Deepening Financial Inclusion

The potential role of micro insurance in driving sanitation
Financing Sustainable Development

The Sustainable Development Goals have been signed. The governments have committed themselves to 17 ambitious goals that are designed to end poverty, protect the planet, and ensure prosperity for all. A question that requires an answer: how are we going to finance this? Many of the goals are interrelated and not exclusive. This implies that activities to achieve these goals should also be interlinked.

During the International Conference on Financing for Development in Addis Ababa in 2015, governments from all over the world came up with a package of more than 100 concrete measures that draw upon all sources of finance, technology, innovation and trade that is supposed to support the implementation the Sustainable Development Goals. “Financing needs for sustainable development are high, but the challenges are surmountable,” said UN secretary-General Ban Ki-moon at the opening of the Conference.

I believe the world has all the resources and expertise it needs to reach those goals. With our Financing Sanitation Paper Series we hope to share our expertise on how we can finance Sustainable Development Goal 6: Ensure Access to Water and Sanitation for all.

Financing Sanitation Paper Series

The Financing Sanitation Paper Series is a unique collection of six articles about different aspects of sustainable financing of sanitation (in emerging markets) - from financial inclusion to private funding and from micro insurance to climate financing.

The first two papers in the series were well received officially and circulated through different fora. A similar process will be followed in launching this paper: personal presentations of the paper combined with making it available on-line. Even more than the first two papers, the theme of this paper “micro insurance and its role in sanitation” is new.

India but also Sub Saharan African countries have a large financially excluded population living in poor sanitation and hygiene conditions. Their hygiene (or their lack of it), financial exclusion and poverty most likely reinforce each other. Their living conditions imply that they could fall sick frequently. In the absence of a health care financing mechanism, this implies costs in the form of medicines and loss of working time and income. Illness is a cause for defaults on (micro) loans. Thus this increases the lending risk for any financial institution. Now suppose that such people could borrow for safe sanitation, would there be financial institutions willing to issue these loans and if so at what cost? This was object of discussion in the two earlier papers.

Now what if this borrowing and sanitation usage can be incentivised by offering a micro health insurance that rewards good behaviour (sanitation usage). This is of great interest to insurance companies as the number of claims is likely to come down and make it a more commercially viable proposition.

This paper serves to highlight lessons learnt in conceptualizing, designing and implementing micro health insurance for the poor and hygiene deprived segments of society in India and Kenya. This is elaborated below.

Health care is indeed complex even in developed economies and much has been written and thought of in the context of its sustainability and affordability. A look at the current state of health care and its financing in many developing countries reveals the following:

Absence of health infrastructure

The lack of an efficient and reliable Government owned / supported network of hospitals / clinics, non-availability of doctors, coupled with other supply side constraints mean that, in practice, people have no alternative and need to pay for expensive private medical treatment (though health care may be free in government establishments). As private insurance penetration is low, it results in self-financing of health care costs, which can be prohibitive. Therefore it is often neglected (even more for women and children). More often than not primary healthcare is not
accessed and that results in avoidable but necessary recourse to expensive secondary and tertiary healthcare at a later stage. Lack of timely healthcare access has a correlation to malnourishment and stunted growth that cause loss in productivity and a downward spiralling effect on human well-being.

**Employees in private and government sector**

The organized sector is perhaps a bit more fortunate in health care access though they constitute at best a tenth of the workforce. Some of the employed class in the organized private sector have recourse to health care through an employee benefit program funded by the employer and backed by private health insurance. Government employees’ health care administered by the state owned health service providers is free of cost. However, in practice the benefits are only available in the larger cities where the infrastructure is somewhat well kept and doctors are in attendance. The deeper one lives in the countryside the lesser the facilities.

**The unorganised sector**

For the unorganized sector, financing of health care expenses is a grave concern and quite often the lower middle class or middle class families can face loss of property or assets, such as land, due to sudden and severe health care costs. On hindsight it would be seen that such a consequence could easily have been avoided if access to primary and preventive care was present in the first place. Needless to say, this makes people extremely vulnerable to economic shocks that can force them back into poverty.

**Bottom of the pyramid**

As we move down the socio-economic ladder and look at the very poor and the bottom of the pyramid, we note that in addition to other risks, poor hygiene and other living conditions trigger a propensity to fall sick more often and with greater recovery costs and time. In other words, not only do low income classes have less money to pay for their illnesses, they also fall ill more frequently due to their living conditions. And because they mostly depend on daily wages with no medical paid leave, like those in the organized sector, the costs of falling sick are even higher as it would mean a wage loss in addition to treatment costs.

**Micro insurance and sanitation**

Generally micro insurance is a product that conventional insurance companies avoid as the small amounts (premium average between €4-15) and insurance covers or ticket sizes do not permit underwriting expenses thus leading to a situation where re-insurance is either not available or far too expensive to factor into the premiums.

Life, accident, livestock, weather, productive assets (e.g. tractor) are forms of micro insurance that have developed in the last few decades. For the purpose of sanitation the most relevant insurance product would be micro health insurance. Micro life and accident insurance is easier to administer but less relevant because, except small kids, few adults die of poor sanitation.

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1. Most of these group health insurance programs are unsustainable for the insurance company as the employees seek their dependent parents / pre-existing conditions also to be covered. For the insurance company the loss on such policies is treated as a cost of doing other profitable business with the employer and in a way cross subsidized just for the sake of topline.

