

**THE ROLE OF MICRO-INSURANCE
AS A TOOL TO FACE RISKS
IN THE CONTEXT OF SOCIAL PROTECTION**

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LIST OF ACRONYMS

ACME	Association pour la Coopération avec la Micro-Entreprise
AIC	Agricultural Insurance Company (India)
CCT	Conditional Cash Transfer
CGAP	Consultative Group to Assist the Poor
CHIC	Centre for Health Insurance Competency
CIDR	Centre International de Développement et de Recherche
ECV	Escudo (official currency of Cape Verde)
FHPL	Family Health Plan Limited
GDP	Growth Domestic Product
GEFONT	GEneral Federation Of Nepalese Trade unions
GTZ	Gesellschaft für Technische Zusammenarbeit
HC	Health Care (provider)
HIV	Human Immunodeficiency Virus
IEC	Information Education Communication
ILC	International Labour Conference
ILO	International Labour Office
ILO	International Labour Organization
INPS	Instituto Nacional de Previdência Social (Cape Verde)
IRDA	Insurance Regulatory and Development Authority
LIC	Life Insurance Corporation
MAS	Micro-Assurance Santé
MFI	Micro-Finance Institution
MIS	Management Information System
MoU	Memorandum of Understanding
MRO	Mauritanian Ouguiya
MSA	Medical Savings Accounts
NGO	Non-Governmental Organization
NR(s)	Nepalese Rupee(s) (official currency of Nepal)
OECD	Organisation for Economic Co-operation and Development
PRSP	Poverty Reduction Strategy Papers
R(s)	Rupee(s) (official currency of India)
SEWA	Self Employed Women's Association
SLR(s)	Sri Lanka Rupee(s) (official currency of Sri Lanka)
SNPS / GR	Stratégie Nationale de Protection Sociale / Gestion des Risques (in Senegal)
STEP	Strategies and Tools against social Exclusion and Poverty
Tk	Taka (official currency of Bangladesh)
TPA	Third Party Administrator
UEMOA	Union Economique et Monétaire Ouest-Africaine
USh	Uganda Shilling (official currency of Uganda)
WHO	World Health Organization

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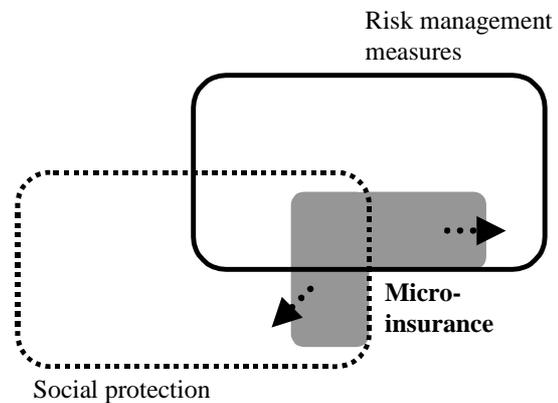
INTRODUCTION

1- Why this document?

There is a growing interest for risk management and extension of social protection in the context of poverty reduction strategies in developing countries. This interest is materialized by a number of initiatives that involve civil society organizations.

Among these initiatives micro-insurance plays a role on both sides: it is certainly a risk management instrument; but it can also be used as a tool to extend social protection.

Micro-insurance is a concept that encompasses a large diversity of organizations: mutual benefit organizations in Africa and Latin America, micro-insurance schemes set up and operated by health care providers, cooperatives, associations, unions, NGOs or MFIs providing an insurance service to their members, sometimes in partnership with a public or a private insurance company, etc.



1. Micro-insurance: a risk management and social protection mechanism

These schemes may cover various risks or contingencies: health, maternity, life, invalidity, assets, crops, etc. They all have in common following features: they use the mechanism of insurance (among others); at least part of their beneficiaries are people excluded from formal social protection schemes in particular informal economy workers and their families; membership is not compulsory (but can be automatic); the members pay, at least partially, the necessary contributions in order to cover the benefits; these schemes differ from schemes created to provide legal social protection to formal economy workers.

Setting up a micro-insurance scheme is not necessarily the right answer in all circumstances. The decision to implement or support micro-insurance schemes should therefore not only be driven by a risk analysis but also by political considerations: on populations to be targeted and on their priority coverage needs; on the relevance of micro-insurance and on its comparative advantages; on the possibility to link micro-insurance to other mechanisms in order to improve each others efficiency; on the integration of micro-insurance within coherent risk management and social protection strategies.

As micro-insurance is too often put in place without a thorough assessment, this instrument is usually not complementing in the most effective way other existing strategies and mechanisms to face risks and to extend social protection, causing a limited impact or sometimes even wasting the scarce resources of the people, most of them being poor. The present document has been produced to reduce this gap of knowledge on the **add-value, strengths and limitations of micro-insurance as a tool to face risks within the extension of social protection.**

This document was jointly produced by the “Strategies and Techniques against Social Exclusion and Poverty” (STEP) programme of the Social Protection Sector of the ILO and the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ). Both organizations have been involved in efforts to explore the potential of micro-insurance schemes in various countries.

2- To who is the document addressed?

The document is aimed at current and potential promoters of micro-insurance (community based organisations, MFIs, NGOs, trade unions, entrepreneurs, insurance companies, projects, local authorities, etc.) irrespective of their geographical location. The document is also aimed at political decision-makers and provides information for the formulation of policies in the field of social protection.

3- What are its objective and scope?

The document is an information and awareness-raising textbook, and is consequently relatively short without going into operational details.

More specifically, the document will allow users to:

- Become aware of existing strategies and mechanisms to manage risks.
- Have an overview of the overall potential of micro-insurance schemes, their limitations, the diversity of their features, and the complementarity with other mechanisms aimed at managing risks.
- Become aware of the factors for success as well as the difficulties of implementation and operation of micro-insurance schemes.
- Become aware of the role of micro-insurance in the extension of social protection and of the advantage to develop linkages between micro-insurance and other components of social protection systems.

This document deals with micro-insurance schemes covering various types of risks (health, death and old-age, disability, injury and/or maternity, crop failure and loss of assets), apart from part IV that focuses on risks falling within the realm of social protection.

4- What is its place in the range of tools produced by the ILO and the GTZ?

Other tools developed by the ILO and the GTZ will complement this document on the operational level. Particularly, the *Health Micro-Insurance Schemes: Feasibility Study Guide* (ILO/STEP, 2005) provides step-by-step instructions and useful tools for designing a health micro-insurance scheme. Other example, the *Setting up a micro health insurance scheme: Relevancy, challenges and process* (ILO/STEP, soon to be published) deals with the advisability of setting up a health micro-insurance scheme, and provides a precise and systematic explanation of how health micro-insurance functions. The GTZ InfoSure methodology for the analysis of health insurance and the CHIC (Centre for Health Insurance Competency) - Management Course enable participants to plan the set up of health insurance, design the benefits package, calculate the transaction costs, etc. The CGAP working group on micro-insurance developed guidelines for the design of micro-insurance and case studies. The financial simulation tool (SimIns), jointly developed by the World Health Organisation (WHO) and GTZ, projects the development of incomes and health expenditures over a 10 years period.

5- How is the document structured?

The document includes four parts.

- Part I **“The need for protection against risks”** describes risks that are threatening workers in the informal economy and their families, and poor households in many developing countries and their impact on households’ income and level of consumption. It draws attention on the necessity to prioritize between risks when considering protecting a given population against risks.
- Part II **“Multiplicity of options to deal with risks”** describes the different risk management strategies, some of their comparative advantages and lists manifold mechanisms that actors (individuals, communities, public authorities) have at hand to deal with risks. It tries to explain what are the main factors of choice among existing strategies and mechanisms of protection against risks.
- Part III **“Micro-insurance: a mechanism to manage risks”** describes micro-insurance and its diversity (in terms of risks covered and delivery models). It also identifies some of the factors for success and challenges for setting up and operating a micro-insurance scheme in a given context, and highlights the advantage to link micro-insurance to other risk-management mechanisms in order to increase its impact and its viability.
- Part IV **“Micro-insurance: a component of social protection”** reminds the necessity to extend social protection to the excluded groups. It gives indications on existing strategies of extension of social protection and the role of micro-insurance in this extension. It finally explains the main implications both for the State and the promoters of considering micro-insurance as a tool for the extension of social protection and suggests pathways to enhance this extension.

