicts can also cause a decentralization of strategy, which sometimes leads to a short-term outlook that can create larger problems in the future. With health care systems failing to meet the needs of the population alternative solutions needed to be found.

Insurance

The concept of insurance dates back to early civilizations when merchants would pay a premium on the price of goods purchased in order to remove their liability for the cost of those goods if the goods were lost or stolen in transport. The seller of the goods could afford to accept these conditions because with several clients he could spread his risk. By calculating the probability that some goods would be lost, he could assure that the premiums that he received would always cover the value of the loss (Kathy Bayes Insurance Agency, 2003).
Health insurance, however, did not have a wide following until Chancellor Otto Van Bismark made it mandatory for German workers in 1881 (Kloman, 1999). Despite the proliferation of health insurance that followed, it is only recently that insurance has been used as a tool used to provide health care services the poor. A little more than a decade ago the poor were considered to be uninsurable because they carried a higher level of risk. Since risk is often used to determine the size of the premium that needs to be paid, low-income individuals would presumably be expected to pay more than wealthy individuals. Thus, health care insurance was considered to be unaffordable and hence, not an option, for the majority of those already disenfranchised from a health care system. Other obstacles which kept insurance from being considered were the difficulty in communicating the idea of health insurance to clients. Low-income individuals still practiced a form of health care that was closer to the old patient-provider system than the modern three-function system, as a result, it was assumed that a system that required members to pay-in even when there was no illness or provider contact would meet with resistance. The other concern that helped to keep insurance as a low-income health care tool out of contention was fraud. Insurance providers were unsure of how to control the system in order to prevent widespread abuse (Dror and Preker, 2002, pg. 77-78).

Despite these perceived setbacks, over the last two decades communities have developed several tools to bring in better access to health care, among these microinsurance. The rise of microinsurance was assisted by the attention that microfinance has received as a means of reducing poverty. The concept of microfinance originated in the 1970s, growing out of experiences in both Bangladesh and Latin America. At that time the poor were not only considered to be uninsurable, but they were also considered to be unbankable. It was assumed that because the poor lacked collateral they represented a higher risk, which would lead to higher rates of interest on money lent, which would make banking services unaffordable to this large segment of the population. However, the experiences gathered over the past thirty years have shown that poor individuals with access to microcredit can improve their economic power, thereby making microcredit affordable even for those earning less than $US1 per day (Preker, Carrin, Dror, Jakab, Hsiao and Arhin-Tenkorang, 2002).

The success of microcredit has thus caused people to take a closer look at what other tools can be adapted for use in low-income communities. In addition, microfinance institutions (MFIs) in studying the results of their efforts have continued to look for ways of removing barriers to economic growth. As a result, they have begun expanding their product offering in order to include savings products, which help borrowers in the planning of economic necessities, and microinsurance in several forms, to provide protection from external shocks.
Client Needs

Risk Protection
As mentioned previously, the poor are considered to be more at risk than their wealthier counterparts. As a result, they are in need of a product, tool, or strategy that will help protect them from these risks. Traditionally there are three methods of managing risk: risk reduction; mitigation; and coping. Coping has been the method most frequently employed by low-income members of society; however, coping often requires the sale of an asset that can hurt the long-term ability of the individual or family to cope with future risks (Del Conte, 2000). An easy example of this is the mother who is forced to sell her cow in order to pay for a child’s illness. If the cow provided milk that the mother could sell at market, then the family’s ability to generate income has been damaged, creating a larger risk to the unit as a whole.

Given that coping can be detrimental in the long term, solutions that emphasized risk reduction and mitigation were sought. However, to determine how these types of solutions could be implemented it is important to understand the risks that low-income individuals and families are facing.

Categories of Risk
The three main types of risks that have been identified are:

- Lifecycle risks
- Structural risks
- Crisis Risks

Lifecycle risks are risks that have a certain degree of predictability. A study of Kenyan women between the ages of 26 and 40 determined that the events that required the most money were: marriage, children’s secondary and tertiary education, a prolonged illness, and the death of a spouse. Though the actual occurrence of these events cannot be planned, a representative majority of women would be faced by all of these events and forced to contribute.

Permanent or long-term changes in the national or international economy cause structural risks. These types of risks can be caused by declining prices in the international market place, by a regime change that leads to occupational shifts in the civil service, or by variations in demand
brought upon by seasonal spending patterns. Individuals without savings, when faced with these situations, are exposed to financial risks which might lead to a loss of education or health care.