2. In recent times such government run health care programs have begun to outsource some of the complicated and expensive tertiary care treatments to the private sector providers, as they are incapable of providing them efficiently in-house.
Role of micro health insurance

The role of health micro insurance (health care financing) in accelerating behaviour change in sanitation practices is however indirect. The FINISH belief is that: if smoking, bad driving and lack of exercise can be a moral hazard to conventional insurance products, then so could unhygienic practices represented by non construction and non usage of safe toilets be a moral hazard for health insurance products in the target market.

Insurance partnerships

To explore whether access to health care financing could be linked to sanitation practices FINISH (India) partnered with TATA-AIG initially and later with L&T General Insurance. Both partnerships aimed to offer to the target market a micro health insurance product where impact of safe sanitation on health insurance claims could be studied. Furthermore, the partnerships also were to explore if incentives can be offered in health care financing that would impact off take and usage of sanitation assets – and lead to sustained behaviour change.

This paper is very close to our daily practices as they are written purely on the basis of our experiences in the insurance industry. This is the reason why you will find no references in this paper.

Finally, to be able to finance sanitation and its impact on health care sustainably, we need to work together, build innovative partnerships and share knowledge. We have developed the Financing Sanitation Paper Series for this specific reason, to share our experiences on financing sanitation and to start an exciting discussion on this topic that can bring to focus linkages that would enhance the attainment of the SDG’s. We therefore invite you to react to the papers on our blog, which you can find on www.finishsociety.org; www.waste.nl; www.SuSaNo.org and as linked-in group.

Looking forward to meet you there.

Valentin Post,
Financial Director WASTE
vpost@waste.nl

*Financing Sanitation - an overview of the financial instruments for sanitation used in FINISH programmes in India and Kenya*, and *“the essence of public and private funding for sanitation” and “Deepening Financial Inclusion - the potential role of micro insurance in driving sanitation”* are part of a series of papers on sustainable financing of sanitation.

Forthcoming papers are:

- Financial inclusion and sanitation from the beneficiary point of view
- Comparative costing of sanitation – from the bill of quantities to the Chinese Motorcycle Index
- Sanitation and climate financing
Deepening financing inclusion

The potential role of micro insurance in sanitation

In the first paper we outlined the Financial INclusion Improves Sanitation and Health programmes in India and Kenya (FINISH respectively FINISH INK). In the second paper we described the essence of public financing of sanitation, both papers are available on www.waste.nl, www.SuSaNa.org and www.finishsociety.org. In this third paper we describe the link between sanitation and one aspect of financial inclusion, micro health insurance.

Financial inclusion

Financial inclusion encompasses offering wide range of financial services to the hitherto financially excluded. These financial services range from financial literacy, micro credit, micro leasing, micro savings, micro insurance, money transfer and micro pensions.

Outline

In this paper we describe: (1) the possible role of micro insurance in development in general and in sanitation in particular; (2) the micro insurance work that we had done under FINISH, and (3) what we see as way forward particularly in relation to the FINISH programme in Kenya. This paper is the most difficult of the financing sanitation papers as we have experienced a rough and as of yet incomplete journey to achieve our objective of linking micro insurance to sanitation. Particularly as health care products limited to hospitalization somehow did not meet the FINISH requirements adequately. On the positive side, DGIS has been very supportive in our quest to make this vital link and we are not easily giving up on this ourselves.

Micro insurance

Micro insurance has a special place in financial inclusion as it protects wealth of low income people against specific perils in exchange for regular payments (premium) proportionate to the likelihood and cost of risk involved. It does this through sharing the risk in the target market so that premiums remain affordable yet equitable.

In general, insurance is administered in two ways: Retailing individual insurance or through group insurance schemes. Both have their own nuances and their relative advantages and disadvantages.

Advantage of group insurance

Group insurance policies typically require a minimum percentage of subscription in a given group. For group insurance to work groups are required to be homogenous so that risks can be fairly shared within the group and secondly groups should not be formed only for the purpose of availing insurance covers as that could lead to adverse selection against the insurance company. Group policies are also typically the form of insurance where a third party i.e. an employer, a bank, cooperative or government is paying for the policy thereby becoming a master policy holder. Depending on the insurance companies’ willingness to enrol a particular group (and cover the risks) and on the size of group the conditions of a group policy may differ substantially and be more favourable when compared to the retail policy in terms of exclusions, coverage etc.

The basic concepts of insurance i.e. sharing of risks, law of large numbers, data on (necessity of) a chance occurrence of a stated peril, apply equally to group and individual policies. However in the case of group policies the premiums and benefits/claims estimated for a stated group only.

In the case of a retail policy the premiums and benefits are calculated across the retail policy holders for that particular products across the insurer. It should be noted that the lower class and lower middle class are not formed into formal groups like and employee group. Besides, if products are designed for the poor, only the premiums would end up being unaffordable, and it would no longer benefit the poor.

Thus the question is: can a sustainable retail product be designed that shares the risks of the peril across different income groups where the risks could be substantially lower, and thereby lowering the premium per policy?
Generally speaking, when insurance coverage is pursued as a group, the administrative costs of issuing the policy is lower. The aggregation of individual premiums in a group means that there is scope to bargain for better terms as well as lower distribution costs (commissions). Needless to say, the larger and more homogenous the group, the better the chances of premiums being lower. However, the underlying principle of insurance is that the risks being covered need to have an element of chance in their occurrence across the group. Failing when the costs could be very high or unsustainable coverage to the insurance company.