PART I. THE NEED FOR PROTECTION AGAINST RISKS

Understanding the risks to which households are exposed and their impact is important in order to design appropriate strategies and mechanisms to face these risks.

1- Brief presentation of risks

❖ Definition of risk, identification and classification of multiple risks

Risk is an uncertain event (e.g. drought) or outcome (e.g. famine). When a risk occurs it can damage well-being. A risk's occurrence with a negative impact is called an adverse event or a shock. Uncertainty may relate to:

- The occurrence (will the adverse event occur?).
- The timing of the event (when will it occur?).
- The severity of the shock (will the shock be serious or minor?).
- Its duration (how long will the shock last?).
- Its frequency (how often will it occur?).

Through most of the developing countries, all households and communities are facing multiple risks, but the workers in the informal economy and their families and the poor and low-income groups are especially exposed to the following risks and negatively affected by their impact:

- Natural risks such as drought, flood, erratic monsoon rain, crop pests, fire that can cause loss of assets including loss of work premises and tools.
- Environmental risks such as problems associated with deforestation, pollution.
- Health risks such as sickness, child delivery, epidemics.
- Life-cycle risks such as old-age and death.
- Economic risks such as unemployment, business or harvest failure, loss of assets, death of livestock.
- Policy based and institutional risks such as a lack of legislation to protect workers, insufficient public services (e.g., a lack of health care facilities or inappropriate public health care policy), taxation.
- Social and political risks such as crime, theft and related loss of assets, gang activity, civil war.

Defining such categories is useful to understand underlying causes of risks occurrence. However it is partly simplifying since a risk can belong simultaneously to various categories. For instance an epidemic which is first considered as a health risk can be also considered as a policy based risk, since the lack of health care facilities or inappropriate public health care policy (e.g., insufficient immunization campaigns and basic health education) can increase the chance of occurrence of an epidemic or its severity.

❖ Risks' impact

Characteristics of risks' impact

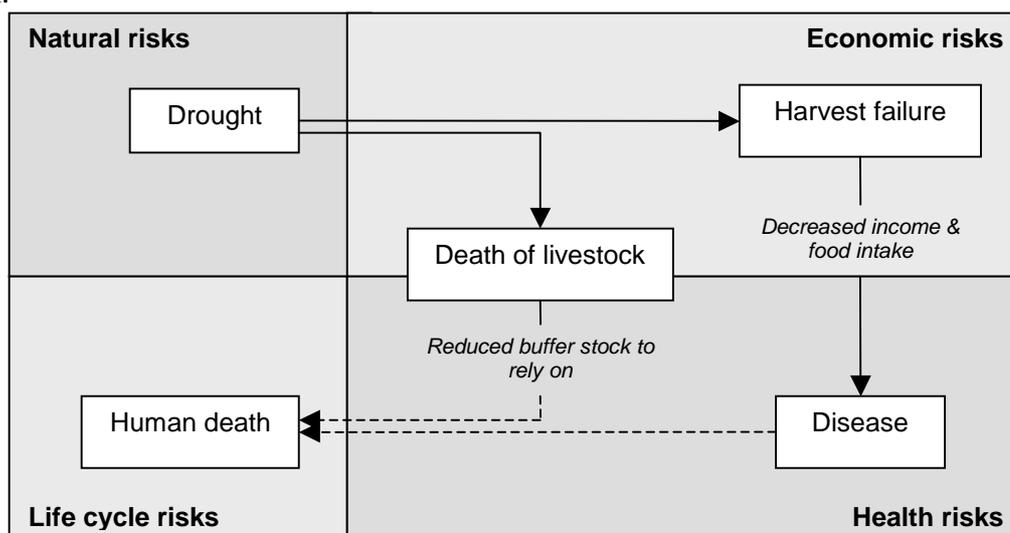
Adverse events have most often financial consequences, that means a negative impact on households' income and level of consumption. For instance illness and injury have both direct costs for prevention, care and cure, and opportunity costs (lost income while ill): the unexpected rise in expenditure on treatment coincides with a drop in income. Some adverse

events may also have consequences on individual's nutrition, health status, on the level of education, on individuals feeling of security, integrity, human rights and even life (when the shock causes death).

Some shocks are few and far between, such as the death of the breadwinner of a household. Some others occur with frequency, such as transient illness. Some shocks even if they are infrequent have a long-lasting effect and may require permanent transfers to the affected households. This is the case of the disability of the breadwinner. There are other shocks that might be of high frequency but whose effects are not very severe. In such cases the required relief is temporary. This is the case of transient illness or temporary unemployment.

Risks' impact on other risks (inter-linkages) and "snowball effect"

Risks are most of the time interlinked. The occurrence of a risk may increase the chances of other risks to occur, and give way to a spate of adverse events. For instance such natural risk as a drought can lead to a harvest failure. Households' income may then fall down. To cope with this situation, households may – among others - decrease their food intake, which may in turn increase the chances of falling ill or even have dramatic consequences (death). A drought may also weaken and kill cattle which farmers in many poor countries use as a buffer stock. Since the households no longer have buffer stocks to rely on they may postpone treatment which will contribute to the decline of the sick persons' health status, leading in some cases to death.



2. Inter-linkages between risks and "snowball" effect

❖ *Insecurity, vulnerability and poverty*¹

Impact of adverse events is stronger on poor households, for they face twin disadvantages:

(1) Poor households face a **greater insecurity**, means they are more exposed to risks, for various reasons: they most often work in the informal economy that is in an unregulated environment with unsafe working conditions; they may lack basic education (illiteracy) and are little reached by prevention or health education programmes and not aware of their social entitlements; they may in addition live in remote areas far away from public social services. As a result, a recent study of poverty in India found that the poor are 4.5 times as likely to contract tuberculosis as the rich [World Bank, 2001]. Poor working women are more exposed to risks than men for at least three reasons: a higher proportion of women work in the

¹ The ideas and notions explained in this section are taken from the literature on risk management, particularly: Holzmann & Jorgensen, 2000; Morduch, 1999; Siegel & Alwang, 1999.

informal economy²; they face discrimination related to their reproductive role such as dismissal when pregnant or upon marriage; they face specific health and economic risks linked with maternity, and unlike women in formal wage employment do not benefit from related safeguards and benefits.

(2) Poor households are more **vulnerable**, means they are less resilient to the shocks since their earnings are low and irregular and since they do not have at hand appropriate tools to manage the risks: they have small if any assets to rely on, they do not have access to insurance, they cannot afford costly preventing measures, etc. For instance, weather-related uncertainties, plant disease, and crop pests create harvest risk for all farmers, but technologies for reducing such risks, such as irrigation, pesticides, disease-resistant varieties, are less available in poor areas. In 1994-96 less than 20% of all cropland was irrigated in low- and middle-income countries (only 4% in Sub-Saharan Africa) [World Bank: 2001]. Other example, in South Indian villages an increase in risk (from monsoon arriving too soon or too late) reduced farm profits for the poorest quarter of households by 35% but left the wealthiest farmers nearly unaffected. Women working in the informal economy who most often have less qualified and less paid jobs are even less resilient to adverse events than their male counterparts. This is one of the reasons why adverse events' consequences are worse for women. For instance, rising food prices led to larger reductions in nutrient intake for women than for men in Ethiopia and India.

« Women's vulnerabilities and security needs differs from those of men. The needs also differ at different points in their lives. Women, especially poorer women, face particular vulnerabilities, constraints and risks associated with different stages of their life cycle. At an early age, as a young girl, they are less likely to attend school, more likely to engage in child labour. Her education, health and nutritional needs are given a low premium. As a young woman, she combines both productive and reproductive roles as well perform unpaid caring work, at home, for the sick, the frail and the elderly. Very often, her productivity and employment are constrained by these very reproductive demands. She experiences the risks to her health and to her work security associated with maternity, and in her old age, she faces economic and social risks associated with widowhood.» [Jhabvala & Sinha, 2006].