Crisis risks arise due to unexpected shocks that can interrupt or decrease an individual’s or family’s ability to generate income. These are shocks similar to the situation of the woman with the cow that was described above and like that situation this type of risk often leads to a reduction in a households assets or a decrease in the household’s consumption. The long-term effect of either is likely to be a household that is in a more precarious position after the shock. (Wright, 1999)

**Products**

Focusing on risk reduction and mitigation, the search for an appropriate solution to the above risks has lead many communities to turn to microinsurance as an alternate tool. Before continuing, however, it is important to note that microinsurance does not refer only to health insurance. The array of products include: life insurance, loan redemption insurance, disability insurance, crop insurance and property insurance. While some of these products such as disability insurance and life insurance can, in some instances, cover medical costs, for the sake of simplicity the focus of this paper will be restricted to health insurance programs.

Health microinsurance acts to reduce risk in two manners. First, a well-designed program will encourage clients to seek assistance early on in an illness. This incentive both reduces the costs of the insurer and reduces risk for clients, since it means that problems can be identified at a stage when their ability to disrupt income generation is reduced. Second, several though not all, microinsurance programs take this idea one step further and offer preventative services, thereby further reducing the risk of a major illness. Health microinsurance mitigates the effect of a shock by providing the products or services that will allow a patient to cope with the problem without requiring that the family sell off assets or reduce consumption.

As mentioned previously, the reduction of risk and the mitigation of its effects are not inherent within the product of health microinsurance. The product must be well designed in order to provide clients with the greatest benefit. A well-designed product is defined as satisfying three main conditions:

- The price of the premium should not be so expensive that it requires individuals to sell off other assets in order to acquire this one.
• The coverage of the service must be comprehensive enough to address those issues that arise and to encourage clients to seek medical care early, rather than late in the process.
• Payments should be structured in a way that does not make it difficult for clients to meet them.

Several examples of payment structures that seek to minimize hassle can be found. One of these is the creation of a fixed deposit account. The balance in the account is set at an amount large enough so that interest earned over the course of a year is large enough to pay the price of the premium. Another method is to collect the premiums on a daily basis, thereby breaking its actual price down into a small enough unit to facilitate payment. Still another possibility is to match the premium payment to a loan cycle or to the seasonal variations in income level. (McCord, 2001)

A compendium of microinsurance programs assembled by the STEP Global Program of the ILO lists 130 microinsurance programs operating out of 26 countries (Lee, 2000). The range of coverage provided by these products and their manner of provision varies widely, so one cannot narrowly define the services of microinsurance. The services offered can cover in- and out-patient procedures, tests, medications, dental, optical, hearing, home care, preventative care, check-ups and health education. Most policies have defined exclusions of service such as certain medications, pre-existing and chronic conditions, and elective surgery. Policy holders can also be limited by the providers that they can use, the amount of money that they can receive on a single illness, restrictions placed upon when services can be used, or the age ranges of those eligible for service.

Business Models

The products and services that will be offered and the manner in which they will be provided are often influenced by the business model that has been used to develop the microinsurance plan. Four main models have emerged in the field of microinsurance:

• Partner-agent model
• Community based model
• Full service model
• Provider model

The partner-agent model is a system with two main players. The agent or insurer provides the financing and know-how to create an effective health care system, while taking on the risks. In
exchange, the partner provides the delivery of the product and the service to individuals and families out in the field. Thus the partners are able to reduce the costs of the insurer by using their already extensive network to generate sales and disseminate information. An advantage of the partner-agent model is that there is a level of control between the clients and the insured who are able to oversee the program in order maintain quality and cost.

The community based model is owned and run by the individuals who use the plan. A group of elected managers are responsible for negotiating the provision of products and services with external health-care providers. These same managers continue to oversee all aspects of the interactions between the external providers and their members. This means that they collect the premiums, review the claims, manage the accounts, and evaluate the risks. A disadvantage of this system is that it requires an extensive level of knowledge for what is essentially a voluntary position. As a result, instances of mismanagement due to errors in judgment can be more common, as is fraud. A second area of concern is that the way that services are negotiated can reduce the effectiveness of the coverage. If community members pay for coverage on a fee-for-service model then they eliminate the incentive for health-care providers to offer preventative services. There is also an opportunity for health-care providers to direct clients towards services with higher margins, even if these services are not the most beneficial to the client.