1. Private bridge and gap financing and attracting public subsidies, Rajasthan, India

Micro insurance [MI] covers financial losses of probable perils to low-income households who need them most. To begin with most low-income households do not have a regular income stream and are often in a state of indebtedness with the more recent microloans replacing the earlier ones. The positive impact of micro-insurance on covering financial losses of the target market in the event of: (1) death / sickness of earning member or the spouse; (2) loss of property due to calamities (3) loss of productive assets due to natural disasters or theft etc. cannot be overemphasized. More often than not the perils above can erode the wealth of the households and push them into further indebtedness.

However, the target market does not understand the way insurance works. Insurance is famous its fine print which makes matters worse. The lack of this education often results in people or the distribution channel having unreasonable expectations from insurance. Mis selling and past experience of dealing with insurance often leads to households not being insured at the right time and that can undermine the whole development process that families/ communities go through.

Micro insurance as wealth protector

Banks lend based on collaterals such as mortgaged assets or regular income streams. Financially excluded households are those that remain outside the ambit of the organized financial sector, i.e. banks. Their access to financial instruments is through self-help groups and micro finance institutions. Both function as aggregators of demand.

In financial inclusion, the role of micro insurance (MI) is that of a wealth protector. In that sense it is a product that can be used as a surrogate collateral for microcredit which, as a rule, is lending without collaterals. It is logical that more credit will be available in the target market if MI was there to cover risks of financial losses.

Micro insurance and livelihoods

Retail individual MI products and all its details have to be explained to potential customers face-to-face. The individual or organisation that does this is called an Agent (individual or corporate) or a broker. MI products need to build in the cost of doing this in the product price itself as distribution cost. In addition, once the sale is made and the policy paper is handed out to the client, there would be field customer servicing requirements as most MI customers would not be able to deal directly with the insurance company. Thus, the Agent will be the single point of customer contact. Having a well-trained agent helps the insurance company to create (i) better awareness in the target market about how insurance works (i.e. rights and duties of the policy holder), (ii) control adverse selection and moral hazard and more importantly (iii) ensure proper utilisation of the product thereby creating a satisfied MI customer who would renew the policy before it lapses and get risk protection over a longer period of time.

Since insurance agents are typically drawn from the community itself, this whole process of insurance distribution can create a few livelihoods in the community. This helps to increase the social sustainability of the intervention. It is important to note here that - given the small premiums - the agents are more likely to be part-timers and mostly housewives/self-help group women as the income from sales and servicing is more in the nature of a supplementary livelihood. If the insurance companies look at the distinct needs of these MI agents, they can develop some of them as regular agents. They can then be trained to sell traditional products that would enhance their incomes and encourage them to become fulltime agents.
Micro health insurance and sanitation links to microcredit provision

Many repayment delays and defaults in the microcredit sector are a consequence of unforeseen medical expenses. Illnesses also lead to a loss of wages on account of employment days lost both for the indisposed and the caregivers. The factor of hygiene could be a big contributor to the health care costs in the target market, as much of the illnesses in the target group can be attributed to poor hygiene and sanitation. By designing a health care financing program around the use of sanitation assets, more money will flow into sanitation. Apart from the fact that propensity to fall ill, this would also reduce, thus creating a positive feedback loop with a multiplier effect.

Can micro insurance enable behaviour change in sanitation?

Making health micro insurance sustainable is a prerequisite for its commercial availability. This depends to a large extent on the target markets ability to demonstrate change in behaviour (hygiene), so that safe sanitation is adopted, resulting in health costs coming down both at the household as well as the community level. If health micro insurance products can be designed with incentives to monetize behaviour change, it would present a win-win situation. This is similar to the concept of charging higher life insurance premiums for people who smoke excessively or to vary vehicle insurance premiums depending of the track record of the driver.

Can micro health insurance be a monitoring tool for sanitation?

If micro health insurance claims can reflect the actual state of hygiene in a community arising out of safe sanitation practices, then it is possible that the claim data are used as a surrogate to monitor development projects in sanitation and measure its impact. Though it's a far-fetched thought, health micro insurance with sufficient subscribers can serve as independent indicator of hygiene in the community. This makes it a live cost-effective monitoring tool for the development agencies. This justifies investments made by these agencies in micro insurance.

Can this be replicated across other development interventions?

The need is to develop models that uses health micro insurance to actually have an impact on development, instead of just target financial inclusion as an end. The same logic would appear to hold true for many programs in or around environment, disaster management, livelihood, water conservation programs, where developmental assets can be built/facilitated by microcredit. If micro insurance can potentially reduce the default in micro loans taken to acquire the developmental assets then more commercial money can replace donor funding thus making development efforts more financially sustainable.

Micro insurance as responsible investment for the insurance industry

Insurance companies find micro insurance interventions within the existing costs structure difficult. Micro insurance will initially present product and process costs, education and promotion costs and above all higher transaction costs as there is no financial infrastructure that micro insurance can leverage. Innovative processes and products, leveraging the technology platform, and efficiency in transaction are imperatives to serve this large new market. Learning’s from such innovations can benefit the conventional insurance operations. That presents a case for micro insurance in general.

By integrating micro insurance into development programs, there would be a strong case for development funds to partially defray the initial costs of a micro insurance program launch. That would also enable faster attainment of sustainability to the micro insurance intervention itself. Therefore, apart from micro insurance being a responsible investment strategy for the insurance industry, such linkages between the financial world and development can further encourage innovation of the kind that makes micro insurance more of a development finance tool rather than only an insurance product.

In the FINISH programme in India, we have made efforts to link these aspects of financial inclusion with sanitation and hygiene (health). This is described below.