Poverty leads to greater insecurity and vulnerability, and in turn exposure to adverse events increases poverty. When exposed to a shock, poor households are often forced to make choices, such as depleting productive assets if any, reducing food intake, or withdrawing children from school, that jeopardize their economic and human development prospects, and leave them stuck in a poverty trap. Moreover, the threat of destitution and non-survival renders the poor very risk adverse: since they have almost no protection against adverse events, they avoid risky situations or actions. They can be very reluctant to engage in higher risk / higher return activities, or longer term projects, and forego potentially valuable new technologies and profitable production choices. As a consequence, poverty is likely to be perpetuated for them and their children.

In Haiti, a micro finance institution (Association pour la Coopération avec la Micro Entreprise, ACME) tried to gain as clients active entrepreneurs in manufacturing sector through the provision of loans with particularly low interest rates; but it could simply not find enough of them. They represent only 10% of ACME's total portfolio whereas petty trade and service activities account for 90%. This reluctance to engage in manufacturing sector may be partially linked to risk aversion since the return on investment is slower and riskier than in e.g., trade and service activities. In a context of acute poverty, it is also difficult for entrepreneurs to invest in an activity that will not provide any revenue during several weeks.

² ILO statistics show that in two thirds of the countries for which separate figures are available, the informal economy accounts for a larger share of total female urban employment than is the case for men. [ILO, 2000a, statistical annex, table 7].

2- Selecting priority risks to be managed

Hence the provision and selection of appropriate protection mechanisms against risks is an important device in order to reduce insecurity, vulnerability and provide a means out of poverty. In many poor countries, resources dedicated to the fight against risks are often limited (lack of resources; sometimes unfavourable budget allocation at the local and central levels). It is therefore important, when considering protecting a given population against risks, to focus on a limited bunch of priority risks.

The choice of priority risks is mainly determined by factors such as: actors' own perception of the risks which may be different from that of the target population, the importance that they attach to the risks, economic and political stakes related with the management of certain risks (including personal interests), political influences and choices, actors' past experiences, etc.

The choice of priority risks may also lean on target population's and other stakeholders' perception. It is important to take population's experience and perception of the risks into account, since people wouldn't be - on a voluntary basis - interested by protection mechanisms against risks that they do not consider as priority. In many cases however, population's perception is biased or partial. People may not notice some risks that are yet threatening. It is why it is also important to take into account other stakeholders' perception: social actors, health professionals, health and political authorities, development agencies, civil society organizations, social partners, etc.

Technical criteria may also be used in order to prioritise between risks. Following list is far from being comprehensive but aims to help actors figure out what criteria should be most appropriate in the context of their intervention. These technical criteria include the seriousness of the consequences, the magnitude of the risk, the length of exposure, and risks' probability.

- The seriousness of the consequences can range from minor to catastrophic. For instance, a slight illness, a few days without work for casual workers have minor consequences whereas a natural disaster, the death of the breadwinner, a loss of work premises have major consequences.
- The magnitude is the number of persons affected at a single occurrence of the risk and its geographic or social spread. When a single occurrence of a risk affects a large number of persons (village, community) its magnitude is large. This kind of risks is called covariate or covariant. Such risks that affect only isolated individuals in the community are called individual or idiosyncratic risks³. For instance, an epidemic or a drought has a large magnitude, whereas a non-communicable disease is only experienced at the individual's level. In practice, few risks are purely covariate or idiosyncratic [Dercon, 2005b].
- The length of exposure or duration can be of several days, such as in the case of a minor illness. It can be of several years such as in the case of war. Length often contributes to increase the seriousness of the risk: the longer a war, usually the more catastrophic.
- Risk's probability is the chance that the risk realizes at least once per person and per year. Probability ranges from 0 to 1. For instance, if there is on average one drought in ten years, probability of a drought occurrence in coming year equals 0.1.

Assessment of technical criteria of choice is far from being an easy task. Since the same event can be considered as catastrophic or easy to overcome, according to the characteristics and past experiences of the individuals experiencing the adverse event, it may be difficult in many cases to find a consensus on first criteria (seriousness of the consequences). To assess the

³ For a definition and examples of idiosyncratic and covariate risks see Holzmann & Jorgensen, 2000.

other criteria (magnitude, length of exposure, probability) it is necessary to rely on precise data, recorded over sometime long periods of time. Particularly for low probability events, periods of several years may be required. These data are unfortunately not available in many developing countries.

When identifying priority risks, it is also important that the actors take into consideration their ability to prevent risks' realization or limit their consequences. Some risks can be dealt with at the local level, some at the regional or national level, some need international intervention, some others such as natural hazard are very difficult to deal with.

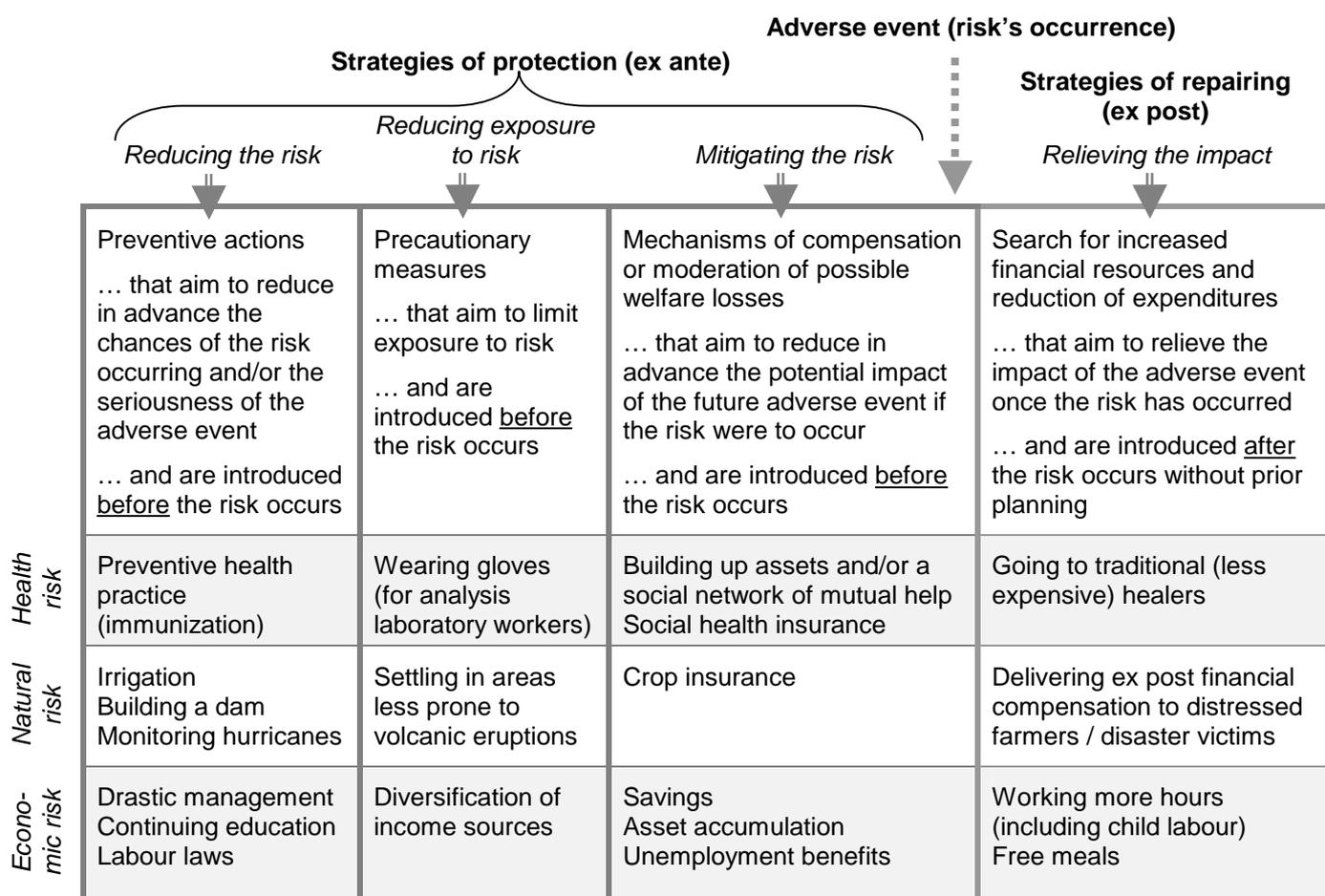
PART II. MULTIPLICITY OF OPTIONS TO DEAL WITH RISKS

1- Generic strategies to face risks

One of the main reason for building the State is the reduction of civil and social threats. The State is supposed to provide for two types of protection: civil protection which is to grant fundamental freedom to people, insuring their security as well as that of their assets; social protection which is the protection against the consequences on individuals' well being of such risks as ill health, accidents, old age, etc. [Castel, 2003]

The society as a whole develops different and complementary strategies and mechanisms to protect its members against risks⁴:

- Strategies of protection (ex ante) involving mechanisms aiming at reducing the risk, means its chances of occurrence and its seriousness (preventive actions), mechanisms aiming at reducing exposure to risk, means avoiding risky situations (precautionary measures), and mechanisms aiming at mitigating the risk, means reducing in advance the potential impact of the adverse event;
- Strategies of repairing (ex post) involving mechanisms aiming at relieving the impact of the adverse event.