In the full service model a single entity is responsible for all aspects of the product. The insurer accepts all risks and receives any profits. It also designs the product and provides the staff for sales, develops the marketing plan, provides customer services and reviews claims for validity. In order to achieve all of these objectives the insurer must have a knowledgeable staff and be able to maintain the appropriate financial controls to avoid problems such as insolvency. This model is the most similar to that used by insurers in developed nations operating in the formal economy.

The provider model is characterized by a health care provider that offers a range of care to individuals or groups through insurance policies. Care is generally limited by the services that the provider is capable of offering; however, implementation is relatively straightforward since by paying a fixed amount, clients are then able to access services whenever they are needed during a defined period of coverage. The provider is responsible for establishing pricing and evaluating risk, which it then assumes. One advantage of the provider model is that because fees are fixed there is an incentive to offer preventative care.

As the microinsurance industry is still young, no consensus has been reached upon which, if any, of these models will prove to be the most effective for providing health-care services to the world’s poor; however, a clear conclusion from the review of these four models is that the model needs to
be designed so that there are well structured incentives for maintaining client health. (McCord, 2001)

Stakeholders

The above discussion gives an indication of the number and variety of stakeholders involved in the provision of microinsurance. Stakeholders in the microinsurance industry are clients, insurance providers, health care providers, donors, and governments.

Clients

As mentioned previously, microinsurance clients can be any of the 1.3 billion poor currently lacking access to adequate health care coverage. The main concern for these clients is how to reduce the risk of illness and mitigate its effects without increasing the client’s exposure to risk in the long-term. Thus far, microinsurance services have been accessed by clients in both urban and rural areas.

Insurance Providers

Many insurers currently providing microinsurance services are acting in the semi-formal or informal realm. Formal insurers have a license and are often discouraged from entering the microinsurance field due to the perceived high costs of providing the service. While on the other hand, many semi-formal—insurers with some type of legal status, but without a license—and informal insurers are discouraged from entering the formal market because of the high reserves required.

In addition to the different legal statuses of providers, there are also different types of providers, ranging from insurance companies, to commercial microinsurers, to community-based insurance plans, to MFIs. As is the case with the business models, no consensus has yet been reached on which of these providers will be the most effective at reaching a broad client base.

Health Care Providers

The health care provider does not have to be a separate entity than the insurance provider; however, in many cases they are not the same. Health care providers can either be a private or public entity that is willing to provide services in exchange for payment either under a contract or on a fee-for-service basis.

Governments
Governments play a role in the provision of microinsurance in two ways. First, they are financing a health care system that may be one of the providers of medical services and products. Second, governments play a large role in the establishment of regulatory norms. An example of this is given by the government of India, which required that a specified percentage of the sales volume must be used for the benefit of low-income groups (Wiedman-Pfister, 2004).

Donors
As microfinance has stepped further into the limelight, donors’ attention has been increasingly drawn to other services that MFIs have been offering such as savings and insurance. As more cases of microinsurance have been put forth, there is an increasing acceptance among the donor community that microinsurance is providing a means of reducing poverty.

As the industry grows and gains greater experience the roles of these stakeholders will become more complex. Similarly, each of these players will begin to exert more force upon the others. Donors will have more say in the provision of insurance, providers will gain a larger voice in the regulation of the industry, clients will be able to demand a larger array of services and health care providers will be able to attract more funds. As these relationships increase in complexity several challenges to the industry will begin to be felt.

Challenges to the Microinsurance Industry

Regulation
One of the main issues facing microinsurance is the regulation of the industry. Regulation has an important effect on the ability of low-income populations to access services as it can serve as either a means of promoting microinsurance or a way of restricting access to it. Some of the current regulations that are impeding access to services are high barriers to entry due to the large amounts of capital needed, restrictions placed on who is allowed to act as an agent of insurance, and regulations that dictate how an insurer can operate.

The issue of capital requirements is an important one. Insurance regulators wish to protect the investment of clients by making sure that insurance firms remain solvent so that they can continue to provide services; however, higher levels of reserves make it difficult for those insurers who are currently offering services as semi-formal or informal insurers to make the switch. This means that these agencies are less well monitored, resulting in greater risk for their clients. For those formal insurers who attempt to both meet the reserve requirements and provide services to the lower
income levels of society problems can arise as well. In one case in Bolivia, an increase in the minimum capital requirements forced a microinsurer out of business (Wiedman-Pfister, 2004).

