

SCALE: THINKING BIG - CASE STUDIES

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1 > INTRODUCTION

This document outlines the eight in depth case studies included in Scale: thinking big. The paper is available at <http://www.microinsurancefacility.org/publications/mp30/>

The case studies include: AVBOB (South Africa), CLIS/Malayan (Philippines), Casas Bahia/MAPFRE (Brazil), Hollard/Edcon (South Africa), Protecta (Peru), Tigo (Ghana) and BISP Waseela (Pakistan) and NAIS (India) (see Table 1 for a summary).

Table 1: Summary of the case studies

Name	Country	Clients/ policies in force	Main distribution mechanism	Product type	Compulsory voluntary or	Subsidy
AVBOB	South Africa	1.3 million	Agents, funeral parlours	Funeral	Voluntary	No subsidy
CLIS	Philippines	3-4 million	Pawnshops	Life, asset	Voluntary	No subsidy
Casas Bahia/Mapfre	Brazil	6 million	Retail partner, agents	Life, asset	Voluntary	No subsidy
Hollard	South Africa	7 million ¹	Retail partner, agents	Life, funeral, various	Voluntary	No subsidy
NAIS	India	25.6 million	Financial intermediaries (banks, etc.)	Agriculture	Compulsory (85%), voluntary (15%)	Government subsidy
Protecta Peru	Peru	1.3 million	Financial and other intermediaries, agents	Life, personal accident, other	Voluntary	No subsidy
Tigo/BIMA	Ghana	550 000	MNO, agents	Life	Voluntary	No subsidy
BISP Waseela	Pakistan	4.2 million	Post	Life	Compulsory	Government subsidy

¹ Of which 60-70 per cent are microinsurance policies (Shezi, 2013).

2 > AVBOB, SOUTH AFRICA

DESCRIPTION OF THE INITIATIVE

A brand that is well established and widely recognized in South Africa, AVBOB has been a player in the funeral and life insurance industry for nearly a century. Founded in 1918 as a merger between two smaller burial societies, the company has since evolved beyond the twentieth century to emerge as one of the largest providers of funeral insurance in the country. It currently has 1.35 million policy-holders and covers 3.5 million lives.²

With 30,000 members in 1938, the company initially focused on serving the white Afrikaner population of South Africa, but began offering policies to all races in 1948. In 1951, AVBOB legally became a mutual society. This development formed the basis of a key aspect of its business model – that profits should be reinvested in members' policy benefits. When apartheid rule ended in South Africa in the 1990s, AVBOB made a conscious shift to begin targeting the underserved black market for funeral policies. This lower income LSM 2-7 market³ forms the overwhelming majority of AVBOB's client base, accounting for nearly 80 per cent of clients.

One of AVBOB's key value propositions is the company's provision of end-to-end funeral services – including funeral insurance, funeral parlours and a manufacturing division that focuses on the production of tombstones and coffins. With scant reliance on outside partnerships, AVBOB has become a kind of “one-stop shop” for funeral needs, which both consolidates the image of its brand in the public's mind and allows it to offer valuable bundles of funeral services to its clients.

CONTEXT OF THE INITIATIVE

Many South African cultures give high priority to large funerals, which constitute a major expense for family and community members. This, in turn, has led to a highly competitive and robust funeral insurance market that has been noted for its focus on innovation, quality and diverse business model approaches (NMG Consulting, 2012, p. 3). Indeed, 89.2 per cent of South African adults who have some form of risk cover have funeral insurance (Smith, de Vos, Mahori, Loots, Chamberlain, & Bowman, 2013, p. 4). These policies touch consumers in all LSM brackets and range from formal, regulated funeral products sold through insurers, retailers and banks, to informal burial societies, *stokvels*⁴, and funeral parlours.

In addition to significant market penetration, funeral insurance is also guided by robust legislation. The Financial Services Board (FSB) oversees both underwriters and intermediaries, with the former being governed by the Long Term Insurance Act of 1998 (LTIA) and the latter being regulated via the Financial Advisory and Intermediary Services Act of 2002 (FAIS). The FAIS regulation, in particular, seeks to protect consumers by ensuring that financial advice is only provided by experienced, qualified professionals. Although beneficial for consumers, this regulation can at times lead to costly and onerous requirements for funeral insurance companies such as AVBOB, which employ extensive agent networks. While both LTIA and FAIS dictate how AVBOB operates, the company is also uniquely influenced by the AVBOB Mutual Assurance Society Incorporation (Private) Act, No. 7 of 1951, which outlines specific requirements for its structure as a mutual society.

² Many policies cover both the main policy-holder as well as additional family members – per AVBOB Annual Report

³ The Living Standards Measure (LSM) index is widely used in South Africa as a tool to segment the population based on living standards, as a proxy for wealth. LSM 1 is the lowest (or poorest) living standards measure, while LSM 10 is the highest (or richest) living standards measure (Eighty20, 2010).

⁴ (In South Africa) savings or investment societies to which members regularly contribute an agreed amount and from which they receive a lump sum payment (Oxford Dictionaries, 2013)

PRODUCT DETAILS

While each product is priced based on individual clients and their needs, AVBOB keeps its product offerings relatively simple, with just five variations.

1. The Family Funeral product, the most successful of AVBOB's product lines, offers benefits that range from 5,000 ZAR – 20,000 ZAR (US\$500 –\$2,000). This policy covers the policy-holder, a spouse, and any children in the family up to the age of 20, with the policy remaining in force until the main policy-holder dies.
2. The Extended Family policy, as its name indicates, allows for coverage to be extended to up to four parents of the insured couple and six additional extended family members, providing a breadwinner benefit⁵ and the option to increase benefits each year by increasing the premium by a maximum of 10 per cent.
3. Introduced in the last few years, the Cashback Funeral plan allows policy-holders to receive a rebate of one year's premium after every five years and has quickly become the most popular product after the Family Funeral plan. As well as providing double accident benefits and a breadwinner benefit, the plan also allows for the addition of children, spouse and parents to the policy.
4. The Cashback Life product uniquely bundles disability and core critical illness coverage, while also spreading the payable benefits of the product over a period of time. Distributing 10 per cent of the cover to the beneficiary immediately upon death, AVBOB then pays 70 per cent when the claim is finalized, with the remaining 20 per cent paid as income spread over the next four months. For the four aforementioned policies, a six-month waiting period exists before any claims can be made, except in the case of accidental death.
5. AVBOB's fifth and final product is a Savings Plan, which allows for investment savings on a ten-year term with monthly contributions. While this plan is not directly linked to a funeral, it provides a different approach for preparing for the future costs of a funeral.

Benefits accrued to policy-holders as a result of the mutual structure of the company, whereby policy-holders are shareholders and share in the profits of the company, have led to a substantial increase in product take-up, according to AVBOB. While the monthly premiums paid by clients are comparable to those of other funeral insurance companies, the potential payouts of policies are much higher, due to the reinvested profits. Over the past few years, surpluses allocated to the improvement of policy-holder benefits amounted to more than 2.5 billion ZAR (\$250 million).

Premium payments from clients are received either over-the-counter at AVBOB funeral parlours and assurance agencies, via debit order, or via stop order. Although new technologies are being explored to facilitate simpler and cheaper payment mechanisms in the future, recent studies conducted by AVBOB indicate that the majority of clients prefer to continue using debit payments. A great many opt for using cash, while only a very small minority prefer a premium payment method that uses new technology, such as mobile phones.

Clients initiate a claim through the nationwide AVBOB funeral service network or by contacting the AVBOB call centre. Although AVBOB offers funeral products, as mentioned previously, clients are not obliged to use the company's services. All AVBOB policy-holders who make use of AVBOB funeral services qualify for benefits, including free transportation of the deceased within the borders of South Africa, a discount off the price of the funeral and free transportation of a tombstone within the borders of South Africa.

⁵ The breadwinner benefit, as defined by AVBOB, indicates that if the main policy-holder dies, the coverage for the rest of the lives originally covered in the policy remains in force. This is contingent on the main policy-holder paying his or her own premiums. (AVBOB, n. d.)

DISTRIBUTION

Although AVBOB utilizes four distinct channels to distribute its products, its use of field agents stands out as a highly effective method for marketing to consumers, selling the policies and retaining clients over the long term. With a substantial agent force of several thousand agents located across South Africa, AVBOB has invested in a workforce that is given incentives to sell policies actively throughout the country. From client feedback, AVBOB has found that clients understand and trust the product more fully when they have direct agent contact. An agent can explain a complex product properly and make it more tangible to the prospective client. Although this distribution model requires AVBOB to make significant investment in training agents according to stringent South African financial intermediary regulations, as previously described, the agents are remunerated on a commission only basis, which both encourages agents to sell and helps keep costs lower for the company.

As well as the field agents, AVBOB also operates 140 funeral agency branches throughout the country. These agencies have in-store agents selling policies, as well as funeral services.

In addition to these field and branch agent models, AVBOB makes use of an outbound call centre with agents who respond directly to enquiries received via AVBOB's website, mobile website, or print and television advertisements.

Finally, AVBOB also reaches some clients by targeting existing group schemes, though this method is used to a lesser extent than the three aforementioned channels. Though more challenging to manage, AVBOB offers group policies to existing burial societies, *stokvels* and churches.

New distribution strategies that use mobile and internet technology are currently being explored.

UNDERSTANDING CLIENTS AND MARKETING

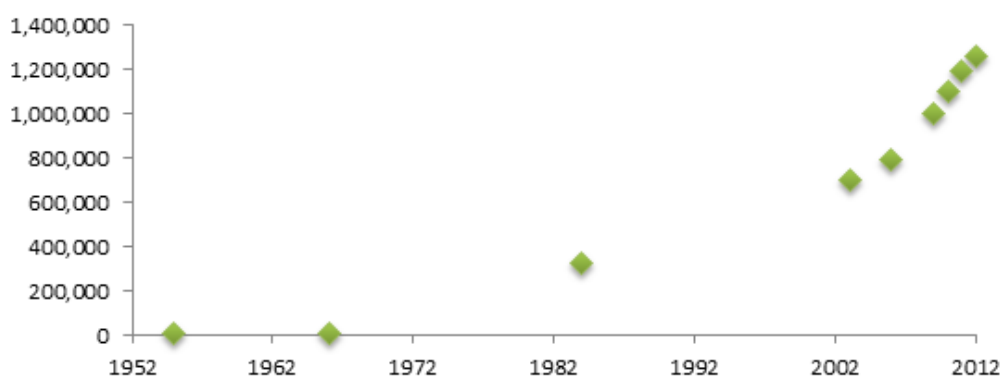
While the agent model used by AVBOB accounts for a substantial proportion of the company's success in reaching 1.35 million clients, the company's ability to both understand clients and market its products effectively has also played a role. By obtaining feedback from clients through surveys throughout the year, AVBOB both collects invaluable data on the satisfaction of its existing client base and analyses market demand so as to tailor its products to meet client-specific needs. It is through such market research that AVBOB has been able to identify that even in the lower income market, clients do not simply want a cheap product. Instead, AVBOB believes that clients demand a product that is both affordable and trustworthy, while still offering high value in terms of customer service and insurance coverage amounts.

Although internal surveys indicate that 91 per cent of people in South Africa are already aware of the company, VBOB still makes a substantial investment every year in marketing via television, print advertisements and SMS on mobile devices. It is by using a combination of all these channels that AVBOB has been able to reach such high brand recognition in the country. A further factor contributes to high brand recognition. As noted by Deno Pillay, General Manager, Group Corporate Affairs, "*When you think of the name AVBOB, you think of funeral insurance. By avoiding complicating the business model with a broad range of products, AVBOB has maintained its focus solely on funeral services for so many years*". This specialization allows consumers to make a rapid link between the company's name and the services it offers.

PRODUCT SUCCESS AND RESULTS

Despite a funeral insurance market that has become relatively saturated in South Africa, AVBOB continues to remain in a solid financial position. Annual reports indicate that in 2012, actuarial surpluses increased to 3.7 billion ZAR (\$370 million). Total assets rose by 16 per cent to 7.2 billion ZAR (\$720 million) and premium income increased by 14 per cent over the previous year to 1.5 billion ZAR (\$150 million). Aside from an increase in premium volumes, the number of clients has also continued to rise over the past decade, as illustrated in the graph below.

Figure 1: Number of AVBOB policies in force



Source: Lucia Momberg, General Manager, Insurance Administration, AVBOB. Note: Data only available for certain years.

Examining the claims ratio, defined as yearly claims paid vs. yearly premiums collected, the 2012 annual report indicates a figure of 32 per cent.⁶ The expense ratio for 2012 was 99.6 per cent.⁷ As regards persistency, roughly 35 per cent of clients allow their policies to lapse, mostly due to issues of affordability.

SUMMARY OF SCALE DRIVERS

When trying to identify what enabled AVBOB to reach more than one million consumers, it is crucial to take account of the cultural traditions surrounding funerals in South African society. Regardless of wealth or poverty, there is widespread demand for quality funerals, with 44.3 per cent of adults having some form of funeral cover (FinMark Trust, 2012). Demand is therefore high for products such as those offered by AVBOB.

Nevertheless, AVBOB has set itself apart from the competition in a number of ways, allowing it to expand its client base significantly over the past twenty years. Firstly, the decision to structure itself as a mutual has enabled the company to reinvest profits in its own customers' policies, thereby providing higher value to clients than that offered by some of its competitors. Secondly, AVBOB has consolidated a straightforward product offering over the course of the past century. By focusing solely on funeral services – insurance, parlours and industrial production – AVBOB has not only internalized the entire funeral value chain, but it has also done so in a way that allows consumers to clearly identify its brand while keeping costs down. While other insurance companies' product offerings may be complex and confusing to consumers, AVBOB's products are identifiable and specific. Thirdly, by building on its unique ability to encompass the entire spectrum of funeral services, AVBOB has been able to offer a number of value-added services alongside its funeral

⁶ AVBOB management has noted that this figure is artificially low if a business is growing quickly, as a higher value of premiums from new business is being compared to claims from business sold years ago (van Son, 2013).

⁷ Expense ratio was calculated as premium income over total expenses for the AVBOB Mutual Society. According to 2012 financial statements, premium income amounted to 1,477,154,000 ZAR with expenses totalling 1,483,077,000 ZAR (AVBOB, 2012, p. 13).

insurance plans. These additions, such as coffins, transport and discounted funeral amenities, add value to policies and help to distinguish AVBOB from the other players in the market.

Differentiating itself from the competition is one factor that has helped AVBOB to expand its client base. However, the company's ability to connect with clients – in terms of distribution, marketing and product design – should also be highlighted as having made a significant contribution to its attainment of more than one million policies. With regards to distribution, AVBOB's use of field agents has not only allowed the company to spread its product widely, but has also helped to facilitate meaningful connections with clients. The agents operate with the mandate of building trust and relationships with clients and although there is already a high level of consumer understanding of funeral insurance, this approach has enabled AVBOB to expand into a segment of the population which was underserved for many decades. Furthermore, AVBOB has used client feedback to inform product design, in an attempt to meet the needs and desires of its target market. By better understanding clients and adapting business strategies based on these considerations, AVBOB has continued to experience growth in the number of clients reached over the past five years. Nevertheless, with a lapse ratio of 35 per cent, it is clear that use of field agents and client-centric product design is no guarantee that clients will be retained over the long term. Moving forward, AVBOB must continue seeking innovative solutions to enrol and maintain clients in a heavily saturated South African funeral insurance market.