Examples of arrangements against health, natural and economic risks

3. Generic strategies to face risks & examples of arrangements

⁴ See the Social Risk-Management framework [Holzmann & Jørgensen, 2000], which includes three strategies to deal with risks: prevention, mitigation and coping.

Some of these strategies and mechanisms call for a public intervention, in line with the State's function of civil and social protection mentioned above, some others may be handled by the private sphere or a combination of public and private actors: central / local government, employers, private firms, local organizations, households, etc. See § 3. *Actors involved in ex ante and ex post strategies and mechanisms* for further details.

Generally, one single arrangement is not sufficient to grant sufficient protection. It is necessary to combine several mechanisms corresponding with different strategies complementing each others.

2- Existing mechanisms to face risks (ex ante and ex post strategies)⁵

❖ *Mechanisms aiming at reducing the risk or exposure to risk*

Preventive actions

Some preventive actions prevent the adverse event from occurring. Others only succeed in reducing the risk: they lower the probability of the adverse event occurring or lessen its seriousness. As far as occupational safety and health is concerned, strategies and mechanisms of prevention should pay primary attention to workers in especially hazardous occupations in sectors where the risks to life and safety are manifestly high, such as agriculture, mining and construction, and those occupationally exposed to abuse and exploitation, such as women, children and migrants.

Despite their benefits, pesticides can, in some circumstances, also cause harm to health and the environment. Wearing rubber boots and gloves while using pesticides when working as an agricultural labourer may reduce the risk of poisoning.

Precautionary measures

Precautionary measures aim at avoiding risky situations or being exposed to a risk.

When households settle in areas that are less prone to natural disasters (floods, volcanic eruptions) they reduce their exposure to these risks.

Precautionary measures also include the diversification of income sources. Households in developing countries are usually involved in a variety of income-generating activities. This diversification enables them to smooth the flow of income over time.

Households may combine farm and off-farm activities and, within farm activities, diversify production - planting different crops, in different fields, staggering plantings, etc. Through crop diversification, the harvest is secured so that if one harvest is disastrous due to certain events, other crops might flourish. Similarly the migration of family members or the marriage of a daughter in another community, allow geographic diversification of earnings sources. In that way remittances can flow between areas depending on who is suffering a negative shock.

→ When the risk or exposure to risk are reduced but not prevented or totally eliminated, complementary protection measures may be necessary => see next paragraph.

⁵ A comprehensive literature exists on ex ante and ex post strategies and mechanisms. For a synthesis and numerous examples, see [Dercon, 2005b].

❖ ***Mechanisms aiming at mitigating the risk, means reducing in advance the potential impact of the future adverse event if the risk were to occur***

Mutual and self help within solidarity networks

Mutual and self help can develop between members of a group to support each others in case of hardship through cash or in-kind assistance. These arrangements are often observed within extended families, ethnic groups, neighbourhood groups and professional networks. They operate through transfers, gifts, or loans between members, typically with expectations of reciprocity.

Building up assets

Households build up stocks (livestock, food, jewellery) that are used as precautionary savings and can be depleted in hard times.

Savings and emergency credit programmes

Savings (financial deposits) can be mobilized through decentralized savings institutions. They create a buffer against expenditure shocks and are more efficient than real assets such as cattle since their value is not depreciated in case of a covariant shock, except in case of high inflation.

Some credit programmes specifically implemented in order to provide emergency credit facilities to their members in case of a shock can be considered as mechanisms aiming at mitigating the risks.

In Uganda “CIDR members settled on two health risk management options to offer to their groups. The first is a community-based insurance programme with risk pooling, and the other is an emergency credit facility. Both are linked to a local hospital and cover in-patient care only.

The insurance program requires a recurrent annual premium payment at the beginning of each year. The emergency health care credit programme requires all members to contribute a set value of capital, equivalent to the first year premium. This forms the capitalisation for the loan fund. All funds are held at the partner hospital, which provides treatment when someone from the group requires in-patient care. Charges are paid directly from the accumulated fund. At subsequent annual renewal periods, members of credit groups simply pay a small fee to cover the minimal operating expenses.

The loan is repaid to the group with no set repayment dates except that full amount must be repaid within three months of hospitalisation. These groups charge no interest. With the insurance program, there is no repayment to the group.

In the first year, all groups were insurance based. In the second year, most were insurance based, and by the third year, all CIDR groups chose the credit option over the community-based insurance option. They found it cheaper overall, and noted that it satisfied their needs better. Several members noted that the three months repayment period allows them a chance to accumulate funds in a more effective manner (away from the desperation of the moment when someone is hospitalised), and that is what they find most helpful.” [Cohen; McCord; Sebstad, 2003].

Community based emergency and solidarity funds

Emergency and solidarity funds are usually implemented within communities (village, church, etc.) or civil society organizations (cooperatives, trade unions, etc.). These funds are financed either through individual contributions of the members or through income generating activities organized by the community. The contributions (or other financial resources) are pooled and used to share the risks i.e. to help the members in need particularly when adverse events have occurred to them: loss of a job, death of the breadwinner, health expenses that exceed individual financial capacity, etc. Some of these funds have well defined benefit packages: the members know in advance how much they will receive in case of specific adverse events (illness, death of a child/adult, etc.) In some others, conversely, the amount of

aid is defined according to needs, on a case-by-case basis. When contributions of the members are paid on a regular basis and when the benefit package is well defined, these funds are very close to micro-insurance mechanisms. However, the main difference between these funds and insurance mechanisms, is that in these funds obligation extends to means available which means that the members do not have any guarantee of coverage (the aid stops when the fund is empty).

In Munno mukabi (“friend in need”) systems of Uganda, a budget is agreed on at the inspection and split equally among the members. The proceeds are used to purchase assets (such as large saucepans, dishes, lanterns, canvas, etc.) as are required for most household social functions: burials, weddings, children's graduations, baptismal parties, etc. After the initial capital investment is made, members attend weekly or monthly meetings at which a collection is made. One group for example, collects US\$200 per head per sitting; others collect up to US\$5000. This money is kept and lent out whenever a crisis strikes. Members also pledge to make their labor available whenever a member faces a crisis or holds a celebration [CGAP, 2000].

Prepayment mechanisms without risk sharing (for health risks)

Prepayment mechanisms are used to facilitate access to health care services. These include: subscription cards, flat rate payment in advance for given benefits. Households pay for future care at a time when they have the wherewithal to do so. This can be advantageous for households with irregular income that might find themselves faced with health care expenses at a time when they have no financial resources. Such prepayment mechanisms without risk sharing are appropriate for maternal and child care, where it is possible to forecast a fixed number of use for each service (example: 2 ante natal consultations, 1 post natal consultation and delivery).

Prepayment mechanisms with risk sharing (for health risks): obstetrical flat-rate payments

Prepayment mechanisms may also include some risk sharing as it is the case in following example.