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4. This implies all aspects of sanitation, generation, collection, treatment and disposal, safe reuse of human excreta.
2. Micro insurance under the FINISH Program India

The FINISH program started off as an international Public Private Partnership between WASTE (Dutch NGO), TATA-AIG (insurance company, India), SNS-REAAL (Dutch insurance banking group), UNU MERIT (UN knowledge institute, Netherlands) and local Micro Finance Institutes (India). Its objective was to develop a model for improving hygiene and health of rural communities in India through construction of half a million onsite sanitation systems whereby nutrients present in excreta could be safely reused and using innovative financial inclusion methods. The program is funded by DGIS (Ministry of Foreign Affairs, Netherlands). It does not support any hardware costs of owning a toilet or a treatment system as those are largely funded through household borrowings, savings and local government subsidies. The FINISH program uses a variety of financing instruments to offset gap and bridge finance required for sanitation assets (see the first paper of this series) as well as develop a supply chain to efficiently use the household resources for safe sanitation.

TATA-AIG, as founding partner of the program, started their micro insurance involvement under the following premise.

2a. TATA-AIG Micro Health Insurance

Policy considerations

Risks for the poor are high due to the low level of health security. Many are forced to borrow money or sell assets to pay for the treatment in private hospitals. In spite of the fact the public spending is ever increasing, about 80% of health costs are still paid by patients out of pocket. For many, even minor illnesses can cause big financial setbacks.

The self-insured population in India is only about 3%. In figures in the fiscal year 2009 the general insurance industry recorded a health insurance premium (premium of both self-insured and those compulsory insured) of Rs 6,625 crore (€ 900 Million). As most of total healthcare expenditure is met from savings, the potential for health insurance businesses is very big. TATA-AIG General Insurance Company (TAGIC) and TATA - AIG Life Insurance Company (TALIC) wished to tap the synergies and build on each other’s strength to emerge as leader in the health domain.

As the increase in average health care costs has outpaced the increase in average earnings, this results in increased level of debt, erosion of savings or in inadequate level of healthcare or all three. This results in critical illnesses / death or reduced productivity / mobility / earning capacity. The prevalence of this trend also has a larger impact on the social fabric. So for the rural poor, health insurance, particularly micro health insurance products could be a way of overcoming financial handicaps, improving access to quality medical care and providing financial protection against high medical expenses.

To help such a deserving section of our population and also to tap a vast potential market, TATA-AIG General Insurance Company (TAGIC) had designed a micro health insurance product with various choices and options. The product was comfortably priced, keeping in view the capacity to pay.

Product details

**Sum insured options:** The insurance is available under six options viz., Rs. 5,000, Rs. 10,000, Rs. 15,000, Rs. 20,000, Rs. 25,000 and Rs. 30,000.

**Benefits:** Expenses of hospitalization arising out of sickness/illness/accidental injuries to the insured person/s towards room rent, boarding charges of the patient, nursing charges, surgeon’s, anaesthetist, medical practitioner, consultants’ fees, cost of drugs and medicines, cost of diagnostic tests, pacemaker, intra ocular lens, and emergency ambulance charges subject to the terms and up to the limits mentioned in the policy document.

**Eligibility:** Non Governmental Organisations, Local Governments, Self Help Groups, Micro Finance Institutions, or any other association working for the welfare of such people or of which such people are members. Such members shall be within the age band of 18 and 65. However, in case of continuous renewals under this insurance, the maximum age limit will be 70 years.
Premium: The premium proposed are in the region of Rs. 1 - 2 per day based on the age and sum insured etc.

Optional coverage: Family floater, maternity benefits, pre-existing diseases (the last two extensions will be offered selectively) are at additional premium.

Availing of benefits: TAGIC will hire the services of a licenced Third Party Administrator (TPA) to provide cashless hospitalization facilities through networked hospitals. A 24-hour helpline will be provided. Beneficiaries will be issued identity cards to facilitate this. Alternatively, claim can also be made on reimbursement basis, i.e. the beneficiary can settle the hospital bills and can claim from TAGIC / TPA subsequently.

Target market

The target market is the life insurance component segment of rural India being catered to by TATA – AIG micro life insurance programme

- Household income below US $3/day
- Higher incidences of common illnesses like malaria, cholera, diarrhoea, and seasonal illnesses as the hygienic conditions (living, water and sanitation) are poor.
- Most vulnerable to morbidity and mortality risks of earning member in the household
- Large percentage of income is normally spent on health costs.

Figure: The micro insurance market in India (targeting large numbers of low income clients)

The challenges foreseen are:

- Unwillingness to pay for tertiary health insurance as primary health services appear more relevant. This also leads to selective subscription by the people likely to file claims which are contrary to insurance principles.
- How to price primary health services and what is the right model/process to provide such services linked with tertiary care services? Needless to say this has been a critical requirement of even conventional health insurance products and even in 2016 very few companies in India have been able to file and launch primary health care products.
- Can factors such as hygiene etc., which have a bearing on primary health care costs, be suitably incentivized so that target market health risks are lowered?
• Can micro health insurance premiums be lowered (and by how much) with the provision of timely primary health care, since that would result in lower total health care costs?

The setback

TATA-AIG had filed their health insurance product (detailed above, a new type of product focusing on primary health) at the end of 2009 with the Insurance Regulatory Development Authority (IRDA). In view of its high potential and being a demand side product, it is one of the six targeted results of the FINISH programme. However, the product was not approved by the Regulator!