3 > CEBUANA LHUILLIER INSURANCE SOLUTIONS (CLIS)/MALAYAN, PHILIPPINES

DESCRIPTION OF THE INITIATIVE

Cebuana Lhuillier Insurance Solutions (CLIS) is the non-life insurance arm of the PJ Lhuillier Group of Companies, a multi-industry group that owns and operates a number of different companies in the Philippines, including Cebuana Lhuillier Pawnshop, the country's largest and leading chain of pawnshops. CLIS was established in 1999 under the name P. Lhuillier Insurance Agency (PLIA), with the goal of providing financial security and peace of mind to Filipinos and expanding the range of financial services offered by the pawnshops, which already included remittances and bill payments.

For this reason, in 2004 CLIS –which at the time was trading under the name PLIA – partnered with Malayan Insurance Co., the biggest non-life insurer in the Philippines, to offer a personal accident coverage product called *Alagang Cebuana*. In 2008, the product was redesigned to offer property insurance against fire and renamed *Alagang Cebuana Plus*. CLIS is responsible for the administration of the scheme, while Malayan Insurance Co. is the underwriter and Cebuana Lhuillier Pawnshop acts as the distribution channel. Since CLIS is a registered insurance agent of Malayan Insurance Co., a master policy is issued and certificates of confirmation (COCs) are distributed to each and every insured individual who purchases *Alagang Cebuana Plus* from the branches. The product has no reinsurance.

In 2009, on the occasion of its tenth anniversary, the company was renamed CLIS, in an attempt to strengthen the product's association with the Cebuana Lhuillier Pawnshop brand, a chain that is widely trusted by Filipino people.

PRODUCT DETAILS

CLIS' main product, *Alagang Cebuana* (in English: "Cebuana cares"), was initially offered in 2004 as accidental death and dismemberment cover. The premium charged from clients at the time was 20 pesos (about \$0.50) for a four-month policy that offered a benefit of 20,000 pesos (\$500).

In 2008, the product was redesigned and renamed *Alagang Cebuana Plus*, offering additional house cover against fire, including all kinds of residential dwellings. The change in the product was primarily made to accommodate client needs. Many of the insurance policy-holders were living in shanty towns and therefore had limited access to formal insurance as a way of protecting their property.

With a premium of 25 pesos (about \$0.62) per certificate, *Alagang Cebuana Plus*' clients can receive up to 20,000 pesos (\$500 dollars) in personal protection and 5,000 pesos (\$125) in fire assistance, depending on the value of the claim. Clients may buy up to five certificates at a given time to increase the claims pay-out, to a maximum coverage level of 100,000 pesos (\$2,500 dollars) for accident and 25,000 pesos (\$625) for property (Cebuana Lhuillier, 2013). Besides the standard coverage, policy-holders also have access to *Doc Cebuana*, a value-added service which allows them free telephone consultations with doctors.

The period of coverage is four months, and this has remained consistent throughout the life of the product. The reason for this short policy term is that after four months, the client has to return to the pawnshop to reclaim the pawned item. After this period, monthly interest is charged on the loan provided for the pawned item. The premium payment term is therefore aligned with the period that the client interacts with the pawnshop.

Alagang Cebuana Plus can be sold to any individual from 7 to 70 years-old (Cebuana Lhuillier, 2013). The client is immediately covered following the purchase of an insurance policy in the pawnshop. Although most clients are also

pawnshop customers, *Alagang Cebuana Plus* is not mandatory. It is cross-sold to the pawnshops' customers, but they are not obliged to buy the product. At the same time, non-clients of the pawnshop can also opt to buy it independently, from any other financial service provider.

In the first year of activity, a million policies were sold. At the time of the study, CLIS was selling a million policies per month, making 12 million policies per year (Batangan, 2013). Since certificates last for four months, CLIS has three to four million active policies running during any given month.

Other microinsurance products offered by CLIS are *TodaCare* (one-year personal accident insurance for tricycle drivers and operators), *SecurityCare* (personal accident insurance for security guards), *TanodCare* (personal accident (PA) insurance for community watchmen), *StudentCare* (PA insurance for students) and *TodoAsenso* (a micro-life product for loan borrowers). These products were introduced in 2012 and have since attracted more than 100,000 clients. However, they target specific groups outside the *Cebuana Lhuillier* network and for this reason are not yet sold in the pawnshops.

DISTRIBUTION AND PARTNERSHIP

Alagang Cebuana Plus is distributed by *Cebuana Lhuillier Pawnshop*, a network of pawnshops located throughout the Philippines. These companies are fellow subsidiaries of the PJ Lhuillier Group of Companies. The policies are underwritten by Malayan Insurance Co. *Cebuana Lhuillier Pawnshop* has a substantial distribution network of more than 1,500 branches around the country.

Insurance is sold by two or three branch personnel working in the pawnshop branches. Since these staff members had never previously sold this kind of product, CLIS provided product specific training in 2004 and 2005. In 2008, similar training took place in order to prepare staff for the modified product. At the same time, CLIS introduced a 2 peso (\$0.05) commission for every policy of 25 pesos (\$0.50) sold, as an incentive mechanism to increase the volume of sales (Batangan, 2013).

More recently, CLIS began experimenting with sub-agents to help with distribution. These currently number around 25 people. The sub-agents are individuals who have previously claimed from CLIS and who use their experience to promote CLIS products in their communities (Batangan, 2013).

CLIS indicated that 60 to 70 per cent of pawnshop customers buy *Alagang Cebuana Plus*.

UNDERSTANDING CLIENTS AND MARKETING

Understanding what clients think and how they perceive the product is important for CLIS. Clients can provide feedback through several channels: a complaints hotline, regular area meetings (at least once a month) and a Facebook page. During the claims process, CLIS requires clients to complete a claims survey form that evaluates claims efficiency and responsiveness. The form also asks who among the branch personnel deserves to be commended during claims handling, as a way of increasing staff morale. This process is overseen by the Service Quality Management Department, which facilitates customer conference and service recovery measures to ensure that complaints are addressed in a timely manner.

Marketing is also important for CLIS. Its intention is to adopt a positive marketing strategy that can show people how good it is to be insured. One example is "The Search for the Happiest Pinoy", a nationwide campaign that aims to rekindle the values of optimism, resilience and hope in Filipinos following the global economic crisis. The goal is to find and recognize the country's most optimistic and passionate individuals, who manage to remain good-natured while

overcoming life's challenges. Through this tool, CLIS highlights the positive impacts of obtaining quality and affordable insurance, such as security, peace of mind and ultimately improved welfare. CLIS creates further brand awareness by distributing medicines and relief goods to claimants during large claims payouts for events such as community fires and flash floods. In mid-October 2013, CLIS introduced an aggressive tri-media (TV, print and radio) campaign to further promote its microinsurance offerings, featuring actual claimants.

CLIS does not depend on donor funding but has recently worked with the German International Cooperation (GIZ) to enhance financial literacy with regards to microinsurance in the country. The company seeks to double its volume of microinsurance clients in the next couple of years.

OPERATIONS

Enrolment occurs directly at the *Cebuana Lhuillier Pawnshop*. Forms from Malayan Insurance Co. (Malayan), called confirmations of coverage (COCs), are distributed to all branches. These are completed when a client buys insurance and are consolidated on a monthly basis to be sent to Malayan for endorsement of the master policy. Premiums are collected by staff at the pawnshop, before CLIS sends them in monthly batches to Malayan.

When clients need to make a claim, they go directly to *Cebuana Lhuillier Pawnshop* branches to file their request, along with the required documents. Every branch has a camera to scan the documents that support the claim, and these are then sent to CLIS in electronic format. For claims relating to fires, which involve cash assistance, clients have to present documentation including photos of the incident, the police report and a declaration from the local government unit head ("Barangay Captain") stating that the accident did indeed occur. In order to simplify the claims process, the usual procedures for fire insurance policy issuance, such as inspection reports, are not required.

As a result of an agreement with Malayan, claims below 25,000 pesos can be settled directly by CLIS. This constitutes approximately 70 per cent of claims. For figures in excess of this amount, Malayan has responsibility for evaluating and settling the claim and does so after receiving the documents from CLIS. This takes between 5 and 10 working days (Batangan, 2013).

The beneficiary receives a text message via cell phone when the claim has been approved. Since the pawnshops already have the capacity required to offer financial services such as remittances and bill payments, they themselves distribute the payouts to clients, who can go straight to the closest branch to withdraw the cash. Using this simple claims process, CLIS is able to settle claims below 25,000 pesos (\$625) within a period of 24 hours.

To improve the claims process further, CLIS has developed a mobile insurance kiosk to settle claims off-site, i.e. at locations other than pawnshops. This is particularly useful in the event of a community-wide incident that affects a number of claimants, such as a major fire or flood.

The claims ratio has amounted to approximately 30 per cent since 2008, computed as the total claims paid as a percentage of total premiums generated per year. The number of claims per year is around 3,000. Of these, 70 per cent are linked to fire coverage.

To date, renewals have not been tracked by the company and there is no active process to try to persuade clients to renew their policies. However, a database with clients' numbers and email addresses is being compiled by CLIS' information technology department, so that the company can contact clients by SMS or email 10 days prior to the end of the policy. The idea is to remind customers of the expiry date and drive future renewals. This system was due to be put in place in January 2014.

From mid-March 2014, Cebuana branches will issue an electronic COC, with all entries inputted via a computer terminal and no manual intervention. This means that customers no longer have to write their name, address and the name of the beneficiary, or add their signature to the COC. As a result, the processing time will be reduced to 2-3 minutes. In addition, the new system will help to prevent over-selling (issuing more than the five certificates allowed) at branches, since the e-COC will be monitored on a real-time basis nationwide and daily sales volumes will be declared to Malayan each week.

EXTERNAL FACTORS

The potential for microinsurance in the Philippines is substantial. The Insurance Commission showed that by the end of 2012, 12.91 million Filipinos had microinsurance coverage, compared with 6.6 million in 2010. Still, only 13 per cent of the country's population of 97.6 million is insured, meaning that many low-income Filipinos remain without coverage (Philstar, 2013).

Besides the general demand for microinsurance in the Philippines, demand for fire products is also very high. For example, Cebuana's agents report that clients are more likely to buy insurance when they are told that their house will be insured against fire than if they are told they will be insured against accidental death (Batangan, 2013).

An enabling microinsurance regulatory environment supports the growth of microinsurance in the Philippines and this has benefited CLIS. There are reduced regulatory requirements for microinsurance, including simplified documentation for microinsurance products. Consumer protection is also bolstered by a regulation that limits the claims process to 10 working days (Batangan, 2013).

DRIVERS OF SCALE

The case of CLIS shows that scale in microinsurance is not achieved by one single feature in an initiative, but is the result of a combination of different factors.

The first driver of scale that we can identify is the Filipino market. With a large number of potential microinsurance clients and a conducive regulatory environment, the Filipino market has certainly contributed to offering incentives for the availability of microinsurance products and to increasing the number of enrollees in the scheme.

The importance of fire-related products in the Filipino context is also a factor that may have influenced the scale achieved by CLIS. The Filipino market sees a great deal of value in products that protect their properties, and this may have increased sales of *Alagang Cebuana Plus*.

Another significant driver of scale has been the pawnshop distribution network of CLIS. Both the footprint and brand awareness of this network in the lower income market was significant to CLIS achieving scale.

The commission paid to agents is a further contributor to scale. Even with a good distribution footprint, agents need to have incentives to increase sales. Agents also contribute to educating consumers about the products sold, providing education and tangibility for the product.

However, take-up rates might have been low even with an effective distribution channel if clients had not perceived the value of the product. CLIS invested substantial resources in designing a product that met client needs and provided value added services. The product has been designed to be simple to understand, convenient to use and affordable for the consumer. Ongoing client feedback, in an attempt to understand and improve the client experience, has also contributed to increasing scale. In one *barangay*, for example, statistics showed that of 200 households affected by fire,

120 were insured by CLIS. The efficient claims settling process has further contributed to increased client value. CLIS attributes a substantial amount of its word of mouth advertising to the effectiveness and reliability of the company's claims process.

In conclusion, the success of CLIS in achieving scale can be partly explained by the favourable Filipino context. However, most of the credit goes to a combination of distribution, sales incentives and product design elements developed by the company.

4 > CASAS BAHIA/MAPFRE, BRAZIL

DESCRIPTION OF THE INITIATIVE

Casas Bahia is a Brazilian retail chain that specializes in selling furniture and home appliances to low-income customers. In 2004, MAPFRE Insurance Brazil, a large international corporation that has been present in Brazil since 1992, formed a partnership with *Casas Bahia* to distribute life insurance, financial protection and personal accident policies through its low-cost stores. MAPFRE initiated the relationship. However, MAPFRE and *Casas Bahia* work very closely together and both are responsible for product design and administration. The broker, Massive Insurance, plays only a limited role in these two functions. As of 2013, there were approximately 6 million policies in force.

MAPFRE PARTNERSHIP

MAPFRE first entered the low-income market by underwriting the Pasi product in the 1990s to assist workers in the building industry. Through the offices of a union, employees decide that they want the insurance and then negotiate it as part of their staff benefits with the employer. Entire unions would therefore be covered at a time (Cenfri, 2010, p. 55). Various channels are currently used to target the lower income market, including retailers, regional banks and cooperatives.

PRODUCT DETAILS

Casas Bahia offers three insurance products underwritten by MAPFRE to its customers: 1) an extended warranty product named *Garantia Estendida*; 2) a financial protection product called *Proteção Financeira*; and 3) a life insurance product named *Vida Protegida e Premiada*. Since the first product is only an extended warranty policy, the focus here will be on products two and three. In both cases, clients must be 18 years or older to obtain coverage.

Proteção Financeira, launched in August 2004, provides *Casas Bahia* credit clients with voluntary insurance against death and unemployment. In case of death from any cause, the outstanding amount of the insured's financing agreement with *Casas Bahia* will be credited to the retail shop up to a limit of R\$1,000 (\$560). In the case of involuntary unemployment, the outstanding monthly repayments owed to *Casas Bahia* by the policy-holder will be covered by the policy for an amount of up to R\$100 (\$56) per instalment, for a maximum of six instalments. Individuals who do not have a steady income, or proof of income/employment, are not eligible for this component of the insurance policy and are only covered for the life and personal accident insurance components.