A mechanism called “obstetrical flat-rate payment” (forfait obstétrical) has been implemented since 2002 in Nouakchott, Mauritania. The package can be purchased by pregnant women only. It covers the cost of follow up and delivery in public health facilities, namely: four antenatal consultations, a biological check up, an ultrasound, normal or complicated delivery including caesarean section if necessary, transfer in ambulance to the referral maternity, hospitalisation, one post natal consultation. The package costs 5,000 Mauritanian Ouguiya (MRO) - about 20 US dollars - which is affordable to most women in urban settings. This amount is lower than the cost of delivery at Nouakchott’s national hospital two years ago (from 14,200 to 42,000 MROs depending on the type of delivery) but higher than the cost of a normal delivery at the Health centre. This prepayment mechanism includes risk sharing between women that will have a normal delivery and those that will undergo a caesarean section [Centre Population et Développement, 2004].

Insurance

Insurance is a mechanism intended to provide coverage against the financial consequences of prescribed uncertain events, by spreading the anticipated costs resulting from the occurrence of those events – also known as risks – among several persons. Insurance is based on (1) the prior payment of premiums, i.e. before the occurrence of the risks; (2) risk sharing; and (3) the notion of guarantee. The premiums paid by insured persons are pooled together and used to cover the expenses of exclusively those persons affected by the occurrence of a certain number of clearly pre-determined risks (see part III for further details). Unlike solidarity or emergency funds insurance is based on results obligation, which means that insured persons obtain the insurer’s guarantee to provide this financial compensation.

Insurance is particularly appropriate to protect against risks which are not very likely to occur, but whose consequences are serious. These risks can be distributed over a large number of individuals or households and the insurance contribution or premium will be low for each

insured household in comparison to the expenses that it would have to pay when a risk occurs (if it were not insured).

Several types of insurance exist in developing countries. Insurance can be either compulsory (e.g., compulsory health insurance for public and private sector employees) or voluntary (e.g., asset insurance). Insurance can be organized at the instigation of public authorities (e.g., social security regimes), by commercial insurance companies, or by civil society organizations, including health care providers. When organized at the instigation of public authorities, insurance schemes may be State-run (statutory unemployment insurance for example), or State-regulated but operated through the private sector. When organized at the instigation of one institution (for instance civil society organizations), insurance schemes may be operated in collaboration with other institutions (e.g. NGOs in collaboration with formal insurance providers).

- Social insurance

Social insurance schemes provide coverage against risks such as unemployment, inability to work due to injury or ill health and/or old age (in the form of pensions), and perhaps some form of health care benefits.

In Niger the Caisse de sécurité sociale does not provide health care benefits. Those affiliated and their families have only access at a discounted price to the health care facilities of the Caisse.
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The establishment and main characteristics of these schemes are stipulated by law and affiliation within the targeted population (e.g., formal private sector employees) is generally compulsory. Such schemes are usually contributory, in that eligibility is based on the payment of premiums. The premiums are in most of the cases jointly paid by workers and employers (except in the case of self-employed), with in some cases a financial participation of the State. Premiums are most often linked with amount of income (percentage of the pay roll).

Social insurance schemes can be handled either by public sector or private sector institutions (e.g., social partners). Where such programs include the participation of the private sector, however, government usually retains a major role in overseeing and regulating their operation.

Social insurance schemes are difficult to implement in certain sectors (very small enterprises, self employed) since many of the workers are not registered and it is difficult to estimate the amount of income (on which premium calculation is based).

- Commercial insurance

Commercial insurance may be either public or private and provides coverage against the financial consequences of certain risks. The coverage is formalized by means of a contract, concluded between an insurer and an insured party (individual or group). In exchange for the payment of premiums, the insurer guarantees the insured party that it will provide a specified level of coverage for expenses resulting from the occurrence of a given risk: fire, flood, theft, accident, illness, loss of harvest, etc.

- Micro-insurance

Micro-insurance schemes are built to cover people excluded from statutory social security, notably the workers in the informal economy and their families. Micro-insurance schemes are most often initiated and operated by organizations of civil society such as trade unions, NGOs, micro-finance institutions (MFIs), cooperatives, community based organizations, mutual health organizations (set up for this specific purpose). For a more comprehensive description see part III.

Social assistance

Social assistance schemes are poverty alleviation systems for citizens and residents in special need [ILO, 2004]. They provide non-contributory, tax-financed benefits, in cash or in kind, generally targeted towards certain categories assumed to be with no or low contribution capacity. Social assistance is funded out of the State budget (national or local) without the requirement for prior contribution from the recipient. Eligibility is generally determined by some means test. In low income countries, cash benefits are rare and subsidies towards State services or exemption from fees for State services may be more common channels of social assistance. This is also true for universal benefits (see below).

In the recent years, a new type of scheme has attracted a lot of interest, especially in middle-income countries: conditional cash transfer programmes. The principle is to condition the provision of the cash benefit to behaviour, generally the household's investment in their children's human capital. Conditions may include school attendance for children, regular visits to health centres and participation in different educational programmes.

In 1997, the federal government of Mexico introduced PROGRESA (Programa de Educación, Salud y Alimentación) for poor rural families. The programme provides cash transfer linked to children's enrolment and regular school attendance and to clinic attendance. It also includes in-kind health benefits and nutritional supplements for children up to age five, and pregnant and lactating women. It was fully implemented in early 2000 and covered then 2.6 million families, that is around 40 per cent of all rural families [Skoufias, 2001]. It was expanded in 2002 through the Oportunidades program and reached 4.2 million families [Rawlings & de la Brière, 2006]. In education this program has demonstrated a positive effect on enrolment rates for both boys and girls. It also showed a significant increase in nutrition monitoring and immunization rates [Rawlings, 2004].

In 2003, the government of Brazil launched the Bolsa Familia Programme, which integrates previous cash programmes into a single one. The transfers are made preferentially to women in each family and are conditioned to children's school attendance, use of health cards and other social services. The programme, which is supported by the World Bank, has grown exponentially since its launch: in January 2005, it covers about 26 million people. It is expected to cover about 44 million people by the end of 2006, at least two-thirds of whom are extremely poor [Lindert, 2005].

Universal benefits

Universal social benefit schemes are benefit schemes for all citizens including tax-financed family benefits and health-care benefits. Universal benefits of services are also financed from general State revenues, but they cover the whole target population without any condition or income test (for instance, those over a certain age).

Examples of universal benefits in health are to be found in many countries where the government provides to all the population a free access (or at a discounted price) to public health facilities.

→ In case of an adverse event (occurrence of a risk), households will rely on the mechanisms of protection that have been set up in advance: they may call on support networks for transfers or loans, they may sell livestock or other assets, they may deplete their monetary savings, their loss of welfare may be compensated by an insurance scheme in line with a predefined benefits package, or they may rely on social assistance and/or universal benefits. **When these mechanisms of protection fail or fall short, households try to offset the consequences of the adverse event => see next paragraph.**

❖ *Mechanisms aiming at relieving the impact (repairing mechanisms)*

If the protection provided through ex ante mechanisms is not sufficient, households try to offset the consequences of the adverse event, once the risk has occurred, through the search of additional financial resources, cutting spending, selling assets, calling on unusual and unplanned sources of financing or support networks. They may borrow money from the

extended family, friends, neighbours, a financial institution or even moneylenders often at usurious rates of interest. They may take money out of the family business. They may use credit not for its original purpose. They may increase their labour supply, working more hours or involving more household members including children. They may migrate to unaffected areas especially when the shock is covariant and the local labour market has collapsed. They may also cut spending, withdrawing children from school, reducing food intake. They may benefit from public emergency programmes particularly in case of covariant shocks: e.g. free distribution of food and clothes.

A recent study [Rajasekhar et al., 2005] conducted among unorganised workers in Karnataka, India shows that 38 percent of the households faced some kind of household level crises during the past 3 years, most of which were related to health concerns and death of household member. The most important source of financing the crises was borrowing from money lenders at a high rate of interest (between 48,29% and 54,92% of households chose this source of funding depending on the occupational group). Sales of assets only accounts for between 2,79% and 3,62%.