This part of the FINISH programme could in its anticipated shape not be operationalised. Needless to say a developmental project that was geared towards collaborating data on micro health insurance, tie up with reinsurer, health care outreach to primary care, community enterprise to maximise awareness and create livelihood, establishment of primary health treatment and protocols hereof, and all these linked to use of sanitation systems was also stalled.

The way forward

TATA-AIG sought more time to get approvals so as to be able to launch their micro health insurance product. FINISH was also hopeful that TATA AIG would eventually launch a more relevant primary care product. In the meantime exploratory discussions have started with a few other insurance companies to consider their partnering in FINISH. The products they offered were tertiary in nature (hospitalisation), though some had an outreach programme too, but linked to the same hospitals. Most of the insurance companies were in principle agreeable to provide premium discounts to those clients that have a sanitation system.

Exploratory discussions with Max Bupa and L&T General Insurance have resulted in L&T joining FINISH and its programme management board. FINISH had been discussing tailor-made insurance products with L&T General Insurance, based on their approved health insurance products. Discussions focused on health insurance premium discounts to those clients that do have a sanitation system. The need was mainly for a primary health care product. Although not the most relevant, the tertiary product appeared to be a good starting point.
2b. L&T General Insurance Company

For most of the risks faced by the (rural) population insurance companies, such as L&T Insurance, specific micro-insurance products were developed.

Although their two micro health insurance products were linked to hospitalisation, at least these were approved and it could be investigated how these could be linked to the sanitation usage by the client.

Micro insurance for health\(^3\) is a very complex insurance product\(^4\) and according to many specialists very difficult to administer and certainly to start it as a regular business. Yet, the private micro health insurance products from L&TGIC were officially launched in Delhi on February 12th, 2013. The first time that such a retail commercial product was launched (as far as we know anywhere in the world!) in the highly regulated insurance industry.

The health insurance bundling in the FINISH sanitation program serves as an endorsement by a third party of the potential health effects of sanitation. It is expected to work in as much the same way as tobacco consumption on a life insurance premiums. It could also be compared to how safe drivers with accident free records could impact car insurance premiums. The question therefore being addressed through the health insurance pilot was whether sanitation behaviour change can be influenced through health insurance incentives.

In respect of this engagement – FINISH identified and suggested entities and persons who are competent and capable of being recruited as licensed micro insurance agents for the company and also advised the micro insurance company on the recruitment of micro-insurance agents or specified persons. FINISH also facilitated necessary documentation enabling enlistment of the selected micro insurance agency as a micro insurance agent for L&TGIC.

FINISH envisaged their role as a distribution marketing company (DMC), which could be the link between the insurance company and the rural distribution intermediaries, whereby the DMC aggregates demand from the micro insurance agents who were also FINISH partners. The registration of the DMC, titled as FINISH Services

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3. Larsen & Toubro a US$ 12.8 billion technology, engineering and construction group with global operations. It is one of the largest and most respected companies in India's private sector. L&T General Insurance Company Limited (L&T Insurance) is a wholly owned subsidiary of Larsen & Toubro Limited.

4. It is very difficult to price even a conventional health insurance product.

5. Materials need to be developed in various local languages, policies in local languages need to be established, trainers need to be trained and finally partners and their staff at different levels need to be trained on aggregating insurance, facilitating information flow for claim settling etc. Initial focus is on setting this product in the market. From the insurance company's perspective, hospitals need to be identified. Information and funding flows need to be tied up etc.
Management Company Private Ltd, was done with the Registrar of Companies, Ahmedabad. This financial innovation would also give us the insight if, and how, we can use insurance to measure the impact of development schemes and, in this case, to use health insurance to measure the impact of sanitation (use).

Focus on partner capacity development in L&T health insurance

Identification and enrolment: FINISH acted as partner to identify and facilitate enrolment of grassroots Civil Society Organizations (CSOs) that were also implementing hygiene and sanitation programs, as Micro Insurance Agents (MIAs) for L&T, in pockets of 3 States (Maharashtra, Rajasthan and Orissa).

Capacity development: L&T Insurance had created special training content for this intervention in an easy to administer format in vernacular languages (Hindi, Marathi and Oriya). The policy documents and proposal forms were also customized in local vernacular languages. L&T Insurance would train FINISH resources who will in turn identify, enrol and train MIAs and Specified Persons (SPs) to sell L&T Insurance micro insurance products.

FINISH would build the capacity of MIAs and the SPs for efficiently bringing width and depth to the distribution and service of L&T Insurance’s micro health insurance products. Once trained, the MIAs would work in identified areas to promote the need and importance of buying micro health insurance alongside their ongoing work of promoting hygiene and off-grid sanitation, with the target market being the rural financially excluded.

The L&T General Insurance Products

L&T developed two products: – “my:jeevika Cash Hospital Micro Insurance” and “my:jeevika Medisure Micro Insurance”. The first one is a certain fixed pay-out per day that could ensue upon being hospitalized. The same is also sometimes positioned as a hospitalization loss of wages product. The second one was for reimbursement of actual expenses to a limit based on submission of hospital bills with a discharge report.

Usually such insurance products require the customer to be hospitalized for a minimum period of time (24 or 48 hours) to rule out any claims arising out of outpatient treatment. Their products were built around tertiary care treatments and protocols related to in-patient treatment. It is believed that this approach is correct because typically, insurance is best suited to handle low frequency and high pay-outs.