In order to be eligible for the unemployment component, the individual must have worked for an employer for a minimum of 12 months before the date of dismissal, and for a minimum of 30 hours per week. In addition, the employment must have occurred under a formal employment contract and the individual must have been dismissed from his/her employment without fair cause. A waiting period of 31 days also applies to unemployment coverage. Due to the fact that the policy is linked to a credit agreement with *Casas Bahia*, *Proteção Financeira* is only available for borrowers of the retailer. Despite the voluntary nature of the product, high take-up levels are achieved due to active sales techniques applied (the product is offered to the client multiple times in store and at the point of sale, the system prompts the salesperson to again enquire whether insurance is wanted).

The second insurance product, *Vida Protegida e Premiada*, launched in August 2008, offers life and personal accident cover to *Casas Bahia* customers (both cash and credit clients). The product is not linked to any financing agreement with *Casas Bahia*. However, it is mostly offered to customers during the purchase of a home appliance. The policy offers the beneficiary a "food basket" to the value of R\$200 (\$112) per month, over a period of three months, in the event of the death of the policy-holder. This food basket takes the form of a prepaid credit card that can be used at preselected

grocery stores, supermarkets, bakeries or similar establishments. In the case of accidental death, beneficiaries are also entitled to a cash payout of R\$10,000 (\$5,600). Accidental death while using public transportation entitles beneficiaries to a cash payout of R\$20,000 (\$11,200). The policy-holder also receives hospital cash indemnity cover that pays out R\$50 (\$28) per day spent in hospital, for a maximum of 10 days, and is entitled to discounts on pharmaceutical products offered at an extensive list of preselected pharmacy chains. The discount varies (up to 60 per cent) according to the type of medication purchased. The list of medication includes a wide selection of prescription and non-prescription products. Lastly, the policy-holder is entitled to a monthly lottery ticket for a R\$1,500 (\$840) prize.

Since the partnership was launched in 2004, high adoption rates have been achieved for the financial protection policy sold through *Casas Bahia* stores. It is estimated that more than one million policies have been sold.

DISTRIBUTION

Casas Bahia has a large distribution network with 550 stores throughout the country, employing 56,000 full-time staff. It also has a strong brand, which improves trust in its products, including the insurance it sells. The insurance product is sold in-store on a face-to-face basis by *Casas Bahia* sales staff. This is done as part of the home appliance sales process, as follows:

- Step 1: The prospective customer enters the store and, with the assistance of *Casas Bahia* sales staff, chooses an appliance.
- Step 2: The customer is offered the choice of buying the appliance with cash or through a structured financing agreement.
- Step 3: In the case of a cash purchase, the customer is offered an extended warranty plan, as well as the MAPFRE *Vida Protegida e Premiada* policy. In the case of a credit purchase, the customer is given the option to select a repayment period, an extended warranty policy, *Proteção Financeira*, as well as *Vida Protegida e Premiada*. The customer is shown on a computer screen how including the insurance policy in the financing plan will affect the total repayment amount and can select the appropriate number of insurance policies. The average financing period (and thus the duration of the *Proteção Financeira* policy) is 10 - 12 months.

MAPFRE is responsible for the training of *Casas Bahia*'s 56,000 staff members. Each employee receives, on average, seven hours of training. Staff are trained in the features of the product and taught how to use the product systems, how to inform the client of the policy and how to market the product effectively. Staff directly paid for by MAPFRE, who work in the MAPFRE back offices, assist with claims and policy activation.

UNDERSTANDING CLIENTS AND MARKETING

The cash compensation paid in case of death for the *Vida Protegida e Premiada* product is presented in advertising as a basket of food, but is made available to the beneficiary in the form of a prepaid credit card. This tangible approach is typical of Brazilian microinsurance products, since this market prefers products to have "during life" benefits, rather than exclusively "post-life" benefits. As is the case with other microinsurance products in Brazil, the lottery component of *Vida Protegida e Premiada* is often proposed as a way of attracting customers. Some clients even buy this insurance for the lottery component, rather than for the purpose of risk management.

OPERATIONS

Cash premium collection is conducted in-store. If clients purchase their appliances on credit and select the *Proteção Financeira* product, the premium is bundled with the monthly instalments. In the case of *Vida Protegida e Premiada*, the policy can either be paid for in full by cash, when the appliance is purchased, or financed by *Casas Bahia* and paid off over the structured loan repayment period of the appliance. The sale of *Vida Protegida e Premiada* is not dependent on the purchase of an appliance. However, it is not widely purchased as a standalone product. According to *Casas Bahia* management, many individuals return after the first year's coverage period to renew the policy, even if they have no remaining credit obligation toward *Casas Bahia*. The insurance policy is immediately suspended upon non-payment and cancelled in the event of two missed payments.

All claims are handled in-store by the sales staff and processed by MAPFRE and *Casas Bahia* back-office staff. For *Proteção Financeira*, the risk event must have occurred during the financing period of the appliance in order for the client to be covered. Further, *Proteção Financeira* payouts are made directly to *Casas Bahia* and credited to the client's instalments. All payments are made within 15 days of submission of the proper documentation.

Casas Bahia has invested heavily in new technologies. This has allowed the company to develop its sales and monitor their progress in real time, reducing delays in reporting and helping management to be more responsive to change.

DRIVERS OF SCALE

Casas Bahia's relationship with MAPFRE is a critical driver of scale. They work closely together to use each partner's specific skill set and capacity to achieve scale. MAPFRE brings substantial experience in insurance and *Casas Bahia* brings a substantial distribution network of 550 stores, together with a large sales team. This allows both partners to access a large number of clients in a cost-effective way. The retailer's brand is another factor that allows it to sell insurance in a credible way. The active selling of the product by the sales force, together with the convenience of taking up the insurance at point of sale, are critical factors that enable *Casas Bahia* to achieve scale. *Casas Bahia* has also understood the necessity to build "benefits in life" into its products, so as to appeal to the Brazilian market. Technology has played a role in enabling scale. MAPFRE and *Casas Bahia's* systems provide real-time insights into sales and servicing, allowing them to service clients and tailor products more effectively.

5 > HOLLARD, SOUTH AFRICA

DESCRIPTION OF THE COMPANY

Since its creation in 1980, Hollard has grown to become South Africa's largest privately owned insurance company, with nearly seven million policy-holders (Hollard, 2012). During the course of its history, Hollard has often pioneered new types of insurance products and distribution strategies. Especially noteworthy has been Hollard's decision to design its business around a partnership model. This strategy has extended Hollard's licence to include non-insurance service players. Hollard has since formed more than one hundred partnerships with various retail, banking and insurance companies – a key strategy that has enabled the company to reach large groups of clients in an efficient manner.

CONTEXT OF THE INITIATIVE

South Africa boasts a robust insurance industry, with 49.7 per cent of adults holding some form of insurance (FinMark Trust, 2012). The insurance market has seen significant growth in recent years, with the number of life insurance licensees increasing from 62 to 79 between 2001 and 2012 and premiums increasing 50 per cent annually between 2009 and 2010 to 262.4 billion ZAR (\$26.2 billion) (KPMG, 2012). Furthermore, the short-term insurance industry saw annual increases in premiums of 173 per cent in 2010, with a number of new insurance players entering the market over the past decade to take a prominent position.

Hollard holds both long-term and short-term insurance licenses, which are regulated by the Long Term Insurance Act of 2002 and the Short-Term Insurance Act of 1998, respectively. In common with AVBOB, the company is subject to the Financial Advisory and Intermediary Services Act of 2002, which provides guidelines for the selling and marketing of insurance products.

STRUCTURE AND EVOLUTION

While Hollard does not specifically focus on microinsurance products, it still manages to reach a sizeable number of low-income clients through its Emerging Consumer Solution (ECS) division, which falls under its Alternative Distribution division. ECS houses products that target customers earning 2000-8000 ZAR (\$200-800) per month, while also helping other non-ECS channels to identify opportunities to reach lower income clients (Shezi, 2013). Within ECS, Hollard distributes products through a number of channels, including partnerships and direct sales.

The partnership model on which Hollard has developed its business seeks to unlock value for the individual consumer, as well as the partner organization and Hollard itself. Through the establishment of joint ventures (JVs), Hollard and the partner organization share responsibility for product design and marketing. The partner organizations tend to bring an existing database of potential insurance clients, as well as sales channels and billing platforms to the partnership. Hollard, on the other hand, offers greater insurance know-how, administration skills and the underwriting of the risk. Hollard offers incentives to the partner through various value sharing mechanisms and flexible product features. In this way, the company seeks to create long-term relationships with its partner organizations. This structure, whilst sacrificing some efficiency due to the unique design of each individual insurance product, does allow space for innovative products that might not be considered by other insurance companies (Leach, 2013).

Over the past ten years, Hollard has offered direct sales, in addition to its main strategy of forming partnerships with distributors. Building on the strong brand affinity that Hollard has established over the past thirty years, direct sales products revolve around funeral policies that are marketed via television and print advertising. Following leads from these marketing sources, the policies are then primarily sold via outbound call centres, although physical Hollard stores are currently being piloted in six locations around the country.

In recent years, a conscious shift towards greater use of face-to-face encounters with agents has added a new element, within both the partnership and direct sales channels. Conversations with Mandla Shezi, Head of Hollard Alternative Distribution, indicate that in the past three years, Hollard staffing levels have grown from zero to more than 1,000 agents, leading to a 400-600 per cent increase in business over comparable distribution methods, whilst not reducing the business coming from existing distribution strategies. These agents, often outsourced from other companies, are motivated through commissions and incentives to sell products both in fixed locations (such as stores) and while roaming (events and door-to-door). Armed with the data to justify this shift towards low-cost agents, it is anticipated that Hollard will continue expanding this distribution strategy in the years ahead.

EDCON - HOLLARD'S LARGEST PARTNERSHIP

It is hardly possible to speak about Hollard's ability to reach scale without mentioning its largest and arguably most successful partnership to date. Establishing a JV in 2000, Edcon and Hollard have since developed their insurance business to include 5.6 million active policies (Edcon, 2012).

History

Edcon is South Africa's largest clothing, footwear and textile retail group, with a wide variety of stores that reach high and low-income consumers alike (Gauteng Provincial Treasury, 2012). One of Edcon's key value propositions to customers is its offer of store credit accounts, a factor that has resulted in Edcon controlling one of the largest credit books in South Africa. In 1999, Edcon approached Hollard seeking a solution to address the bad debt on its books, and the two companies jointly launched a credit life product that would help protect Edcon from the disability or death of its clients. Following the launch of this successful product, the JV expanded to include voluntary cell phone insurance products in the early 2000s. The partnership eventually extended its offerings to include a broad suite of diverse voluntary products, from funeral and life insurance to motor, home, accident, dental, legal and travel insurance. In recent years, the JV has made a concerted effort to refocus on simple life products, which are easier to sell and have simpler administration processes.

The joint venture leveraged Hollard's experience in product design and administration, while Edcon provided the premium collection platform, client base and administration surrounding the sales force. Edcon's database of 3.8 million accounts also provided information on age, gender, monthly spending and other consumer preferences, enabling the partners to understand their clients and craft products based on their needs. Responsibility for decision-making on product development has been shared between both Hollard and Edcon under the joint venture design, whilst Hollard has remained solely accountable for underwriting.

Distribution

The Hollard/Edcon JV uses three different strategies to distribute its products to clients. Outbound call centres have been the foremost channel since the launch of the partnership, allowing staff to tap into Edcon's customer database of more than 3.8 million store account holders. These call centres are able to enrol customers inexpensively and quickly, with the help of existing "know-your-client" information in the system.

In the past three years, however, Edcon has begun introducing in-store agents who actively sell the products to clients. These agents are currently found in some 70 per cent of the company's 1,200 stores nationwide, with the JV making a conscious effort to place agents in larger stores and locations that attract a clientele that is most likely to purchase insurance. While a third party company supplies the agents - both those working in-store and in the call centres - Hollard still oversees the training materials that the employees receive. Agents are remunerated via a commission structure that varies based on the type of products sold. Staff are given the freedom to determine which products to

push and, in making this decision, the agents tend to balance the commissions paid for the various products with the ability to sell certain types of products more easily than others.

As well as using telemarketing and in-store insurance sales agents, Hollard also trains all in-store staff on the insurance products. However, this strategy bears a higher risk than the other distribution channels, since retail staff have a higher turnover than insurance sales agents and, as a result, do not always acquire the required levels of training during their time at the store. This limits the role that retail staff can play in sales without facing the risk of non-compliance with South African regulation, which requires certain levels of skills to sell financial services.

In terms of new policy sales, roughly 40 per cent are generated by the outbound call centre, while 60 per cent originate in-store through the dedicated agents. On the whole, conversations with JV management did not appear to indicate that regular retail staff contributed substantially to overall product sales. In the future, it is anticipated by management that Hollard will continue to place a greater focus on in-store agents, as they have the ability to access everyone in the in-store customer base and can simultaneously encourage new store credit accounts.

Marketing and consumer education

Hollard has primarily taken advantage of Edcon's in-store marketing channels – including banners, television and radio – to market insurance products to customers, although they have also attempted direct response marketing via SMS and the Internet to solicit inbound calls. This latter marketing strategy has experienced limited success in comparison with its in-store counterparts. The JV also uses product brochures to educate clients on how to use the products. Likewise, Hollard has received funding through the Gates Foundation to facilitate additional education campaigns outside the stores.

Product design and operations

As noted previously, Hollard and Edcon offer a wide range of insurance products, although the focus has shifted recently towards simple life and funeral products. Roughly 45 per cent of active policies are credit life, with an additional 1 million funeral and 1 million cell phone policies (Sekhute, 2013). Once a product is sold via the in-store agents or the call centre, premiums are collected on a monthly basis via store accounts. These are a key feature of the Edcon/Hollard JV, which have facilitated low-cost, consistent payments. Since roughly half of all Edcon customers use cash to pay when shopping, the JV expects to explore cash sales further in the future.

Policy-holders initiate claims either in-store or via call centres, and may have to submit certain verification documents via mail. Depending on the type of product, Hollard pays claims into clients' bank accounts (funeral/life) or directly to Edcon (credit life). Some policies also result in a payout of services/products rather than money (cell/legal).

While research in this study has not been able to identify exact claims ratios, Hollard/Edcon JV management indicate that these figures are largely in line with market norms. In terms of persistency of policies, the ability to collect premiums monthly via the store cards has led to lower lapse rates in the first year that a customer has a product. In subsequent years, lapse rates tend to realign with industry averages.

OTHER PARTNERSHIPS: PEP

In addition to Edcon, Hollard has also entered into agreements with numerous other partners, including another significant South African retailer, Pep. The partnership between Hollard and Pep began in 2006 and in many ways shares similarities in structure with the Edcon JV described above. Products which initially consisted of funeral, cell and accident insurance have since been reduced to a simpler range of five funeral products, based on experience in the market.

In contrast with Edcon, Pep products are solely distributed off-the-shelf, with customers choosing an insurance starter pack, paying their first premiums to the cashier, who also collects a copy of identity and beneficiary information. Clients are then responsible for paying future cash premiums each month in-store. Clients are sent SMS alerts to remind them to pay premiums in-store, but customers also have the option to pay in advance.