The search of additional financial resources will certainly raise ready cash in the short term, although it might take some time to find one or more lenders, but may ultimately compound the family's poverty (e.g., heavy indebtedness). In cutting spending households incur a high long-term cost by jeopardizing their economic and human development prospects. Ex post arrangements often lead to child labour and malnourishment, with lasting damage to children⁶ [World Bank, 2001; Rosati, Mealli & Guarcello, 2003]. Besides, such arrangements often impose an inordinate burden on women whose workload increases with stress, yet their duties at home are not lessened.

3- Actors involved in ex ante and ex post strategies and mechanisms

The respective roles of the different actors (central / local government, employers, private firms, local organizations, households and individuals, etc.) are defined by the societies themselves and may depend on the socio-economic model followed and the means available. In countries where the State faces fiscal constraints and institutional weakness, strategies and mechanisms to fight against risks and to extend social protection are more and more involving the active participation of the private sphere or a partnership between public and private actors⁷.

Although preventive actions and precautionary measures may be introduced at the household's level, they are not widespread among poor households in most developing countries. The State may play a major role in the promotion and implementation of such ex ante strategies and civil society organizations in disseminating these measures among the population. At the global level, the collaboration of various actors (donor agencies, independent private agencies, international organizations, NGOs, private companies, etc.) may be required to provide global precautionary measures (e.g., global epidemiological surveillance) and to finance, promote and deliver those preventive actions considered as global public goods (e.g., immunization programmes, protection of the environment).

Among risk mitigation arrangements some may be introduced by the households themselves (e.g., building up assets and social networks); some - such as the set up of a solidarity fund, an emergency credit programme, a micro-insurance scheme, etc. - require the intervention of

⁶ Several reports and research are to be found on the Web site of Understanding Children's Work, an Inter-agency Research Cooperation Project, <http://www.ucw-project.org>.

⁷ For a discussion on the role on the State in the extension of social protection please see part IV.

organizations which may be of various types according to the context: NGOs, health care providers, community-based organizations, commercial insurance companies, employers, etc. The State (local, regional or central) of course may have an important role to play in the design and administration of such arrangements (e.g., social insurance schemes, social assistance and universal benefits programmes), in the regulation of these mechanisms (legislation, control, redistribution, etc.) and in the design of national strategies of risk management and extension of social protection. The State may develop redistribution mechanisms within the population and call on international support for some kinds of risks (e.g., malaria, tuberculosis, HIV/AIDS) or groups of population.

Repairing mechanisms (ex post) against the consequences of idiosyncratic risks are usually handled by the households themselves, with support of their social network when necessary. The State has a major role to play in relieving the impact of covariant risks (floods, earthquakes, epidemics, etc.), with the support of external actors when necessary.

4- Choice of most appropriate strategies and related mechanisms

The choice of most appropriate strategies and related mechanisms depends mainly on the influences, relations and interactions between the different actors involved; their agreeing or disagreeing; the priority given to short term versus long term objectives (particularly for politicians, directors of private companies, etc.); the economic and political stakes of risk management including personal interests; past experiences in risk management; actors' capacity of action in terms of resources and knowledge; existing financial incentives; existing legislative frameworks; etc.

Other factors may also play an important part in the choice of strategies and related mechanisms of protection:

❖ *The characteristics of the risk*

Some risks may be prevented. For instance, immunization can prevent certain diseases from occurring. But most of the time prevention and precautionary measures do not eliminate the risks or exposure to risks, they only reduce risk's chances of occurrence or the seriousness of the adverse event. Therefore they may not always be a sufficient response.

Existing risk mitigation mechanisms usually only provide an appropriate protection against a limited number (or type) of risks and may be more or less efficient in dealing with major risks, risks repeated over time and covariant risks.

Savings, emergency credit programmes and prepayment mechanisms (for health risks) are individualized mechanisms. Households can only draw upon the amount of money they have saved or borrowed, or use the amount of services they have pre-paid. These mechanisms do not therefore offer enough protection against major risks that exceed an individual's ability to pay (e.g., hospitalization).

Building up assets gives an appropriate protection in case of minor and idiosyncratic (non covariant) risks. In case of major risks the store of assets may not be sufficient to achieve adequate protection. During widespread shocks (covariant risks) assets prices tend to fall as demand shifts inward and many sellers flood the market with distress sales. When shocks are repeated over time, the household may deplete its assets as a response to the first shock and have no asset left when the second shock occurs.

When risk increases in intensity and in geographic or social spread, insurance can give a more effective response than individualized mechanisms.

❖ *The characteristics of the population to be covered*

Some mechanisms are working better when the population is large and geographically spread (e.g., insurance). On the contrary, mechanisms based on selective membership and guided by a principle of balanced reciprocity such as solidarity networks might function well in small populations. But such mechanisms entail the risk of excluding from membership vulnerable

households (e.g., in-migrants to communities, very poor households, ethnic minorities, elderly and infirm, chronic ill persons) particularly since no counter-gift can be expected from them.

Educational and cultural barriers may sometimes prevent households to undertake precautionary measures. Workers in the informal economy may moreover not be sufficiently aware of the risks they are exposed to: therefore setting up or joining mechanisms of protection is not felt as a priority.

When they are aware of the risks they may be also reluctant to join schemes since the protection provided does not match felt priority needs. This may be the case of statutory social insurance schemes providing for instance pensions or unemployment benefits, whereas many households in the informal economy are most interested in smoothing health care expenditures, assistance with funeral and survivor costs, and smoothing the impact on expenditure and income foregone that result from maternity, childcare and basic education. When the setting up process of the mechanism is participative, there is a greater chance that the protection provided better matches the protection needs of the target population.

❖ *The resources at hand: financial requisites, level of knowledge, etc.*

When wishing to diversify income sources, entry constraints (skills, start-up costs) may prevent poor households in leading high returns activities. Similarly undertaking preventive actions may need an initial investment that is often unaffordable for poor households. Financial mechanisms that involve regular payments (savings, emergency credit, insurance, prepayment mechanisms) cannot – in the absence of subsidies⁸ - reach the very poor that have a limited ability to pay or to save. When the setting up process of these financial mechanisms is participative, contribution requirements often better take into account the ability to pay of the target populations and of their variable income patterns.

When the community decides to set up mechanisms of protection it may also be slowed down by entry constraints at its level: financial initial investment (e.g., building a dam to reduce the risk of floods), skills and knowledge required that are lacking among community's members (e.g. implementing a micro-insurance scheme).

❖ *The cost-efficiency*

When choosing strategies and mechanisms of protection it is important to favour most cost-effective ones i.e. mechanisms with lowest cost and highest impact in reducing insecurity and vulnerability. This is the case of ex ante arrangements, which are usually more efficient than ex post ones in terms of resource allocation. They also manage to reduce both insecurity and vulnerability. On the contrary when households rely mainly on ex post strategies, they incur a great stress when a risk occurs, and the response they give to cope with the shock often contributes to increase their vulnerability towards future adverse events.

Within ex ante arrangements, preventive actions and precautionary measures are all the more so important in developing countries as the majority of households have only limited access to risks related information, as a result, among other things, of their low level of literacy and are more exposed than others to risks. For instance workers in the informal economy are very often exposed to dangerous working conditions and may not be aware of the threatening risks of sickness and injury, such as those connected with the use of machinery (frequently

⁸ Different kinds of subsidies exist among which subsidies of the premiums targeted to the poor members (equity subsidies) are the most equitable. However the implementation and management of such subsidies is not an easy task.

obsolete, unsafe and without protective devices) and those connected with the use of dangerous substances, air or water pollution, or simply inadequate ventilation or lighting.

Although they appear to be necessary, preventive actions and precautionary measures are not wide spread among poor households and efficient mechanisms of risk mitigation are in most developing countries little developed, for various reasons (see further). The State may play a major role in the promotion and implementation of such ex ante strategies (for further details please see part IV).

Besides, other measures can prove to be efficient in order to protect households from the consequences of adverse events and reduce insecurity and vulnerability although they are not specifically mechanisms of protection.

Examples include: instruments aiming at improving security of access (e.g. tenancy reform, protection of access to common property of resources) as well as distributive measures (e.g. land reform) and income generating activities.
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PART III. MICRO-INSURANCE: A MECHANISM TO MANAGE RISKS

1- What is micro-insurance?