By offering only secondary and tertiary care insurance the possibility of insurance claims only arises when the policyholder is hospitalized in a network hospital thus appearing to give the insurance company a better chance of controlling moral hazards and/or fraudulent claims. A big cost factor in only offering hospitalization is that there could be overtreatment in the absence of clear protocols. Besides a detriment could be connivance between the policyholder and the provider/administrator.

It also means that most young and healthy people who buy hospitalization insurance are not going to feel that they will benefit from it, as they are unlikely to get hospitalized. So, in theory, there could be a high incidence of adverse selection as buying hospitalization insurance would be more beneficial to the old and the unhealthy. Most insurance companies control the possibility of adverse selection through medical tests before issuance of policy, waiting periods and exclusions though in large group policies they could get covered.

The third category of health care expenses, i.e. primary health care, is the costs that one encounters while visiting a General Physician. Usually the first point of contact of the person requiring health care in the system in most developed countries. Most primary care costs remain uncovered by insurance programs in developing countries. Some Group Policies may offer limited primary care costs coverage in select hospitals but individual policies seldom offer any coverage of outpatient costs.

Non-coverage for primary care costs through insurance could result in some simple, easy to treat ailments remaining neglected and untreated due to affordability reasons, which then end up in acute or chronic manifestations of the illness, requiring hospitalization that could be more expensive to treat. A good example of this would be untreated diarrhoea, which could result in dehydration, and kidney and bladder infections.

Insurance companies therefore would tend to agree that having a comprehensive health care policy is best, as that would ensure that primary care illnesses are treated and hence, the incidence and intensity of secondary/tertiary care hospitalization costs would come down. After all, prevention costs would be far lesser than cure for hospitalization. Yet, there are too many issues and moral hazards preventing most to enter this field.
The academic partners of the project (UN University Maastricht/IFS London) were to check the hypothesis that better sanitation facilitates result in lower spread of communicable diseases and therefore lesser hospitalization incidents leading to lower health insurance claims. Once the project had substantial data to prove this, it would be useful for designing comprehensive risk covers and differentiated health insurance products that can equitably benefit poorer sections of society.

Health insurance hospitalization products

One of the foreseen results under the FINISH programme was: micro finance institutions that developed marketing channels for micro-insurance products. Its progress in time is captured in the table below.

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<tr>
<th>Indicators</th>
<th>RESULTS</th>
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<tbody>
<tr>
<td>Health insurance products developed</td>
<td>regulator did not approve primary health care product of TATA-AIG</td>
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<tr>
<td>Insurance sales channels developed</td>
<td>Training of 13 trainers, 2 MI training for 46 MI specified persons 2 coordinators recruited</td>
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<tr>
<td>Number of policies sold</td>
<td>158, 2,245, 5,659</td>
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<tr>
<td>MFI provide micro insurance products independently</td>
<td>MFIs selling different MI products</td>
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<td>MFI sell MI products. Proposal sanitation linked primary health insurance DFID/WSP</td>
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<td>Partners MFIs and NGOs are selling different MI products of different companies</td>
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<td>MFIs and NGO sell MI products. Contract IFS, local partner &amp; FINISH for study in 40 GPs(1) of partner</td>
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<tr>
<td>MFIs and NGO sell MI products. Additional 64,152 Personal Accident policies TAGIC</td>
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(1) Gram Panchayat, smallest local Government unit
It was anticipated that a correlation between the launched health insurance and proper sanitation could be established. This financial innovation should give us the insight if, and how, insurance can measure impact of development schemes. Or in our case: could we use health insurance to measure the impact of sanitation (use)? For the insurance company: could they factor sanitation use in the design of its health insurance product?

The number of policies being on the lower side (insurance being all about numbers), the developmental and sanitation impacts of insurance could not really be tested. This coupled with the fact that the insurance environment in India was not very conducive for experimentation, especially in the presence of an already implemented group insurance scheme fully subsidized by the government.

It was like a chicken and egg story. The hypothesis that sanitation link with health costs, required a product to be available for a sufficient period of time. Such a product required sufficient correlation data to be filed with actuarial validation. This resulted in FINISH looking into expanding elsewhere for the micro insurance piece.

3 The way forward, can Kenya (FINISH INK) lead the way?

Based on the results of the FINISH program in India, a similar program called FINISH INK (FINISH in Kenya) was conceptualized and commenced operations in 2014. The partners are WASTE, FINISH Society (India), AMREF (Kenya), Goodwell Investments (Netherlands), K-REP Bank (Kenya), Actiam (earlier SNS-REAAL Asset Management), Ministry of Health (Kenya), Social Equity Fund (Netherlands) and Family Bank (Kenya). The objective is to develop a financial inclusion dovetailed sanitation program for construction of 40,000 household sanitation systems in two target counties; Busia and Kilifi.

Financial Inclusion in FINISH INK

In FINISH INK financial inclusion is in the form of financial literacy, microcredit for financing sanitation assets (in different forms – please refer to the first paper) and introduction of micro insurance. In Kenya regulations for microcredit have enabled microfinance institutions that seek out niche applications. Sanitation is positioned to be one such niche that has the interest of Sidian Bank (formerly K-REP Bank) and Family Bank (both FINISH INK partners) and - more recently - Savings and Credit Cooperatives (SACCOS).
The micro insurance interventions in FINISH INK are conceptualized around the following objectives:

1. Using retail micro insurance (life, health and general) as financial products that create a financial asset that can be deployed as a collateral to enhance borrowing capacity of households.

2. Using retail and group micro insurance products as a new service available to rural households that would enable some members of the community earn supplementary income.