While the Pep distribution strategy has remained consistent since the launch of the partnership seven years ago, in-store agents were piloted in November 2012 with highly successful results. Stores with agents saw a 350 per cent growth in insurance sales (Makgoro, 2013). Despite the success of these agents, plans do not currently exist to expand the agent model, as it fails to fit into current business strategies employed by the clothing retailer.

Discussions with Pep/Hollard JV management indicate that the factors that have largely contributed to Pep's success have been the affordability of the products – which range from 20-70 ZAR (\$2-7) per month – and the trust that consumers have in the Pep retail brand. The ease of processes for purchasing insurance is also cited as a reason for the product's sustained success.

SUMMARY OF DRIVERS OF SCALE

In examining how Hollard has been able to expand to cover more than seven million policy-holders, it becomes apparent that in many cases it has been a two-step process. Firstly, the company has leveraged its core strategy of partnerships to facilitate the enrolment of a large number of clients quite quickly. This strategy was introduced in a period when few other insurers were contemplating using partnerships to distribute insurance, and as a result, captured an unserved market. The partnerships have often tapped into existing customer bases to extend products via retail channels in a cost-effective manner. One partner, Edcon, played a particularly significant role. With Edcon, Hollard used one of the largest consumer databases in South Africa to target new customers, and they linked into Edcon's successful billing system to ensure that premiums were collected regularly and cheaply. With Pep, Hollard created off-the-shelf products that targeted the retail store's typical clientele. Using data on consumer preferences and buying habits, while continually refining its products based on feedback, the company has reached a unique segment of the market with lower distribution costs. Partners are retained due to flexibility in product design and profit share, as well as the strength of Hollard's brand.

More recently, Hollard introduced face-to-face agents with considerable success. Senior management in the company has indicated that data justifies the use of agents to maintain and expand sales volumes in relatively saturated markets. With Edcon, agents have become responsible for almost 60 per cent of new sales in just three years. With Pep, although not developed further, pilot tests with agents have shown sales growth of 350 per cent. According to Hollard, these agents increase levels of trust and consumer education, while incentives and commissions encourage active selling.

Looking to the future, it appears that Hollard will continue to place a greater emphasis on these agents while still retaining its partnership strategy as it seeks to maintain its position as one of South Africa's largest insurers for the low-income market.

6 > NATIONAL AGRICULTURAL INSURANCE SCHEME (NAIS), INDIA

DESCRIPTION OF THE INITIATIVE

Agricultural insurance was first tested in India in 1972 when the General Insurance Corporation (GIC) of India introduced a crop insurance scheme. After gaining this initial experience, the Pilot Crop Insurance Scheme (PCIS) was launched by the GIC in 1979. It was based on the “area yield-based approach”⁸ for widespread calamities and the “individual approach” for localized risks, such as hailstorms, landslides and cyclones etc. (World Bank India Country Management Unit, 2007). The scheme covered cereals, millet, oilseed, cotton, potatoes and chickpeas and was limited to farmers with loans from institutional sources of rural credit⁹, on a voluntary basis. The PCIS had various shortcomings and was closed down in 1984.

After these experiences, the Comprehensive Crop Insurance Scheme (CCIS) was introduced by the central government during the year 1985-86. Both PCIS and CCIS were restricted to farmers who had borrowed seasonal agricultural loans from financial institutions. The main contrasting feature of the two schemes was that PCIS was marketed on a voluntary basis, while CCIS was compulsory for farmers taking out loans in the participating states and union territories.

In 1999, CCIS was replaced by the National Agricultural Insurance Scheme (NAIS), which was sold on both a voluntary basis and a compulsory basis to farmers with loans. NAIS is currently available in 24 out of 29 states and in two out of seven union territories (UT), with only the states of Punjab and Arunachal Pradesh excluded. The scheme covered 15.97 million farmers as of 2013. Although this figure makes NAIS the largest crop insurer in the world, the penetration of crop insurance is less than 20 per cent, (World Bank India Country Management Unit, 2007) indicating significant potential for future growth.

As a multi-agency scheme, the central and state governments, banks/cooperatives, farmers’ organizations etc., all play a significant role in the implementation of NAIS. The Agricultural Insurance Company of India Limited (AIC), which was created in December 2002, took over implementation of the scheme from GIC in April, 2003. AIC underwrites NAIS on behalf of the Ministry of Agriculture, through its Regional Offices located in 17 state capitals. The central and state governments act as the ultimate reinsurer, paying for any losses that may arise from the scheme.

NAIS is mandatory for farmers who access seasonal crop loans from national and state-level agricultural banks (including cooperative banks) and is voluntary for non-borrowers. The scheme targets small-scale and marginal farmers who own less than 2 hectares (ha) of land (about 80 per cent of all farmers in India own less than 2 ha of land). Small-scale and marginal farmers have accounted for two-thirds of all farmers insured under the scheme (Mahul & Stutley, 2010, p. 108).

PRODUCT DETAILS

NAIS is based on an “area yield” indexed approach: if the observed seasonal area yield per hectare of the insured crop for the defined insurance unit falls below a specific threshold yield, all insured farmers growing that crop in the defined area receive the same claim payment (per unit of sum insured). The seasonal area yield estimate for a given crop in a given insurance unit – the actual yield – is determined by harvested production measurements taken at a series of randomly chosen Crop Cutting Experiment (CCE) locations. Approximately 1 million CCEs are conducted across India

⁸ The area yield based approach entails providing insurance cover against a deficit in realised crop yield below a predetermined threshold level.

⁹ Institutional sources of rural credit include state governments, co-operative societies, land development banks and commercial banks as well as regional rural banks.

every year, with the number of CCEs increasing with the reduction in size of the insurance unit – an administrative area specified by the state.

Risks covered include: 1) Natural fire and lighting; 2) Storm, hailstorm, cyclone, typhoon, tempest, hurricane, tornado etc.; 3) Flood, inundation and landslide; 4) Drought, dry spells; 5) Pests/diseases, etc. Losses arising out of war and nuclear risks, malicious damage and other preventable risks are excluded (Current Affairs: India & World, 2011).

While the initiative broadly specifies the crops eligible for coverage, the state governments decide which crops and which areas within the state are to be included for insurance before the beginning of the crop season i.e., Kharif¹⁰ and Rabi¹¹. The product offered since NAIS was launched has not changed, but new crops have been added to the initial scheme. Crops covered include all food grains (cereals, millets and pulses), oilseeds and annual horticultural/commercial crops for which past yield data based on CCEs is available for an adequate number of (approximately ten) years. Among the annual commercial and horticultural crops, sugar cane, potatoes, cotton, ginger, onion, turmeric, chillies, coriander, cumin, jute, tapioca, banana and pineapple are covered under the scheme. Currently, there are around 35 different crops insured during Kharif season and about 30 insured during Rabi.

In states and union territories that choose to participate in NAIS, insurance for food crops, oilseeds and selected commercial crops is mandatory for all farmers who borrow from financial institutions and is voluntary for farmers without loans. The minimum sum insured, in the case of borrowing farmers, is the amount of the loan borrowed. This figure can be further extended to up to 150 per cent of the average yield. For non-borrowing farmers, the sum insured can likewise be up to a value of 150 per cent of the average yield.

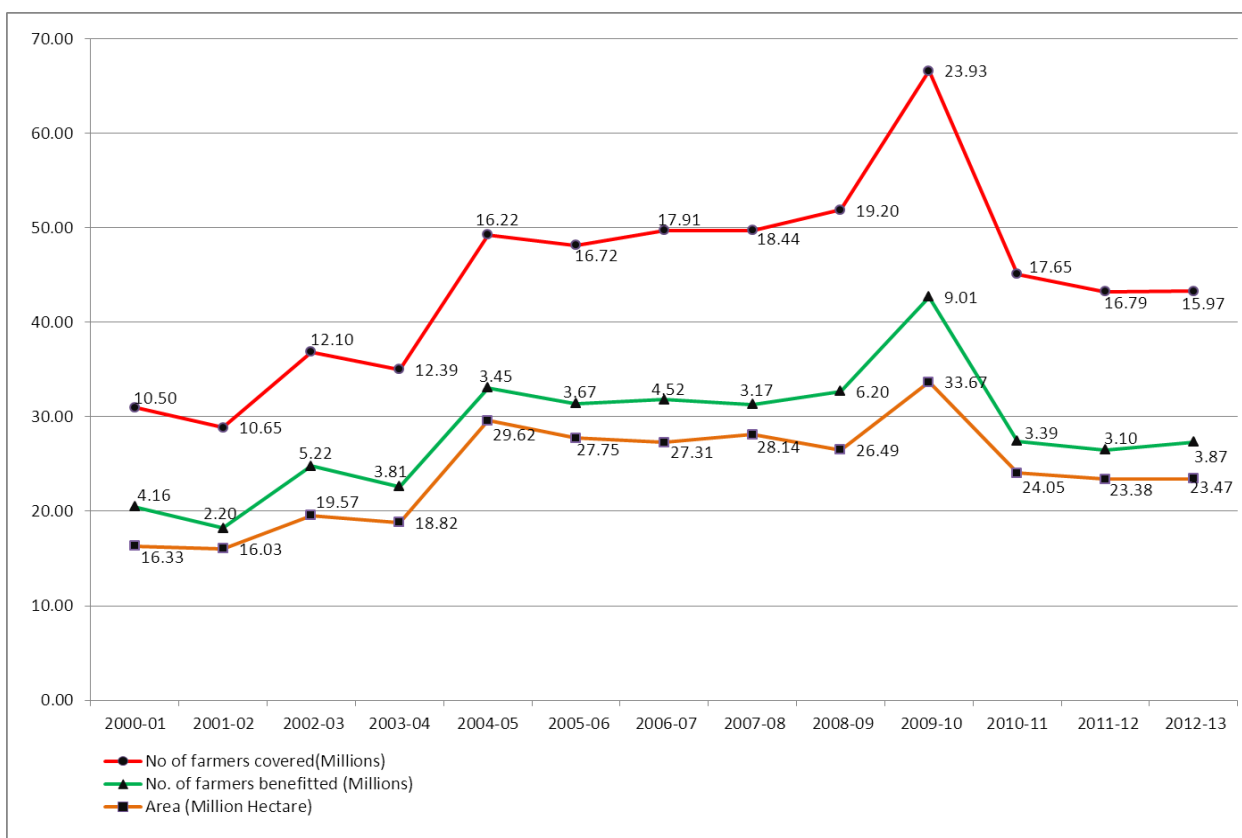
There are significant differences in the type of insured farmer, depending on the crop grown. Eighty per cent of NAIS farmers insuring paddy (the staple food crop in India) have been small-scale and marginal farmers; they have received 55 per cent of all claims paid for paddy. Small-scale and marginal farmers have accounted for no more than half of insurance contracts for cash crops, including sunflower, bajra, red gram, soya bean, jowar, and horse gram (Mahul and Stutley, 2010).

Initially, only nine states and union territories participated in the National Agricultural Insurance Scheme. It covered 580,000 farmers and 780,000 ha of cropped area. The coverage under NAIS increased dramatically after 2000, as shown in Figure 2, and has been significantly more extensive during Kharif seasons than during Rabi seasons. In seven Kharif seasons, since Kharif 2000, a total of 73,140,000 farmers have been covered, compared with 23,940,000 farmers in the eight Rabi seasons since Rabi 1999-2000. During the entire period from 1999-2000 through 2006-2007, NAIS covered 97,080,000 farmers on a total area of 156,210,000 ha. With about 20 million farmers insured for the 2009 Kharif season, this is the largest crop insurance programme in the world (World Bank India Country Management Unit , 2007).

¹⁰ The *Kharif* crop refers to crops sown in at the end of spring during the monsoon season and harvested in autumn.

¹¹ The *Rabi* crop refers to crops sown in winter and harvested in spring.

Figure 2: Growth of NAIS coverage (2000-2001 to 2012-2013)



Source: AIC, 2013 (Anbarasu, 2013)

Due to delayed claims settlements that have caused problems for clients, coupled with inefficient financial design of NAIS, two other crop insurance schemes, the Modified National Agricultural Insurance Scheme (mNAIS) and the Weather Based Crop Insurance Scheme (WBCIS), are now being tested in India.

In November 2013, the Government of India introduced a National Crop Insurance Programme (NCIP), which involved withdrawing the NAIS and applying the mNAIS, WBCIS and Coconut Palm Insurance Scheme (CPIS). The schemes are implemented by AIC of India and nine more private companies subject to availability of infrastructure. In all the above schemes, the premium is subsidized, but not the claims.

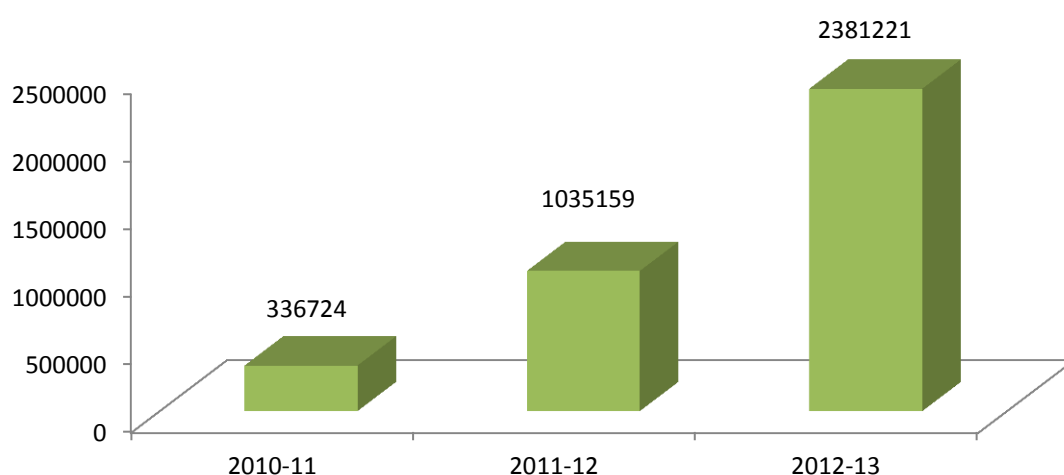
The mNAIS scheme operates on an "actuarial regime" in which the government's financial liability is predominantly in the form of premium subsidies given to the insurance company and funded ex-ante. This limits the contingent and uncertain ex- post fiscal exposure faced by the government under NAIS and reduces delays in claims settlement. Since claims liability is the sole responsibility of the insurer, this scheme may stimulate the use of informed reinsurance arrangements, rather than using the government as a free insurer. Figure 3 below shows the growth in the number of farmers insured under mNAIS. As of 2013, these numbered 2.38 million.