In this section we will try to give a definition of micro-insurance and describe two aspects of the diversity of existing micro-insurance schemes: diversity of micro-insurance products on the one hand, diversity of micro-insurance delivery models on the other hand. This description has some limitations since diversity can be captured through other lenses or dimensions: the size of the schemes, their geographic location and expansion, the level of empowerment of the target population and/or members, the type of management tools used, the degree of integration in national risk management or social protection strategies and policies, etc.

❖ Definition and characteristics of a micro-insurance scheme

A micro-insurance scheme is a scheme that uses (among others) the mechanism of insurance whose beneficiaries (at least part of) are people excluded from formal social protection schemes, in particular informal economy workers and their families. The scheme differs from schemes created to provide legal social protection to formal economy workers. Membership is not compulsory (but can be automatic), and members pay, at least partially, the necessary contributions in order to cover the benefits⁹.

The use of the mechanism of insurance implies:

- Prepayment and resource-pooling: the regular prepayment of contributions (before the insured risks occur) that are pooled together.
- Risk-sharing: the pooled contributions are used to pay a financial compensation to those who are affected by predetermined risks, and those who are not exposed to these risks do not get their contributions back.
- Guarantee of coverage: a financial compensation for a number of risks, in line with a pre-defined benefits package.

The expression “micro-insurance scheme” designates either the organization (e.g., a mutual benefit organization) or the set of institutions that provide insurance (e.g., an NGO and an insurer linked in a partner-agent relationship) or the service itself provided by an organization that conducts other activities (e.g., a micro-finance institution that provides micro-insurance to its clients).

As insurance, micro-insurance works better when the adverse events and the population covered have certain characteristics listed in 1st box below. Beside, micro-insurance is also threatened by insurance’s inherent risks (moral hazard, adverse selection, etc.) that may jeopardize the scheme’s financial viability. These risks are described in 2nd box below.

⁹ Since their capacity to contribute is most often low, the coverage provided by these schemes is - in the absence of subsidies – usually limited, with a small number of risks covered and low levels of benefits.

General principles of insurance that can be also applied in the case of micro-insurance¹⁰

Insurance (and micro-insurance) work provided that the adverse events show the following characteristics:

- (1) The adverse event should be random i.e. unpredictable in terms of whether the event will occur or not, and/or when it will occur, and/or how often it may occur. If the event is predictable, other risk management strategies (e.g. planned savings) may be more appropriate¹¹.
- (2) The adverse event should cause a financial loss to the individual. If the individual does not suffer a financial loss, there is no insurable interest.
- (3) The adverse event should not have occurred at the time the member joins the scheme. It is therefore not possible to insure a house against fire when the fire has already occurred.
- (4) The occurrence of the adverse event should not be under the direct control of, or caused intentionally by, the insured member or any other related party.
- (5) The expected loss should be measurable. For the design of the benefit package and calculation of the premium, the expected loss for a particular population has to be determined and measured prior to the occurrence of the insured event.
- (6) The adverse event occurrence should be easy to prove and its consequences (financial losses) be easy to measure. Otherwise, insured individuals could make false claims.

Insurance (and micro-insurance) work better when the insured persons or units are numerous, homogeneous and when risks are independent from each other:

- (1) Large number of insured persons or units (houses, assets, cattle): premium calculation is based on an estimate of the future losses of the insured persons/units. With a large number of insured persons/units the average real losses have a greater chance of being close to the estimate.
- (2) Similarity of insured persons or units: a hut and a factory, for instance, are not sufficiently similar to be covered by the same insurance policy. In reality, insured persons or units are rarely similar: some insured persons have a greater probability of death or illness due to their age, sex, health status, occupational group, place of residence. When calculating the risk, the insurer may classify insured persons and units in homogeneous categories (same age, sex, occupation, etc.). In each category, the risks are regarded as similar¹².
- (3) Independence - or at least non dependence: the occurrence of the insurable event should be statistically independent from individual to individual or unit to unit. This means, the chance of the event happening to one individual is not affected by the fact that it has happened to another. For instance, the fact that one insured individual in a village breaks its leg does not mean that all other insured in the same location will break their legs as well.

❖ Diversity of micro-insurance products

Micro-insurance schemes may cover various risks (health, life, etc.); the most frequent micro-insurance products are described in following paragraphs.

Life micro-insurance (and retirement savings plans)

Life micro-insurance provides coverage against the financial consequences of the death of the breadwinner or of old age. Although life insurance is normally meant to be subscribed for a long period, the poor generally buy life micro-insurance products for a short period (1 year) with no guarantee of renewal. There are two categories of life micro-insurance products.

¹⁰ These are common principles; they do not include specificities of certain schemes, such as mutual benefit associations that may share other principles.

¹¹ In many countries the costs for the daughters wedding or for other traditional ceremonies can cause high indebtedness for poor families. In these events micro-insurance is not suitable as the probability of occurrence is very high, the timing of the occurrence is predictable since it is a planned event and their impact, cost for the wedding/the ceremony, is controllable. Therefore, planned savings and/or mutual and self-help groups assisting each other at these occasions are more suitable.

¹² Classifying the risks does not necessary lead to levels of premiums that are linked to the risks. A health micro-insurer may for instance decide that all insured (either young or old, male or female, in good or bad health) pay the same level of premium.

Under the first category, the compensation is paid on the death of the insured person. The life micro-insurance pays the pre-defined benefit to the designated beneficiary of the deceased policy holder. A distinction can be made between term life and credit life products.

- Term life micro-insurance: the nominee, in most of the cases a family member, receives a lump sum in the case of the death of the insured person during the term of the micro-insurance policy. The amount can be a fixed amount sometimes limited to the coverage of the costs of the funeral and other (immediate) expenses. The amount may also be variable.

It may be linked to the amount of savings of the deceased policy holder, such as in the case of the Jamaican credit unions where the designated beneficiaries receive 3 times the amount saved.

- Credit life micro-insurance is the name given to term life micro-insurance when it is required by micro-finance institutions in order to secure the reimbursement of their loans. If the insured person (the borrower) dies before the end of the given term, the benefit goes to the lender (the micro-finance institution) to cover the repayment of the outstanding balance of the loan. One of the main purposes of credit life micro-insurance is to secure the loan portfolio of the MFI and to provide a relief for the family of the deceased borrower, who are thus relieved from the burden of loan repayment.

Under the second category, the compensation is due after a predetermined period (usually after a minimum of 5 years) either on the death of the policy holder or while the insured person is *still alive*. These long term policies provide maturity benefits that could take the following two forms: endowments and annuities. They combine death protection benefits with savings accumulation.

- Endowments: If the policy holder survives the predefined term she/he receives a lump sum from the insurance. In the case of death during the contracted period a fixed capital may be paid to the nominee.
- Annuities: After the predefined term the insured person receives a pension until death. If the policyholder dies before reaching the term, the nominee may receive either a lump sum or a series of payments. Retirement savings plans are usually based on this mechanism.

The Annapurna Mahila Mandal based in Mumbai, India, provides for a pension scheme in collaboration with the Life Insurance Corporation (LIC). Members (women) mobilize their small savings and once the amount reaches Rs. 5,000, the amount is invested in LIC pension scheme. Savings amounts are invested in sound securities and after 20 years amounts to Rs. 50,000. On this principal amount a fixed amount of Rs. 500 per month is paid to the woman as old age pension. The principal can be paid to her nominee at the time of her death (only natural death) [ILO-STEP, 2005b].

Health micro-insurance (hospitalisation, primary health care, maternity, etc.)

Health micro-insurance provides coverage against the financial consequences of ill health and maternity. The financial consequences are of several natures: direct medical costs for prevention, care and cure (fees for consultations, laboratory tests, medicines, hospitalisation, delivery, etc.); direct non-medical costs such as costs for transportation, food in case of hospitalisation; and indirect costs (opportunity costs), as ill health and maternity usually cause a loss of productive time for both patients and caretakers. Health micro-insurance schemes most often cover direct medical costs with a predetermined list of risks (or health services) that are covered. Very few provide cash benefits (income replacement) in case of ill health and maternity.