3. Create a financial infrastructure for delivery and servicing of insurance suitable for penetration of other micro insurance products like weather derivatives, property, livestock etc.

4. Linkages between sanitation densities in a community and health micro insurance benefits to the community.

The micro insurance component in FINISH INK can be introduced at an early stage so that it can evolve into a sustainable, growing and independent financial inclusion activity by the time the sanitation project draws to a closure from the point of view of donor funding, i.e. by April 2018.

FINISH INK’s planning for micro insurance interventions stems from the advantages that FINISH INK has on account of its partners. These are the Ministry of Health and AMREF (historically a health service provider and based on the work in the health sector, they have generated a lot of goodwill) in the health financing space. The capacity and potential for grassroots interventions exist with the micro finance and other financial partners that have committed themselves to FINISH INK, as well as the experience of the FINISH Team from India (between them about 50 years of experience in micro insurance, implementation of a pioneering micro insurance program in India from 2001 to 2010).

The FINISH board in India also has an ex-CEO of a non-life insurance company who is experienced in licensing/commencing and bringing to scale new insurance companies. He is now the Partner and Leader for Insurance for PricewaterhouseCoopers (PwC) India.

WASTE is primarily a specialist in technologies and social aspects of waste management. Through its leading role in FINISH and FINISH INK, it has demonstrated its substantial experience in successful sanitation program implementation through civil society partners and microfinance intermediaries. WASTE is interested in combining their interests in sanitation with financial inclusion activities.

FINISH INK also had the advantage that the insurance regulators of the country had put out a draft set of micro insurance (MI) regulations which set the guidelines for its growth in the country. The regulations for MI appear to encourage a new category of “MI only licensed insurance companies” with lower capital requirements and deregulation of training and other compliance requirements to suit MI penetration, growth and take up. The roadmap proposed below for FINISH INK in MI take into account all of the above.

Phase 1 (Year 2016 - 2017): the focus was to be on developing the delivery, servicing, training/capacity building components of an MI intervention through existing health MI underwriters in the counties of Busia and Kilifi. Thus, that would be effective, efficient and compliant to current regulations as well as the FINISH INK objectives.

**Phase 1 Distribution management of customized MI product(s) from existing insurance companies**

FINISH INK has recently begun implementation of its core sanitation project following its 3rd PMB meeting in August 2014. FINISH Society (India) who have been deployed to study the proposed MI interventions in Kenya under FINISH INK have had preliminary discussions with several existing insurance companies already into micro insurance and briefed them about the proposed MI interventions under the FINISH INK project. These interventions are positioned to forge a link between sanitation assets/usage and health care financing incentives.

Two insurance companies, i.e. BRITAM and CIC, are frontrunners in health micro insurance development in Kenya. Both having gone through the learning curve in micro insurance, appear most suitable to partner with FINISH INK. They were shortlisted following two rounds of face-to-face meetings with these companies at middle/senior management levels.
Broadly Phase I was to consist of the following activities:

1. Identify and select the micro insurance health partner.

2. Together with AMREF finalize the proposed intervention with the Insurance partner from the point of view of:
   a. Products: Preferably only primary care or a combination of primary and hospitalization.
   b. Partners/distribution to be deployed for both Kilifi and Busia Counties.
   c. Sales and policy servicing process.
   d. Training and capacity building of distribution channels.
   e. Regulator intervention if required on products/training etc.

3. Claims data from insurance for sanitation/health costs correlation.

4. Feedback to regulator on morbidity data for new product development.

Period of planning/product filing/program design and implementation, September 2016 (actual starting date will depend on progress sanitation programme) to March 2018. FINISH INK Funds for Phase 1 is €75,000

Phase 2 (concurrent in development with Phase 1, but rollout from 2018 onwards) could focus on setting up a Micro Insurance Company/take stake in existing insurance company with MI activities (given the impact of the new regulations). In Phase 2 FINISH would add product development, underwriting, claims management capability to Phase 1 activities to reduce dependence on third party risk carriers. With Phase 2 the MI interventions restricted to two counties in Phase 1 can be so expanded across the other counties of Kenya. It would render MI as a sustainable and independent financial inclusion activity that can support FINISH INK philosophy with suitable products, but not be restricted to it or its partners.

**Phase 2: Formation of micro insurance company in Kenya**

The formation of a micro insurance company is mainly to de-risk the withdrawal of the products introduced in Phase 1 and to continue with the philosophy that development activities like sanitation etc. can indeed be sustained through incentives on health care financing.

€ 25,000 of FINISH INK programme funds will be earmarked. This is to fund the costs of travel to meet with investors and insurance companies to eventually prepare a detailed proposal and business plan for a full-fledged micro insurance venture that can take on the underwriting as well as claims functions that were being outsourced to the MI company in Phase 1.

In that sense Phase 2 will benefit from the learnings, data and collaterals and processes developed in Phase 1. Additionally, in Phase 2 the insurance company will look at expanding the micro insurance penetration of Phase 1 beyond the counties of Busia and Kilifi. It will also look into introducing other profitable risk product lines that will add to the sustainability of health micro insurance.