The following are some features of mNAIS:

- It contains an area-yield guarantee, based on the Crop Insurance Scheme of the Government, where the unit area of insurance is reduced to village/village *panchayat* level for major crops;
- Insurance coverage is available for cereals, millet, pulses, oilseeds and annual commercial/horticultural crops;

- Coverage is available to all farmers - mandatory for borrowing farmers and voluntary for non-borrowing farmers;
- The scheme is serviced through the network of Rural Financial Institutions (RFIs);
- Up until September 2013, the scheme operated as a pilot in selected states/UTs (covering 25 crops in 37 districts of 16 states in *Rabi* season and 22 crops in 31 districts of 16 states in *Kharif* season). It has since been extended to all districts in the country;
- The scheme includes an indemnity payment for prevented sowing/planting risk; and
- An on-account payment of up to 25 per cent advance of likely claims as immediate relief.

Figure 3: Number of farmers insured under mNAIS



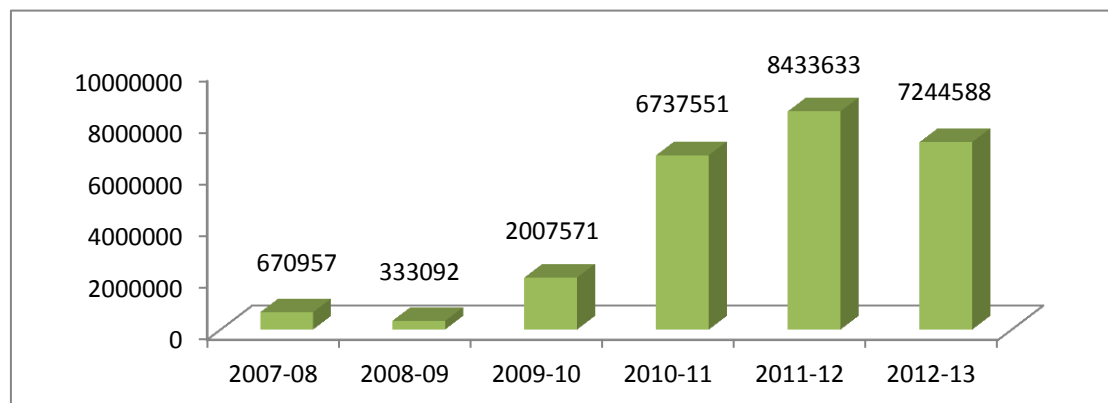
By contrast WBCIS offers weather-based insurance that is automatically paid if the index is triggered by any of the conditions covered by the product. In both cases, AIC competes with private insurance companies in implementing the pilots.

Figure 4 shows the number of farmers enrolled under WBCIS. Up until the end of 2013, the scheme operated as a pilot in selected states and UTs (covering 31 crops in 140 districts of 14 states in Rabi Season and 26 crops in 105 districts of 13 states in Kharif season). It is now available in all districts of the country.

The following are some salient features of WBCIS:

- The scheme provides protection against potential crop losses due to adverse deviations in weather parameters, such as rainfall, minimum temperature (frost), maximum temperature (heat), humidity, high wind speed, etc.;
- It covers weather risks during critical stages of crop growth, the sum insured being broadly equivalent to the 'cost of cultivation';
- It is actuarially priced - AIC is thus responsible for all claims;
- It has subsidized premium rates - the gap between the actuarial rates and the rates charged from the farmer are bridged by the government.

Figure 4: Number of farmers insured under WBCIS



Almost 55 to 60 per cent of farmers in India considered to be small-scale and marginal, with less than 2 ha of land, participate in and benefit from all three schemes.

Although mandatory, approximately 25 to 35 per cent of loanee farmers take part in the schemes. Voluntary participation of non-loanee farmers constitutes around 20 per cent of the total farmers. These policies are not evenly distributed during the season. The bulk of these policies effective towards the end of the season.

The NAIS scheme was exclusive to AIC in terms of implementation, but the other two schemes - mNAIS and WBCIS - are also open to private companies (Anbarasu, 2013).

DISTRIBUTION

The Agriculture Insurance Company of India is the only organization authorized to sell NAIS to farmers, and both farmer insurance premiums and claims payments are channelled through the banking system. Primary Agricultural Cooperative Societies (PACS) and nationalized commercial bank/"scheduled bank" branches, including regional rural banks which are mainly located in rural areas, are the financial institutions that distribute the product to the farmers.

All borrower farmers are automatically and compulsorily covered under the insurance scheme when crop loans for insured crops are disbursed to them. The Reserve Bank of India (RBI) and the National Bank for Agriculture and Rural Development (NABARD) have issued guidelines for financial institutions and banks, making it mandatory for them to cover eligible crop loans in respect of notified crops in notified areas. However, on account of system gaps, there are still a large number of uninsured crop loans.

Non-borrower farmers wishing to take out insurance coverage can contact the nearest bank branch before the stipulated time frame. They also require a bank account and must pay the requisite premium to receive insurance coverage. Applicant farmers are informed about the benefits available under NAIS during each marketing season, mainly through publicity, advertisements and pamphlets. However, these initiatives are still very limited, which is why the percentage of voluntary farmers insured continues to be extremely low.

For Kharif crops, the farmers' premium rate¹² is fixed at 3.5 per cent for all oilseed crops and 2.5 per cent for all other food crops. For Rabi crops, the farmers' premium rate is 1.5 per cent for wheat and 2 per cent for all other food crops. In both cases, premium rates are not actuarially calculated and therefore they do not reflect the real risk assumed by the insurer. Conversely, in the case of commercial and horticultural crops, premium rates are not pre-determined but are actuarially calculated at state level¹³.

Initially, the premium in the case of small-scale and marginal farmers was 50 per cent subsidized, with the costs shared equally by the government of India and the state/UT concerned. The premium subsidy was due to be phased out over a

¹² The premium rate is the percentage of the sum assured that has to be paid by the insured for the risk to be undertaken by the insurer.

¹³ Premium rates for commercial and horticultural crops are determined using a Normal Theory Method for each crop, under which yields are assumed to be normally distributed with mean and variance calculated using ten years of data for that insurance unit.

period of five years, but at present, a 10 per cent subsidy is still provided on the premium payable by small-scale and marginal farmers. Besides premium subsidies, claims subsidies are also offered in the case of a claims ratio higher than 100 per cent since, as stated above, most premium rates do not reflect the real risk assumed by the insurer.

In the first years of the scheme, only 3 per cent of non-borrower farmers adopted crop insurance offered under NAIS. In 2005-2006, the proportion of voluntary take-up was 15 per cent. Despite the growth, this shows that the scheme is operational mainly because the insurance is mandatory for farmers receiving loans from institutional sources.

OPERATIONS

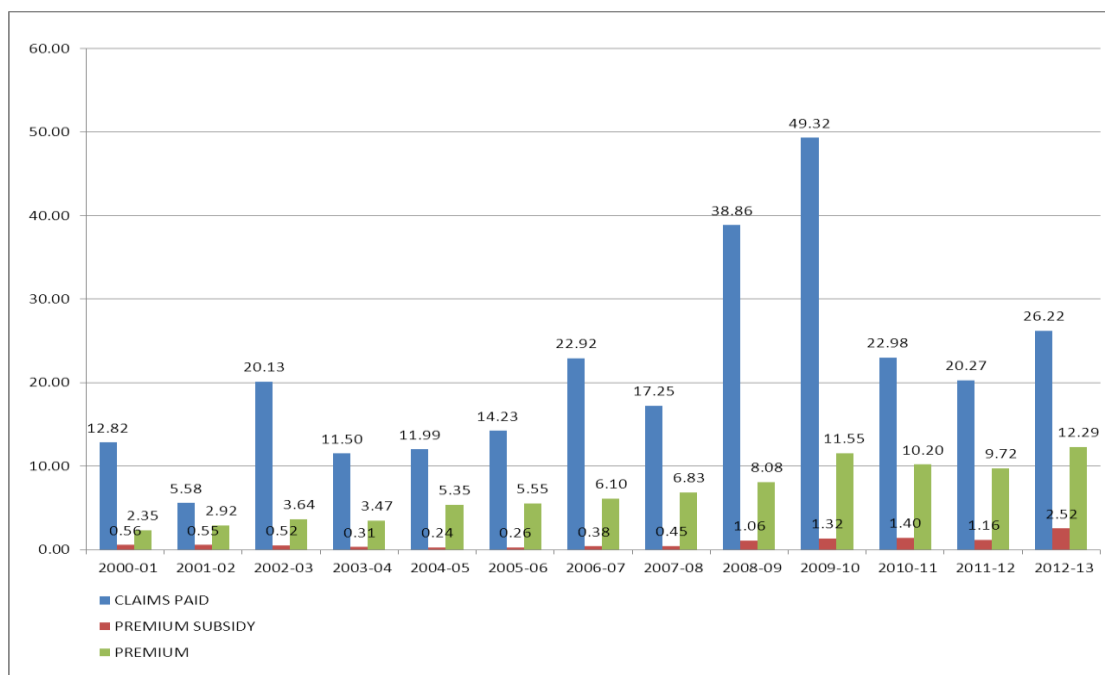
Under NAIS, premiums are collected at the PACS/bank branch level. For farmers with loans, the premium is additional to the loan and the value is automatically included in repayment instalments. Farmers who enrol in the initiative voluntarily must pay premiums directly to the bank.

Claims are automatically calculated based on the shortfall in each season's yield, as compared with the threshold yield. Claims are settled through the rural banking network. Claims assessment and payment is conducted after receipt of the requisite yield data from the relevant government agency, so farmers do not need to inform the insurer or bank of crop losses. Crop losses, if any, are paid as claims through the bank. Even in the case of farmers purchasing the product voluntarily, claims payouts are made by way of cheques or through designated bank branches, directly into policy-holders' accounts. No claims would be admissible or payable in the event of a season's actual yield exceeding the threshold yield. Claims settlements take between nine and twelve months, since the process involves conducting the CCEs at the areas covered by the scheme. This can be a major concern for farmers who require capital to invest in next season's crop, and can therefore expose farmers to a vicious debt cycle.

Until transition is made to a full actuarial regime, central government and states bear equal shares of claims that exceed 100 per cent of the premium collected in the case of food crops and oilseeds. In the case of annual commercial/horticultural crops, claims that exceed 150 per cent of premiums in the first three or five years, and 200 per cent thereafter, are borne by the central government and state on an equal basis.

As shown in Figure 5, during 2000-01 and 2002-03, the claims amounted to more than five times the total premium paid. During 2003-04 and 2004-05, the claims amounted to more than double the total premium collected. Since claims exceeded premiums, there was a net loss for the scheme, even excluding the administrative costs. The annual claim/farmers' premium ratio was higher than 100 per cent. Lack of an actuarially sound premium rating methodology was the cause of this imbalance, which has proved harmful for the budget management of central and state governments and delayed claims settlements.

Figure 5: NAIS performance in US\$ million (2000-2001 to 2012-2013)



Source: AIC, 2012 (Anbarasu, 2013)

In the future, it is expected that state support will continue in the form of premium subsidies, leaving the insurers to pay claims from their reserves or through a risk transfer mechanism, such as reinsurance. If state support is withdrawn completely, the scheme may not be sustainable.

As a multi-agency scheme, it is essential that all the entities participating enhance their technological capabilities so as to improve the quality of service. Several technologies are being used by AIC and some more are in the pipeline. Techniques such as Forecasting Agricultural Output Using Space, Agro-meteorology and Land-based Observations (FASAL) are also proposed for more accurate yield estimation. Besides, most of the nationalized and scheduled banks have computerized their operations and the cooperative banks are expected to do so shortly. This would improve the administrative time taken to process and settle claims payments.

EXTERNAL FACTORS

India is a large agricultural country, and most households face risks during harvest. Of 110 million farmer households, 80 per cent can be characterized as small-scale and marginal, making them potential clients for microinsurance. In a scenario such as that of India, the task of reaching a significant number of farmers for coverage – for example 26 million – requires less effort than in other contexts.

Regarding competition, AIC was created as the sole implementing agency for NAIS. As well as being a financially strong risk carrier, with backing from the government, AIC's strength lies in its technical capabilities. It plans to leverage these so as to remain a significant player in the crop insurance market.

DRIVERS OF SCALE

Although NAIS is the largest crop insurance programme in the world, with 26 million farmers insured, the drivers of scale in the Indian case are less related to the value perceived by the clients and more linked to the design of the scheme and the context of where it was implemented.

Firstly, since India is the *second* most populous country in the world, with a long agricultural tradition, the market potential for crop insurance in the country is significant. Substantial demand for this type of insurance is favourable to scale, as can be seen by the 15 per cent voluntary take-up of these policies.

Besides the country's own characteristics, further important drivers of scale are the distribution model chosen by NAIS and the auto-enrolment feature. Given the fact that the product is distributed by financial institutions, that insurance is mandatory for borrower farmers and that the number of loans taken out by farmers is high, demand for credit is a crucial driver of insurance take-up.

Alignment with partner incentives is a further important driver of scale. The banks and other institutions making loans have incentives to offer insurance since it reduces their credit risk by increasing the likelihood of the loan being repaid, even when crops fail.

Subsidy is another significant factor that drives scale. The subsidies lower the cost of the premiums, making the product more affordable to consumers. A proportion of the losses are also subsidized by the state, making it more sustainable for the insurer to provide this type of product.

Finally, the large numbers of farmers who have received indemnity in the past may have helped other farmers to realize the benefit of being insured. This in turn may have stimulated voluntary take-up. However, it is not possible to gauge the extent to which this dimension has contributed to driving the scale reached by the product.

7 > PROTECTA, PERU

DESCRIPTION OF THE INITIATIVE

Protecta was launched in December 2007 with the purpose of targeting the microinsurance and low-income mass insurance market in Peru. It was the first Peruvian insurer to specifically target this market.

It was created by Grupo ACP, a trans-Latin American non-profit corporation specialized in providing low-income people with access to services such as training, capital, housing, markets and insurance. Grupo ACP owns 83.5 per cent of Protecta, with the World Bank's International Finance Corporation (IFC) owning the remaining 16.5 per cent (Class and Asociadas S.A., 2013, p. 3). MiBanco is a large Peruvian MFI and also a subsidiary of Grupo ACP. MiBanco had about 500,000 clients when Protecta was launched. Protecta initially provided credit life insurance to MiBanco customers.

The rationale behind the Protecta strategy was to launch a product which gave the policy-holder more tangible benefits, beyond coverage of the outstanding loan. The formula reduced conventional and pre-existing exclusions, while integrating added services to the products, such as discounts in a drugstore chain and access to free health care, as well as discounts for restaurants, transportation companies, leisure centres and other facilities.

Protecta also began to expand its client base beyond MiBanco. At first, it offered similar credit life products through a number of smaller MFIs, before going on to sell life insurance with health added services through different organizations, particularly universities. Protecta also offers voluntary insurance through a chain of pharmacies, Boticas Arcángel, and through municipalities, although these channels remain very small.

As of June 2012, Protecta had a total of about 1.3 million active policies, with 800,000 sold through MiBanco. These covered a total of some 1.9 million individuals.

CONTEXT OF THE INITIATIVE

Grupo ACP is a non-profit organization that aims to accomplish "its social mission with business efficiency (Grupo ACP, 2012)." The organization is explicitly "promoting the growth of micro and small business owners and entrepreneurs who start at the base of the pyramid (Grupo ACP, 2012)."