Requirements delineating who is allowed to serve as an agent of insurance also can cause restricted access. Many governments will not allow NGOs to act as insurance agents, forcing those providers to continue operating in the semi-formal and informal economies if they are unable to find appropriate formal partners. In addition, requirements placed upon the level of qualification and years of experience needed to act as an agent raise costs and eliminate potential providers from the market. While the complexity of providing insurance certainly requires regulation, governments must walk the thin line between being to restrictive and failing to provide proper protection.

A final area of concern involves the regulation of insurance operations. Some regulations affecting operations involve limiting the provision of insurance to those agencies whose sole line of business is insurance. As a result, organizations such as MFIs who wish to offer insurance as an additional service to their customers must establish a separate staff and in some cases separate offices in order to provide the same clients with a new product. Other regulations, such as those that dictate the information that must be included in a policy, increase the complexity of client-provider interactions. Low levels of literacy and education among microinsurance clients require a product that can be explained in a straightforward manner. Thus regulations that require sophisticated language can decrease clients understanding of the product, thereby decreasing the likelihood of participating in microinsurance plans.

Regulators are being asked to walk a fine line that protects clients without restricting their access. Protecting customers can be done by putting in place rules that regulate delivery channels, complaints and rate setting. They can also enforce disclosure norms in order facilitate the transfer of information from provider to clients. In addition standards should also be set for insurers regarding qualifications, reserves and risk limitations, but it is important that in setting these standards regulators distinguish between insurers and microinsurers in order to ensure that the standards are appropriate. (Wiedman-Pfister, 2004)

**Reinsurance**

Insurance is designed to spread individual risks over a larger group in order to provide protection from loss. However, even insurers are limited in the size of a risk that it can accept or the amount of coverage that it can provide. Reinsurance allows insurers to also spread their risks, thereby protecting themselves from loss. By paying premiums on their insurance portfolio to a reinsurer, the insurer pools his risks with those of other insurance providers. When faced with losses the
insurer is then protected from bearing the full force of those losses by the reinsurance claim. Reinsurance also allows insurers to improve financing, increase capacity, decrease fluctuations in claims from one year to the next and to protect themselves against catastrophes, which could otherwise destroy the business (Dror and Preker, 2002, pg. 59-61).

The solvency protection offered by reinsurance is of crucial importance for the microinsurer and its clients, yet many reinsurers are only able to work with a formal insurance company, that is a company with a license. This means that most microinsurers are left more vulnerable than their formal sector counterparts. If microinsurers want to be able to maintain solvency and stability then they will have to find ways to work around this issue, either by partnering with formal insurance providers or through lobbying for regulation that is more supportive of the microinsurance provider (Wiedman-Pfister, 2004).

**Education and Communication**

The concept of risk pooling is one that must be clearly and effectively communicated to clients if insurers do not want to lose these clients through attrition over time. In a study of four microinsurance programs, providers were surprised to find that retention was an issue that required their attention. This is due in part to lack of understanding of how risk pooling works. In general, those clients who had bought into an insurance program, but had not used the services because of lack of need felt that the service was a waste of their money, while those who had benefited from the service were pleased with the results. If the purpose of insurance is not well communicated then clients will stop purchasing the service. As the number of clients falls, the risk pool becomes smaller and more vulnerable to a shock, which can put the entire microinsurance program at risk. Therefore, increased efforts to educate clients about how insurance functions must be implemented. Continuing communication on the part of the microinsurer should also be established in order to strengthen the message (McCord, 2001).

**Conclusion**

The microinsurance industry is still young, meaning that it has both few proven successes and few proven failures. At this stage in its development most parties are still optimistic because it is known that lack of options for managing risks has continued put poor people at risk and impede their rise from poverty, thus any tool that allows client to reduce risk and mitigate adverse effects is cause for hope. Past successes in the area of microfinance have added to this optimism by demonstrating that the same products that work to provide opportunity and security among middle-
and high-income individuals can be adapted for use with low-income individuals. Thus an insurance product geared to the needs of low-income communities holds promise.

Nevertheless, there are important obstacles that must be overcome if this optimism is going to prove valid. The majority of microinsurers continue to operate outside of the regulated economy. This lack of supervision amplified by a deficit of technical knowledge and an absence of supporting structures such as those provided by reinsurance has the potential to put microinsurers in jeopardy of insolvency, which will not only damage today’s clients but also build distrust that could have a long-term negative effect. In addition the business models that develop must place an emphasis on communication and education, both about how microinsurance works and about preventative health care. It is only if microinsurers pay close attention to these issues while continuing to learn from the increasing number of experiences in the field that one can really hope to smooth the volatility of life for the world’s remaining 1.3 billion uninsured.
References