Phase 2 starts concurrently with Phase 1 and is expected to lead to a detailed project report by the end of September 2017, along with expression of interest by the investors to the regulator. FINISH/AMREF and other implementing partners of FINISH INK are proposed to be given significant ownership of the new venture

During the period post September 2017 there needs to be an infusion of capital and deployment of human resources (team) to put together the application for licensing of the new FINISH micro insurance venture. If all goes well the new venture will start its operations in 2018.
Challenges encountered:

In Kenya the objective has been interventions for sanitation and particularly improved sanitation. Without any subsidies from the government for hardware, this implies a complete reliance on microcredit. Unfortunately the flow of microcredit by the project partners towards improved sanitation has been tardy due to their own restructuring issues. As a consequence the improved sanitation numbers have not been significant enough to make it attractive for a micro insurance intervention. Besides, BRITAM is a part of Equity Bank who have partnered with Water.org for their sanitation interventions. The latter’s position on dovetailing health micro insurance into sanitation is yet not clear.

Direct primary health care interventions through World Health Partner’s (WHP) telemedicine program

WHP are incorporated as an organization in the USA and having obtained their initial funding for a telemedicine project in India have recently expanded their operations into Kenya in the Kisumu County.

FINISH is in the process of finalizing a partnership with WHP for dovetailing primary health care interventions into their target market of households with improved sanitation. The plan is to build capacities in the health volunteers of AMREF in Busia and Kilifi County, to become WHP intermediaries. Thereby also creating an income generating opportunity for the volunteers who are already engaged in promoting improved sanitation systems.

If the above partnership can be successfully operationalized, the desired number of insurance companies can be approached to put out a hospitalization product to make a comprehensive health care insurance product available in the target market.

The thinking in FINISH INK, while this paper is being written, is hopefully to work on a resolution along the lines of the above, provided the sanitation numbers increase.

Conclusion:

Given the size of the financially excluded communities, insurance companies would do well in looking at serving this underserved market with customised micro insurance products. Using innovative processes, it can become a revenue stream for the insurance companies while addressing the need for inclusive growth in society (impact).

However, instead of looking at micro insurance penetration as only a financial inclusion activity, an insurance company could consider to partner with a development program and dovetail MI products so as to add value to the program in the form of greater impact as well as serve as a commercial monitoring tool.

The approach in FINISH has been the latter: to integrate MI with sanitation behaviour change processes. Success can be enhanced by (i) availability of suitable products with insurance companies; (ii) encouragement by the regulator in using MI as a development tool, and; (iii) capability of insurance companies to put sustained effort and resources to innovate on processes that would make MI sustainable.

Behaviour change campaigns in sanitation are most likely to impact health care at primary level. Primary care products with fulfilment through outpatient facilities at hospitals may be a good combination for traditional high premium health insurance policies.

However, more than the hospitalisation insurance products, it would be beneficial if primary care financing products are integrated into the sanitation penetration program so that all stakeholders stand to gain thereby creating a win-win combination.

Micro-insurance would appear to be best combined with low cost telemedicine for the fulfilment of primary care requirements. This approach also suits the typical habitation of MI communities who are likely to be rural/located in places where secondary and tertiary health care infrastructure (clinic respectively hospitals) is not easily accessible without huge travel costs, which the poor will find difficult to bear.

With the possibility of fulfilment and last mile reach of primary care through a committed telemedicine provider it appears that there could be stronger resurgence of effort towards the attainment of the micro health insurance embedment into the FINISH program.
एलएंडटी इंशोरेंस पेश करेगी
एसएमी के लिए पॉलिसियां

नई दिल्ली

मुख्यमंत्री

निजी क्षेत्र की साधनता और बीमा कंपनी एलएंडटी इंशोरेंस को लाइव 6 एमिटी एंड महोत उद्घाटन (एसएमी) की समीक्षा ओर उपयोग के लिए 10 बीमा उपाद जारी करने।

इलेक्ट्रानिक के संसाधनों से एक बीमा कंपनी निवेशक निजी क्षेत्र की समीक्षा ओर उपयोग के लिए 10 बीमा उपादों को लाया है।

एलएंडटी इंशोरेंस के मुख्त कार्यकारी अधिकारी असंह और एलएंडटी इंशोरेंस के मुख्त कार्यकारी अधिकारी असंह और एलएंडटी इंशोरेंस के मुख्त कार्यकारी अधिकारी असंह और एलएंडटी इंशोरेंस के मुख्त कार्यकारी अधिकारी असंह और एलएंडटी इंशोरेंस के मुख्त कार्यकारी अधिकारी असंह और एलएंडटी इंशोरेंस के मुख्त कार्यकारी अधिकारी असंह और एलएंडटी इंशोरेंस के मुख्त कार्यकारी अधिकारी असंह और एलएंडटी इंशोरेंस के मुख्त कार्यकारी अधिकारी असंह
L&T Insurance forays into SME, home space with 10 new services

NEW DELHI: Private sector general insurer L&T Insurance on Tuesday said it plans to launch 10 products in the small and medium enterprises (SME) and home space soon.

“We have got regulatory approval for SME and home products,” L&T Insurance Chief Executive Officer Joydeep Roy said here. The company proposes to launch six home insurance products and four in the space of SME, he said.

It will launch six home insurance products, four in SME sector

adding that they will be rolled out in due course of time.

The company has tied up with Finserv (Financial Inclusion Improves Sanitation and Health), a public-private-partnership company for distribution of its micro insurance products. Under the partnership, Finserv, supported by Dutch government, would train the employees of its micro insurance partner or NGO for distribution of two micro health insurance products in the three identified states.

These states are Maharashtra, Rajasthan and Orissa. Cash hospital micro insurance and medi-sure micro insurance would be offered under the programme, Roy said. Micro insurance has huge growth potential and will play an increasingly important role in the penetration of the sector in the country, he added.

—PTI
L&T Insurance to enter home space

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