In line with these goals, Grupo ACP founded MiBanco in 2002 in order to provide microfinancial services to low-income Peruvians, especially those belonging to Peruvian socio-economic classes C and D (some 90 per cent of Protecta clients fall into socio-economic classes C and D). Protecta was established in 2007 to provide credit life insurance on MiBanco's credit book. Providing credit life insurance firstly alleviated the credit risk to both MiBanco and the individual creditors, as is the case with traditional credit life insurance. Secondly, it also achieved the social goals of ACP through the tangible health benefits included in the coverage.

Following more than a decade of robust economic growth, Peru's low-income population is increasingly upwardly mobile. This population is enjoying greater access to services and opportunities through education. It is this population that Protecta is targeting, so these increasing income levels and opportunities are key elements of the company's growth strategy, as illustrated by its decision to target universities.

Stringent customer protection legislation on registered microinsurance products, as opposed to mass market insurance products, has hindered the development of Protecta in this space, although it has also allowed it to carve out a specific niche as a specialist Peruvian player that provides insurance to low-income groups. For example, Protecta has indicated that, in particular, the know your customer (KYC) requirements have been onerous and expensive under the microinsurance regime.

A consultation with Protecta General Manager Alfredo Salazar Delgado also elicited the view that "passive sales do not work in Peru." This has been one of the reasons behind the company's decision to pursue groups as a channel for reaching large amounts of potential clients, as opposed to individual sales. Such a strategy has been partly prompted by the relatively undeveloped insurance culture in Peru, where there is low awareness and understanding of insurance. Together with its partners, Protecta itself engages in significant consumer awareness initiatives in an effort to overcome this problem (Protecta, 2011).

PRODUCT DETAILS

Protecta primarily offers group policies to MFIs, universities, etc., who then automatically cover all their clients, members or students respectively. These institutions provide Protecta with details of the people covered under the policy. Protecta can then base its pricing strategy on the pool of people covered under the group policy. Protecta receives the databases from its partners and it can then automatically enrol the different members into their system. The fact that Protecta deals with groups means that gathering information in terms of specific costs and statistics related to a particular group allows it to have very accurate pricing for each organization. Protecta has its own proprietary software, CICCRRM, which enables it to manage these large groups efficiently.

Compulsory embedded credit life insurance accounts for the vast majority of Protecta's total number of policies, with its MiFamilia product accounting for the rest. As of June 2013, Protecta derived 85.95 per cent of its total premiums from credit life.

Credit life is provided on a compulsory basis by Protecta to credit clients of MiBanco and other affiliated MFIs. The credit life product covers clients' outstanding loan repayments in the event of death. Clients have the option to purchase a sum insured that is higher than their outstanding balance. The benefits are paid directly to the loan provider, (MiBanco or other MFI) with any amounts in excess of the outstanding loan paid to the client's beneficiary.

The basic MiFamilia product offers coverage to individuals between 18 and 69 years and covers natural death, accidental death, funeral expenses, total and permanent accidental disability and sudden family abandonment. The policy has a 1 year term length, with a monthly premium of either 1.5 soles (US\$0.5) or 2.43 soles (\$0.81), depending on the benefits. Premium payments can be made either monthly or annually.

The Protecta Benefit Card is included for members covered under the group insurance policies and aims to provide a tangible benefit to the policy-holder, beyond simple insurance. The benefit card grants a range of discounts and preferred rates in the establishments affiliated in the region, principally related to health. These extra benefits include:

- 20 per cent discounts for a pharmacy chain and access to free health care provided at health centres run by the same pharmacy chain across Peru.
- Policy-holders can receive general practice, dental and eye health services, as well as discounts at restaurants, transportation companies, leisure centres and other facilities.
- A set of discounts at different retailers, food chains, laboratories, hospitals, entertainment parks, etc.

Protecta has changed the amounts of the sum insured from one renewal to the next, evolving according to client demand. The path of product evolution is also heading towards offering additional value added services, as can be seen from the expanded services offered through the benefit card.

Protecta offers a variety of other products, although, with the exception of credit life, university accident insurance and Mifamilia, none has achieved significant take-up.

PARTNERSHIPS AND DISTRIBUTION

Protecta's key initial partnership was with MiBanco. Access to the MFI's client base formed Protecta's initial client database and this partnership still remains a key factor in Protecta's scale, accounting for about 800,000 active policies out of a total of 1.3 million.

Protecta has developed a strategy of also working with distribution channels beyond MiBanco. The goal is to find existing groups which have enough people to whom group policies can be sold, rather than selling individually. Protecta initially identifies potentially viable groups and then works with that group to design and tailor an insurance product which meets its specific needs, rather than simply selling a pre-defined product.

Protecta has formed partnerships with a number of financial institutions beyond MiBanco, such as Profinanzas. Protecta has also partnered with education centres - branching out from universities to include specialized colleges that target the low-income population - and sees this as an area of additional growth potential. Targeting youth is a specific long-term strategy, since today's young people are future sustainable purchasers of insurance, if they undergo a positive market discovery. A partnership with local municipalities has also been started, although this has only produced about 1,000 active policies (May, 2013).

Protecta has tried to work with Boticas Arcangel (a chain of drugstores), but has failed to achieve the impact it had hoped for. The pharmacy channel has been generally considered less successful, as, according to Protecta, customers feel disconnected from the product. Other challenges with this channel in its current form include limited marketing, limited training of sales staff and lack of incentives to sell the product through the intermediation channel. Unlike other channels, the product offered through this distribution system is an individual, rather than a group policy.

A future plan is to try to work with mechanic or craft workshops, offering insurance to these groups of individuals through references and referrals. Protecta also indicated in consultations that it is interested in pursuing partnerships with large retailers, naming Ripley and Belcorp as potential partners (Cenfri, 2013). MiBanco has a referral programme, which Protecta would like to replicate for the insurance sector.

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Protecta believes that public confidence is a key driver of demand and hence has a significant focus on paying claims in order to help build that trust. The claims ratio in its mass market insurance and credit life sector is reportedly close to 50 per cent. In the health expenses and other sectors, the ratio is 60 per cent, with an average claims turnaround period of 15 days, which is the best in that market.

Claims are settled through the channel through which the policy was initially sold or distributed. The beneficiary claims through the channel, which then claims from Protecta. The channel also settles the claim with the beneficiary. This approach has been successful in keeping claims costs low.

Protecta spends less than 10 per cent of total budget on marketing, as it typically focuses on ex-post marketing, so marketing is conducted after the client has already enrolled in the initiative. Marketing campaigns are primarily conducted to inform clients about their policy and make them aware that they now have that policy.

Although the majority of Protecta's policies are sold through groups, insurance is also distributed to individuals through a partnership with Boticas Arcangel and the company has an outbound call centre to make sales.

Protecta maintains that efficient back-end technology and processes have been a major enabling factor. This is especially true in the case of administration, since the largest burden is capturing data, for which automatic processing systems have now been developed. Improvements in information systems have led to the volume of staff remaining relatively constant, despite an increase in the volume of business. Protecta reports an expense ratio of 12.3 per cent, compared with an industry average of 21.75 per cent (Cenfri, 2013). These low costs result in relatively high profitability ratios of 15-20 per cent.

Protecta is also investigating extending the use of front-end technology, given that technology is currently mainly used to process back-end, internal information. Improving communication with clients on payment of premiums and claims should increase value to the customer, according to Protecta.

DRIVERS OF SCALE

The partnership with MiBanco has been a key initial and continuous driver of scale. Access to the MFI's client database, combined with auto-enrolment of all loans, has allowed Protecta to rapidly scale up and become profitable. This large, solid base of clients has enabled Protecta to expand its product offering – offering additional tangible benefits, such as the Protecta benefit card. It has also allowed it to expand its partnerships and distribution channels to include other MFIs, universities, municipalities and pharmacies.

Protecta has also had a first player advantage, in that it was one of the first Peruvian insurers to actively target the low-income market and explicitly provide microinsurance products to low-income clients. This was particularly true in terms of its strategy of specifically targeting groups. A number of other insurance companies in the market have since tried to copy the group enrolment model for low-income people.

All this has meant that the value proposition of Protecta's insurance offering has improved over time and the introduction of the Protecta Card, as well as the company's commitment to rapid claims payouts, has helped to build tangibility and trust in the products, thereby improving value to consumers. A further key enabling factor for reaching scale and

achieving success has been the efficiency gained through effective technology used in administration; this has enabled the company to maintain a constant workforce, despite more than doubling policy volumes, and has helped it to achieve a significantly lower expense ratio than that of the industry standard.

Lastly, Protecta's model of mainly targeting groups has allowed it to scale up more rapidly than if it had sold individual policies. The strategy has helped to keep administration costs low, since the groups handle most of the policy administration and distribution. The company's flexibility in offering specifically tailored products to specific groups has been an important factor in allowing Protecta to secure these partnerships.

8 > TIGO/BIMA, GHANA

DESCRIPTION OF THE INITIATIVE

In 2010, Millicom – an international telecommunications and media company focusing on emerging markets in Latin America and Africa – partnered with leading mobile insurance provider Bima to explore the idea of a mobile-based life insurance product that would serve the purpose of increasing customer loyalty and average revenue per user (ARPU). Understanding the importance of launching in a market that was sufficiently large to reach the mass required for a microinsurance product, Millicom targeted Ghana, a country in which Tigo (the company trade name of Millicom) was well established. Tigo is the second largest mobile network operator in the country. Furthermore, Ghanaian culture, in common with that of many African countries, strongly values the ability to provide a proper funeral for family members. Thus, this type of product aligned with consumer needs, although education would be needed to help create an understanding of, and demand for the unfamiliar concept of insurance. The market called for this type of coverage.

Bima, an independent Swedish company, was set up in 2010 at the same time as the product was launched in Ghana. It had the capabilities to build the technology that would link the end users, the mobile network and the insurance product. It was to become the primary entity, not only for providing the technology platform, but also for managing the project partnerships and playing an ever increasing role in product administration. Seeking to complement the capacities of the two partners, Bima also brought on board MicroEnsure,¹⁴ which came to the table with broad microinsurance expertise. Finally, Vanguard Life Assurance Company joined the partners to assist with pricing and ultimately to bear the risk of the product as the underwriter.

Having worked in collaboration on product design, the partners formally launched the Tigo Family Care Insurance life product in December 2010 as free loyalty cover for prepaid mobile customers who used a certain amount of airtime on their mobile phones during the course of a month. The greater the amount of airtime added, the greater the amount of free coverage for the policy-holder and an additional insured life. In October 2011, the product added the feature of doubling a policy-holder's coverage on payment of a small fee – a vital progression in the product's evolution. Building on the capabilities of technology, the product began offering self-registration via mobile device in September 2012, and by June 2013, the product had reached more than 550,000 registered users, of which 400,000 signed up to pay the small premium to double their cover. Although the partnerships and the product have evolved over time, Tigo and Bima remain committed to their mobile life insurance product and have expanded with a mobile hospitalization insurance product, launched in July 2013.

CONTEXT OF THE INITIATIVE

In common with many developing countries, insurance penetration in Ghana remains relatively low. In 2010, when the Tigo-Bima product was launched, only 4.1 per cent of the population held any formal insurance policy, a figure that rose to 5.4 per cent when informal insurance mechanisms were included (Grundling and Kaseke, 2010, p. 37). While insurance penetration levels might have mirrored those of its peer countries, the product had the benefit of quite a favourable regulatory environment, with relatively little obstruction from the National Insurance Commission (NIC), according to project management. In early 2013, this regulatory body introduced a new regime that allows for relaxed authority approval for microinsurance products, as well as provisions for certain institutions to distribute microinsurance products without an insurance license. These were both factors that were expected to play a role in facilitating future evolution for the Tigo-Bima product, as well as for other microinsurance products.

Aside from the benefit of a relatively favourable regulatory environment, the Tigo-Bima product has been able to leverage a market with extremely high mobile penetration. In December 2010, when the product was launched, Ghana had a mobile penetration rate of 74.2 per cent (National Communications Authority, 2010), a figure that had risen to

¹⁴ MicroEnsure began in 2002 as part of Opportunity International. By 2005, it was spun off as the Micro Insurance Agency. In 2008, the company changed its name to MicroEnsure (MicroEnsure, n. d.). By 2009, just before it partnered in the *Tigo-Bima* project, the company had offices in Ghana, India, Kenya, Tanzania, the Philippines and Uganda, as well as pilot projects operating in Malawi and Rwanda. MicroEnsure helps to develop and implement a wide range of microinsurance products, including health, life, housing, agriculture and weather-index (MicroEnsure, 2009, p. 6).

100 per cent by May 2013¹⁵ (National Communication Authority, 2013). While high mobile penetration rates provide the foundation for a mobile insurance product, they also indicate strong competition in the industry. In December 2010, Tigo had the second largest client base in the country, with just under 4 million subscribers (22.9 per cent market share) (National Communications Authority, 2010). By May 2013, Tigo's raw customer numbers (and market share) had fallen significantly, mainly due to increased competition from other mobile companies (MTN, Vodafone, Airtel, and GLO) (National Communication Authority, 2013).

Although Tigo-Bima's Family Care Insurance product was the first of its kind in the Ghanaian market, MTN has since launched its Mi-Life mobile life insurance product in 2011, with Airtel launching a similar product in 2012. MTN's product relies on the mobile money platform to collect premium payments, while Airtel's cover is a free loyalty product for active users of Airtel's mobile-money wallet.

PRODUCT DETAILS

With the aim of increasing loyalty and ARPU among customers who have a wide range of choices in the Ghanaian telecom market, the Tigo Family Care product offers free life insurance coverage to customers based on the amount of airtime they use during a given month. By consuming a monthly minimum of 5 GHS (US\$2.50) worth of airtime, a Tigo prepaid customer would receive 200 GHS (\$100) worth of coverage. Coverage has a maximum limit of 1000 GHS (\$500), a level that would require monthly airtime usage of 40 GHS (\$20).

Clients are notified via SMS on a monthly basis about how much insurance cover they have earned for the previous month. In order to enrol, a client must complete a one-time registration at a Tigo customer service centre, through trained Tigo-Bima insurance sales agents at a call centre or via USSD.¹⁶ Clients provide data on both themselves as the primary policy-holder and on one other covered person (beneficiary). Clients then automatically receive cover for any subsequent months when they again consume the amount of airtime required for free coverage.

Table 2: Customers registered for Family Care Insurance Product

	Paid	Free	Total
June 2011	-	100 000	100 000
June 2012	100 000	300 000	400 000
June 2013	400 000	150 000	550 000

Source: Bima, 2013

Following successful take-up of the free product over the course of the first year, Tigo began offering clients the option to double their monthly coverage by paying an additional 1.3 GHS (\$0.65) per month. Tigo deducts this premium from a client's airtime balance over the course of a month, removing 5 Ghanaian Pesewas (\$0.025) per day. As with the free product, once clients register for the "freemium" product, they remain automatically enrolled for subsequent months, until they opt out. Using targeted marketing for those clients who registered for the free insurance, the Family Care product was able to convert 250,000 policies in the first year to the paid product, with these numbers rising to 400,000 paid policies in June 2013. Tigo cites the relatively inexpensive price of 1.3 GHS for doubling of coverage as a key factor in reaching such a large number of consumers with the hybrid free-paid model.

All Family Care Insurance policies allow policy-holders to cover both themselves and one other individual, without any waiting period. Following the death of either insured party, the policy beneficiary contacts a call centre operated by Bima, which explains the necessary documentation that must be submitted at the nearest Tigo customer service centre. Once documentation has been processed at these locations, claims are paid out within 72 hours via Tigo Cash. Having formerly paid out via cheque, the product made the switch to the Tigo mobile money platform, in order to reduce costs, shorten payout times and increase usage of Tigo Cash. Client can collect their payouts at any Tigo Cash agent location, a process which management claims has resulted in the absence of any complaints from clients.

¹⁵ This does not necessarily indicate all Ghanaians have access to a mobile phone, but rather that some individuals actively use more than one SIM card.

¹⁶ USSD is a means of real-time communication on GSM mobile devices, usually between cellular phone users and a service provider. Because USSD opens a timed session with a mobile phone user, it allows a two-way exchange of data more responsively than SMS.

PARTNERSHIPS

For a better understanding of the insurance product, and how it has achieved scale, it is important to examine the partnerships that helped to shape the product. In the case of the Tigo Family Care Insurance product, the roles of the various players have changed over time, illustrating how each party evolved alongside the product. This is illustrated in Figure 6, below.

Tigo, with its 3.7 million mobile subscribers, provides the customer base for the product, as the Family Care Insurance initiative is tied to airtime usage. In addition to this, Tigo contributes:

- Monthly data on clients' mobile usage (to determine insurance eligibility);
- Customer service centres, as a point-of-service for the product nationwide;
- Mobile wallet platform and Tigo Cash agent locations for benefit payouts;
- A strong brand, to build trust with clients.

Bima, which began with the project in Ghana and has since expanded to a number of other markets around the world, provides:

- Technology that connects the mobile customers to the back-end insurance system;
- SMS notifications of client eligibility;
- A distribution network (management and training of insurance agents);
- Policy administration (inscription, policy management, customer inquiries, claims payment);
- Management of the partnerships between itself, Tigo, and the insurer;
- A customer call centre.

Express Life recently joined the initiative, replacing Vanguard Life Assurance as the product underwriter in July 2013. Express Life shares a major investor with Bima.

When the initiative first began, MicroEnsure contributed its specialized knowledge of microinsurance to ensure effective customer service, overseeing agent training, claims processing and the management of the customer call centre. As the project has progressed, however, Bima has expanded its capacity and now handles the tasks initially performed by MicroEnsure, which is no longer an active partner as of August 1, 2013.

Figure 6: Current and former partnership roles

	Product Design	Technology	Enrollment	Product Administration	Claims Payment
Current	 	 	 	 	  
Former				 	

The evolution of partnerships for this project illustrate that when dealing with microinsurance products, especially those with small margins, such as the Family Care product, it is challenging to maintain a large network of partners, who all receive a share of the profits. Nevertheless, at the time that the product was launched, the unique value chain contributions of each partner definitely played a role in creating an efficient and effective product that was able to grow in a relatively short time to reach scale. Different partners may have different roles to play in achieving scale over time.

DISTRIBUTION, MARKETING AND CONSUMER EDUCATION

Reaching the consumer in a cost-effective way that provides value to the user is one of the key challenges in achieving scale. The Family Care Insurance product reaches clients through four distinct distribution channels. From the outset, Tigo and Bima have employed a group of 65-75 roaming agents whose sole task is to register and educate clients on the product. These specialists have face-to-face interaction with clients throughout the country, though primarily in urban areas. According to Bima, they have played a key role in driving customer understanding and, ultimately, scale. Agents are remunerated through a combination of fixed salary and commission, a model that provides security of income while still encouraging hard work. As Eliza Kucukaslan, Ghana County Manager for Bima, notes, "It is also very important that agents receive proper training and that training sessions are arranged continuously, where learnings can be shared between agents. If the agents are properly trained, the face-to face method becomes successful since the agent can explain the product and the benefit to the customer in a way that the customer feels comfortable with."

In addition to the network of insurance specific agents, all Tigo customer care centres are trained to distribute the product and process customer claims. These physical locations, of which there are more than 30 around the country, formerly housed one trained insurance specialist. The system has since shifted so that all front-office staff members are familiar with the product.

As well as the agents and customer service centres, Tigo and Bima also use an outbound call centre that targets previously registered, free product clients for enrolment in the paid product. This distribution strategy has allowed the product to quickly reach large volumes of paid clients, achieving a nearly 90 per cent conversion rate with customers who can be reached by telephone, according to Tigo. Finally, starting in 2012, the product has allowed self-registration

for customers via USSD. Although keen to tap into technology to reduce costs, the project partners note that this method of distribution remains underused, as clients are unfamiliar with the concept.

To complement its network of channels for product distribution, Tigo-Bima has had to mount a large marketing and consumer education campaign. Targeting via call centres has proved effective in converting clients from the free to the paid model, but SMS messages have been the primary point of contact for reaching clients eligible for accessing the free model. Throughout a given month, as clients use airtime, they receive SMS notifications to inform them of the option of receiving insurance coverage. Although they are more expensive, television and radio advertisements have also been used at various points during the product's history. However, the most effective form of marketing and consumer education remains face-to-face interaction between agents and clients, according to project staff at both Bima and Tigo. By attending community events and going on product "road shows", the 65-75 insurance specific agents have built consumer awareness of the product.

PRODUCT SUCCESS AND RESULTS

Tigo notes that the product's shift to a freemium model is increasingly helping to cover the cost of the premiums to the insurer. It claims to have seen tangible benefits from the product, as results have shown that insurance users remain more loyal to the company, in comparison with non-insurance customers. However, these claims would appear to run counter to the decline in Tigo's customer base and market share. The figures indicate that while the insurance product has touched a large number of clients over the past three years, Tigo's mobile phone customer base and market share have declined over the same period. The company has not necessarily been successful in maintaining and expanding the Tigo mobile client base. However, the loss of Tigo customers and market share is not necessarily linked directly to the insurance product since, as is the case with any mobile network operator, a broad suite of products and factors plays a role in determining overall success.

With claims ratios exceeding 40 per cent, according to Bima, the product appears to be viable to the company, as well as providing value to the clients it serves. Although lapse rates are not publicly available, a number of policies could be expected to expire each month due to insufficient airtime usage. Nevertheless, the product's one-time registration process ensures that these clients are automatically re-enrolled for coverage, once airtime usage reaches the threshold in the future.

Through field agents and call centres, Tigo and Bima have used client feedback to directly inform development of both the Family Care Insurance life product and that of the recently launched hospitalization product. In the future, Tigo also hopes to increase the product's financial sustainability by seeking tax exemptions for airtime-based premiums.

Considered alongside the more than 1,000,000 lives registered through the product, all these factors indicate that the Family Care product will continue to remain viable and valuable in the short and medium-term future.

SUMMARY OF SCALE DRIVERS

As previously noted, all parties agree that the primary driver of the Family Care Insurance product's ability to reach scale has been the strong network of field agents trained and managed by Bima. These representatives have given a vital face to the product, providing an opportunity to effectively educate the public about it, improve trust and enrol clients throughout the country.

This remote registration capability is just one of the many ways in which mobile technologies have played a key role in reaching scale. Whether it be by tapping into Tigo's large existing customer base, by using airtime for premium collection, by focusing marketing through call centres or by using Tigo Cash for claims payments, the product has leveraged mobile technology to reach clients at scale in a cost-effective manner.

Furthermore, by building on an understanding of the Ghanaian market, Tigo and Bima have been able to create a product that tapped into existing demand for life insurance, while shaping it around local use of mobile devices. While Ghanaian competitors Airtel and MTN have focused on using mobile money accounts for premium payments and loyalty-based free cover, the Family Care partners saw that mobile money usage had not yet penetrated the market and recognized the importance of using airtime premium payments instead. Whereas other companies built paid-only mobile insurance products, Tigo-Bima suspected that a free product had the ability to develop an initial customer base, which, with a solid product client value proposition, could eventually shift to a hybrid paid model. This strategy turned out

to be successful, and was further aided by keeping premium costs low for the paid clients (1.3 GHS per month), indicating that affordability or cost effectiveness has also been a key driver in converting a large client base to the paid model.

Finally, by tapping into diverse partners and harvesting client feedback, the product has been able to continually learn and evolve. Building initially on MicroEnsure's strong industry understanding, and subsequently learning from Tigo and Bima products launched in other countries, the Ghana product has undergone a refining process to ensure that it offers value, both to customers and to the companies behind it.

9 > BENAZIR INCOME SUPPORT PROGRAMME (BISP) WASEELA-E-SEHET GROUP LIFE AND HEALTH INSURANCE

DESCRIPTION OF THE INITIATIVE

Benazir Income Support Programme (BISP)

Waseela-e-Sehet Group Life and Micro-Health Insurance falls under the Benazir Income Support Programme (BISP), which forms part of the social protection programme and the poverty alleviation strategy of the government of Pakistan. It is an autonomous body with its headquarters situated in the federal capital Islamabad and has provincial, regional, district and Tehsil (sub-district) offices across Pakistan. The programme was launched in August 2008 throughout the country, benefitting 7.2 million households, identified through the Poverty Score Card (see section on Poverty Score Card below).¹⁷ The short-term objective of the program is to cushion the adverse impact of the food, fuel and financial crisis on the poor, but its broader objective is to provide a minimum income support package to the very poorest individuals and to those who are highly vulnerable to future shocks.

Waseela-e-Sehet Group Life and Micro-Health Insurance

The Pakistani government has identified the death of a breadwinner as a major contributing factor to the poverty trap. The Waseela-e-Sehet (WS) Group Life Insurance initiative was therefore launched on 1 January 2011 under the auspices of the BISP. The initiative is underwritten by a government entity, the State Life Insurance Corporation (SLIC) on a four year contract, which is set to expire on 31 December 2014. In February 2012, BISP signed another three-year agreement with SLIC to provide health insurance to its registered beneficiary families. Currently (August, 2013) the health insurance programme is piloted only in the Faisalabad District in Punjab province, with plans to expand to the rest of the country.

There has been rapid growth in the number policyholders: at the end of 2011, 2 million people (Abbas, Saik, & (Dr), 2013)¹⁸ were enrolled. This increased to c. 4,138,150 group life, and c. 58,000 health insurance clients as of November/December 2012.

Security of Public Money

CCRA:

BISP created a (CCRA) Consolidated Claim Reserve Account, a new group insurance product under the name of "Group Life Deposit Administration Plan" by SLIC after getting formally approved from Securities Exchange Commission of Pakistan. This arrangement allows SLIC to invest the premium paid by BISP and the profit thus generated would be owned by BISP and available for adjustment of future premium liability and financial sustainability of the initiative.

ERF:

Under the HI, an Equalization Reserve Fund (ERF) has been established which allows the profit to be shared between BISP and SLIC. If there is net credit balance at the end of three years contract term then the amount in ERF will be shared in the ratio of 95%: 5% respectively. If there is a net loss, it will be absorbed by State Life and no portion thereof be will be shared with BISP.

¹⁷The BISP is implemented in all four provinces—Punjab, Sindh, Balochistan, and Khyber Pakhtunkhwa (KP)—the Federally Administered Tribal Areas, Azad Jammu and Kashmir, and Islamabad Capital Territory.

¹⁸Unless otherwise stated, all information was collected during interviews with Dr Javed Abbas (Director General, WS); Dr Irum Shaik (Deputy Director, WS); Dr Ayub (Deputy Director, WS). Interviews were also conducted with Nadeem Bassy (General Manager, SLIC) and Hafeez Uddin (Sector Head, SLIC) in June/July 2013.

Budget allocation

When WS Life Insurance was launched in 2011, it was allocated PKR 560 million (USD 6 million), of the total PKR 70 billion (USD¹⁹ 0.71 billion) BISP budget, with the mandate to enrol 2 million beneficiaries. For the year 2012-2013, the budget allocation was increased to PKR 2 billion (USD 20.41 million), to enrol a total of 4 million beneficiaries.

The WS Health Insurance was initially allocated PKR 98 million (USD 1 million) of the BISP budget for the 2012-2013 financial year, increasing to PKR 102 million (USD 1.04 million) for the Faisalabad district for 2013-2014. With the expansion of the initiative to a further 5 districts, the 2013-2014 budget will reportedly increase to PKR 363 million (USD 3.70 million).

Poverty Score Card

Since 2009, households eligible for benefits under the BISP (including WS insurance) are identified through the use of the Poverty Score Card, a proxy means test (PMT)-based targeting instrument and the first of its kind in South Asia (World Bank, 2013). A household survey, consisting of 10 questions to indicate household welfare level, was conducted in 2010, covering c. 27 million households. The survey results are converted into a PMT-measure indicating household welfare on a scale of 0 to 100. In order to qualify as beneficiaries from BISP, households must:

- score below 16.67 in the PMT (7.2 million households fell into this category in 2010);
- have one female beneficiary in the household; and
- the female beneficiary should hold a computerised national identification card issued by the National Database and Registration Authority (NADRA).

CONTEXT OF THE INITIATIVE

Pakistan is the 6th most populated country in the world, with a population of 179.2 million people as of 2012, of which 22.5% are below the poverty line of USD 2 per day. In a microinsurance diagnostic report commissioned by the SECP and FIRST Initiative, around 70 percent of the labour force is informal, largely unskilled and less-educated than the formally employed; with limited access to capital. This population is identified as the most vulnerable to economic and environmental changes. (Microinsurance in Pakistan: A Diagnostic Study on Demand and Supply, 2012, p. 9) A relatively low GDP growth rate of c.3% in 2011/12 (this is much lower than neighbouring India (c. 6%) and Bangladesh (c. 6%) (World Bank, 2013)) translates into limited income mobility and thus little chance for a reduction of poverty incidence. The Pakistan government has elected Waseela as a risk-coping mechanism to alleviate the impact of poverty.

Microinsurance in Pakistan is still a new concept for many conventional insurers. There are three major formal private insurers who are engaged in microinsurance development including a few NGOs. Main distribution channels include MFIs, banks, NGOs and rural support programs (RSPs). (Chaudhry, 2013) This means that Waseela will likely be many low income Pakistani's first interaction with insurance and hence positive market discovery (Bester, Chamberlain, & Hougaard, 2009) is important for the long term development of insurance within the country.

All private insurance companies, including the SLIC, are governed under the Securities and Exchange Commission of Pakistan (SECP). The regulatory and supervisory system for insurance in Pakistan does not explicitly recognise microinsurance, and hence does not provide any special treatment that could reduce costs or explicitly support the development of microinsurance. However, the SECP have started with industry consultations on developing a regulatory framework for microinsurance (SECP & FIRST Initiative, 2012).

PRODUCT DETAILS

Waseela-e-Sehet comprises group life insurance (countrywide), comprising c. 4,138,150 policies; as well as health insurance (piloted in Faisalabad province only, with c. 38,000). As the health insurance comprises a very small proportion of Waseela's active policies, the focus of this case study will be on the life insurance. Box 1 provides a summary of the health insurance product, while Table 3 shows the details of both products.

Table 3: Key features of the Group Life and Health Insurance

¹⁹ An exchange rate of PKR98 ~ 1 USD (6-month average Jan-Jun 2013)

Key Features	Group Life Insurance	Health Insurance
Number of people enrolled	c. 4,138,150	c. 38,000
Scheme started	January 2011	February 2012
Initiative Contract Agreement	Three years (01-01-2011 to 31-12-2014)	Three years (01-04-2012 to 30-04-2015)
Policy Period	One year (from Jan-Dec)	One year (from Jan-Dec)
Geographical Operation	Nationwide	One district (Faisalabad)
Insurance Partner	State Life Insurance Corporation (SLIC)	State Life Insurance Corporation (SLIC)
Policy Cover	Accidental and Natural Death	Hospitalisation, Normal/Caesarean delivery, Day-care surgeries, Diagnostic tests, Pre-existing diseases
Exclusions	Suicide	Outpatient, Cosmetic Surgery, Force Majeur, Suicide, Routine Medical examinations/check-up, HIV/AIDs or related, dental examination, eye correction costs are the main exclusions.
Beneficiaries	Next of kin of breadwinner, at least one female beneficiary per household.	BISP female beneficiary, her spouse and dependent children
Age Limit	Male: 18-65 yrs Female: 18-70 yrs	No age limit
Annual Premium	PKR 150 (USD 1.53)	PKR 1800 (USD 118.37) per family (In 2012, it was PKR 2,250 (USD 22.96) per family)
Co-Payment	None	None
Premium payment/subsidy	Govt. Of Pakistan	Govt. Of Pakistan
Sum Insured	PKR 100,000 (USD 1,020.41)	Up to PKR 25,000 (USD 255.10) per family
Claim Payment	Through Post Office	Cashless: through the BISP Health Card

Group Life Insurance

Beneficiaries are automatically enrolled for the insurance and are notified through a letter in the post. The insurance covers the breadwinner of a family to compensate the dependents (widows/mothers/children) with PKR 100,000(USD 1020.41) in the event of his/her natural or accidental death. The annual premium per household is PKR 150(USD 1.53) (PKR 450 (USD 4.59) for three years), fully subsidised by the government of Pakistan and paid directly to the SLIC.

PARTNERSHIP

Evolution of partnerships

As part of the creation of the BISP, donors, including the World Bank, Asian Development Bank (ADB) and the UK's Department for International Development (DFID) offered technical and financial support. These donors continue to provide technical support, while Waseela is financed through the fiscus, rather than through donor support.

Initially, the World Bank provided technical assistance in designing the Waseela-e-Sehet Health Insurance product design, with cooperation from the ADB. GIZ also provides technical assistance to support BISP ahead of the implementation of the different pilot projects.

The State Life Insurance Company (SLIC) who was appointed due to their large network of divisional and regional SLIC is part/wholly owned by the Pakistani government and is the largest commercial insurer in the country.

The other partner-bodies are also state entities:

- The Pakistan Post is the distribution partner to communicate with policyholders and settle life insurance claims
- NADRA is the government database entity used to identify eligible families to be covered under the two WS insurance initiatives.

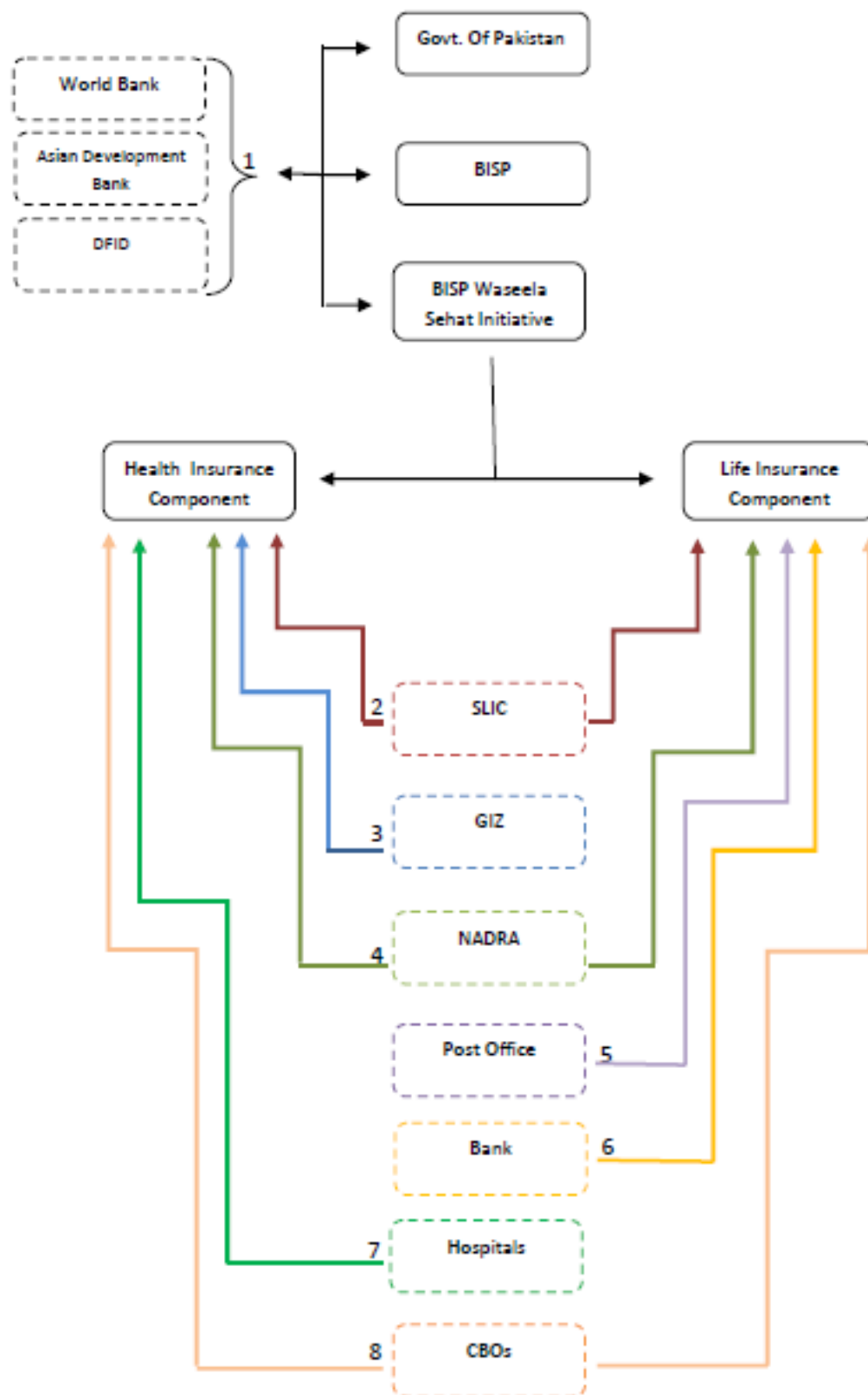
Box 1: Waseela-e-Sehet Health Insurance & RSBY Health Insurance (India)

Launched in January 2012 the Waseela-e-Sehet Health Insurance offers fully subsidised health insurance up to PKR 25,000 per year for BISP beneficiaries. The scheme is cashless and beneficiaries utilise the Benazir Sehet Card to claim services, allowing beneficiaries to visit nominated hospitals at no cost. Currently, 38 000 families are enrolled in the pilot district of Faisalabad, with plans to expand to an additional 5 districts in the year 2013-2014.

The scheme is inspired by RashtriyaSwassthyaBimaYojna (RSBY) in India which pioneered the use of a cashless claims system to fund health services by issuing members with a smart card. In 2010, RSBY covered 340 districts in 25 states with 23 million active cards and 63 million lives covered. Unlike Waseela, beneficiaries contribute 10-25% of the premium, with a government subsidy covering the rest.

Figure 7 below is an illustration of the different partnership roles.

Figure 7: Illustration of the parties involved in BISP-WS



DISTRIBUTION AND OPERATIONS

Group Life Insurance

The Policy Certificate, received in the post, contains the details of insurance cover, documents required in the event of a claim, claims process and the address of SLIC Claim section offices in the area. There is no other communication with clients.

Upon the death of the enrolled breadwinner of the household, the next-of-kin reports the event to the local BISP office which forwards the relevant claims documents, submitted by the beneficiary, to the SLIC; or notification can be sent directly to the Claims section of SLIC. There are c. 540 Tehsil offices serving as a hub for delivering services to the beneficiaries at the lowest administrative level. Claims are reportedly processed within 30 days of submission once all of the required documentation is provided. SLIC carries out verification and the payments are made to a nominated beneficiary's bank account.

The claims ratio on the Group Life Insurance Product is reported as 2.4% in 2011/12. Suggested reasons for the low claims ratio include:

- high illiteracy (an estimated 55% of the population is illiterate);
- low awareness of the policy;
- target market is highly informal, living in remote rural areas;
- difficulty in identifying of next of kin;
- difficulty in accessing documents required for claim application, such as the death certificate; NADRA CNIC cancellation certificate; the bank account details of next of kin; and loss of the insurance certificate sent through the post.

DRIVERS OF SCALE

We have identified three primary drivers of scale for Waseela:

The government policy imperative, including the BISP dedication to the Waseela initiative as an instrument of social change, is the primary driver of scale for the Waseela initiative. Using microinsurance as part of a social safety net for the poor was the reason for the creation of the scheme and drives coverage of members. Ongoing government support is critical to the continuation of the scheme.

Once the enrolment criteria are met (through the poverty score card customers are automatically enrolled in the scheme. This is a key contributor to scale, as the initiative instantly has a large number of policyholders based purely on the eligibility criteria. The next challenge is ensuring members are aware that they are covered to fully benefit from their policy. The current distribution challenges need to be overcome to effectively drive awareness and understanding of the benefits associated with the policy. RSBY used a third party administrator to distribute a information as well as a benefit card to inform clients of the benefits of the policy. (Ruchismita & Churchill, 2012) In this way, the programme was modelled on the RSBY scheme in India, where "below poverty line" (BPL) families pay a small registration fee to get a biometric-enabled smart card containing their fingerprints and photographs.[1] This enables them to receive inpatient medical care of up to INR 30,000 (approx. US\$670 [≈ Comcast cable internet for a year, 2011] as of March 2011) per family per year in any of the empanelled hospitals. Pre-existing illnesses are covered from day one, for head of household, spouse and up to three dependent children or parents.

Access to a group: through the Poverty Score Card and the NADRA database, there is access to data to facilitate both the definition of the target market; as well as the access to the postal addresses of the beneficiaries – the primary distribution channel.

While not yet at scale the WS health insurance initiative should provide substantial value to consumers and it will be interesting to see the extent to which this product is taken up and how quickly it achieves scale beyond the pilot stage

Presently the provinces of KP and Punjab have initiated the same type of Micop-Health Insurance intervention in their respective regions and the capacity of national government / private insurance companies have developed the confidence after the experience of pilot phase by Waseela-e-Sehet.

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11 > APPENDIX A: LIST OF PEOPLE INTERVIEWED

People interviewed for the case studies:

Institution	Name	Title	Interview date
<u>AVBOB</u>	Mr Deno Pillay	General Manager: Group Corporate Affairs	23 May, 24 June 2013
	Mr Colin van Son	Group General Manager: Insurance Administration	24 June 2013
	Ms Lucia Momberg	General Manger: Insurance Administration	24 June 2013
<u>Waseela</u>	Dr Javed Abbas	Director General	20 June 2013
	Dr Irum Shaikh	Deputy Director	20 June 2013
	Dr Ayub	Deputy Director	20 June 2013
<u>State Life Insurance Company - Pakistan</u>	Mr Nadeem Bassy	General Manager	7 August 2013
	Mr Hafeez Uddin	Sector Head	7 August 2013
<u>Hollard</u>	Mr Freedom Buthelezi	Head: Retail at Hollard Life Assurance	10 June 2013
	Mr Mandla Shezi	Head: Alternative Distribution	10 June 2013
<u>CLIS</u>	Mr Jonathan Batangan	General Manager	11 July 2013
<u>Tigo Milvik (Bima)</u>	Ms Eliza Kucukaslan	Ghana Country Manager & Global Financial Reporting Manager	3 June 2013
<u>MicroEnsure</u>	Mr Peter Gross	Regional Director - Africa	21 May 2013
<u>Milvik (Bima)</u>	Mr Gustaf Agartson	Chief Executive Officer - <i>Milvik</i>	24 May 2013
<u>Tigo Ghana</u>	Mr Abdul-Nasser Alidu	Solutions Category Manager at <i>Tigo</i> Ghana	
<u>Protecta</u>	Mr Alfredo Salazar	Chief Executive Officer	18 April 2013
	Mr Enrique Chambergo	Commercial Director	24 April 2013
	Mr Jose Ernesto Bazo		
<u>Casas Bahia</u>	Desk-based research		
<u>NAIS</u>	Desk-based research		

Additional people interviewed in order to identify initiatives that have achieved scale or obtain further input on initiatives that achieved scale:

Name	Area of Input/institution
Clémence Tatin-Jaleran	Thailand
Ana Cunha	Latin America
Brandon Matthews	Ex Zurich - Latin America
Jim Roth	Leapfrog Investments
Tahira Dosani	Leapfrog Investments
Eugene Kruger	Metropolitan Life
Stefan van der Westhuysen	Old Mutual
Jody-Ann Dearham	Doves/Union Life funeral
Nishid Dosa	African Bank
Francois Grobler,	JD Group
Jaco van Jaarsveldt	JD Group
Renee Griessel	JD Group
Charlotte Tshishonga	Scorpion
Gavin Soll	Clientele Life
Hugo Louw	Clientele Life
Ben Myburgh	LipCo
Edgar Evans	Edcon
Paul le Roux	PEP
Mokale Sekhute	Hollard/ Edcon
Ferdi van Zyl	Edcon
Richard Lefley	MicroEnsure
Dennis Garand	Health schemes
John Wipf	Philippines
Michael McCord	Microinsurance Centre
Antonis Malgordis	Philippines
Mark Achaw	Ghana
Pedro Pinheiro	CNESG Brazil
John Pott	Aga Kahn Agency for Microinsurance

MICROINSURANCE INNOVATION FACILITY

Housed at the International Labour Organization's Social Finance Programme, the Microinsurance Innovation Facility seeks to increase the availability of quality insurance for the developing world's low income families to help them guard against risk and overcome poverty. The Facility was launched in 2008 with the support of a grant from the Bill & Melinda Gates Foundation.

See more at: www.ilo.org/microinsurance