AssEF in Benin is a micro-finance institution that developed a health micro-insurance scheme in 2002 [Louis dit Guérin, 2006]. This scheme offers its members a 70% coverage of health expenses in the main general practice,

maternity and hospitalisation services that meet the needs of women and their children. This coverage is valid within a network of contracted health care providers who, furthermore, participate actively in the smooth running of the system, particularly by intervening in the verification of entitlement to benefits

AssEF's members, only women, have had a leadership role in defining the health micro-insurance benefits. That is why the benefits largely focus on women's needs, with a special emphasis on reproductive health (gynaecology and obstetrics). As women are generally left with the sole responsibility of paying for their children's healthcare, the benefits were also designed to meet children's needs, particularly through coverage for consultations and outpatient care, since they are the primary consumers of those services.

In general, coverage is subject to a number of conditions, e.g. exclusion of chronic diseases, the limitation of medication to essential generic drugs and/or the restriction of services to a limited number of defined health care providers.

There may be a contractual arrangement concluded with a health provider detailing all services to be provided. There is also another version where there is no such agreement, services are reimbursed at a pre-set value to the policyholder who can go to the health provider of his own choosing.

SEWA's micro-insurance scheme in India covers hospitalisation for general diseases, gynaecological ailments and occupational health-related diseases [ILO-STEP, 2001a]. Hospitalisation refers to any in-patient admission to a hospital and can include any treatments the patient undergoes while actually admitted to the hospital. Members are free to choose the public or private hospital where they wish to receive treatment. Usually they base their choice on the hospital location, personal knowledge, and of course, cost. The scheme has no formal agreement of any sort with private or public health care providers or charitable organizations offering hospitalisation. Members have to pay the whole cost of hospitalisation and are then reimbursed by the scheme (no third party payer agreement). A new method of servicing members called "prospective reimbursement" helps reducing delays in claims settlement and reimbursement [Garand, 2005]. According to this method an insurance promoter (Vimo Aagewan) visits hospitalised members within 24 hours and collects information from the hospital to estimate the claim amount. Based on this cost estimate a partial reimbursement, up to 80% of the estimated claim amount, is provided on the spot, with the balance provided on discharge when all the required documentation is received.

The Yeshasvini plan (India) covers 1600 surgeries available only at approved hospitals on a cash less basis to beneficiaries. The Yeshasvini plan pays the participating hospital a fixed tariff for each of these defined benefits. It is believed that the tariff is 40-50% off the regular price of the private hospitals.

Disability micro-insurance

Disability micro-insurance provides coverage against the financial consequences of invalidity, whether temporary or permanent, depending on the contract. Disability is called temporary when the physical loss is reversible and lasts for a limited period of time (generally up to three years). Disability micro-insurance may cover a variety of disabling events that need to be precisely defined in advance. The pre-defined financial compensation can be proportional to the severity of the disability (also called disability rate). The disability rate needs to be assessed by a doctor.

NIDAN (based in Bihar State in India) offers a life and disability insurance product to the members of the self-help groups that it is working with. The package includes an amount of Rs. 50.000 for permanent disability due to accident, Rs. 50.000 for loss of two eyes or two limbs or one eye and one limb due to accident, and Rs. 25.000 for one eye or one limb due to accident (between ages 18 and 60 years). This product is insured by the Life Insurance Corporation of India [ILO-STEP, 2005b].

Disability micro-insurance is often appreciated by micro-finance institutions in order to secure the reimbursement of the loans. It is then called "Credit disability micro-insurance" and covers the repayment of the outstanding balance of the loan in case of disability of the borrower.

Property micro-insurance – assets, livestock, housing

Property (or asset) micro-insurance provides coverage against the financial consequences of the damage or loss of personal assets, work premises and tools (e.g. hut micro-insurance against fire, theft of items, or death of livestock). The insured person is usually the owner of the assets and/or tools. The financial compensation is assessed once the adverse event has occurred.

Proshika in Bangladesh provides Livestock insurance to 91,000 members. If animal dies due to disease, etc. policy holder is paid Tk 0 if death occurs within 90 days policy, 5% of cost of animal if death occurs within 91-180 days, 10% of cost of animal if death occurs within 181-270 days and 15% of cost of animal if death occurs within 271-365 days [ILO-WEEH, 2003].

Crop micro-insurance

Crop micro-insurance provides a financial compensation in the case of crop failure generated by uncontrollable adverse events (e.g., drought, crop pest). The financial compensation is assessed once the adverse event has occurred. Assessment of the value of the loss is, however, difficult. In developing countries there have been little examples of successful crop micro-insurance without substantial reliance on government subsidies, for several reasons (e.g. frauds, moral hazard).

In India, the inventory conducted in 2004 (updated in 2005) identified only 1 crop micro-insurance scheme, organized by BASIX, a community based micro-finance institution settled in Andhra Pradesh. BASIX has initiated a micro insurance scheme for its members since 2000. Affiliation is compulsory for all BASIX's members. Among other risks, the scheme covers crops in case of rainfall deficit. The contribution for the crop insurance product is Rs. 30 per thousand sum insured (expected yield); the contribution may vary according to the type of crop insured (Groundnut, Jowar, Paddy, Sunflower, etc.). The crop micro-insurance scheme receives no subsidies.

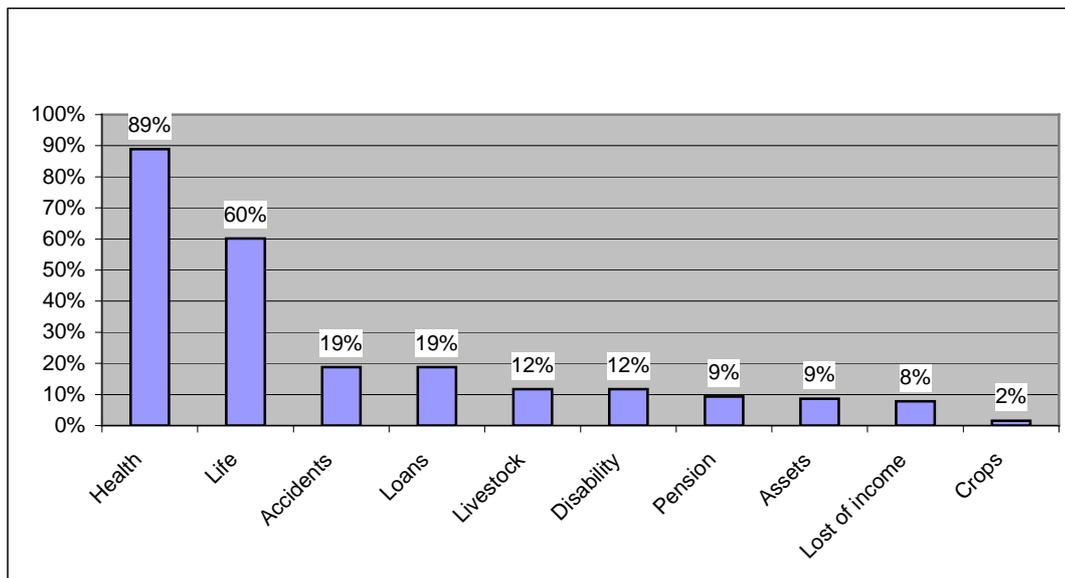
Although it cannot be considered as a micro-insurance scheme, the National Agricultural Insurance Scheme in India is an interesting example of crop insurance. The scheme is being implemented by Agricultural Insurance Company Limited (AIC), a government of India initiative. It is presently covering 20 million farmers out of a target population of 170-180 millions (target population by 2010). The scheme covers loss of yield in case of natural fire and lightning, storm, cyclones, flood, inundation, landslide, drought, pests / diseases, etc. The premium varies from 17 Rs. per 1000 Rs. insured to 40 Rs. per 1000 Rs. insured depending on the season (there are two crop seasons in India) and the type of crop. A subsidy of 10% of the premium is being financed by central and state governments and is available only for small and marginal farmers. The crop insurance is made compulsory for loanee farmers (those availing crop loans from any of the notified financial institutions). All normal claims are being settled by Implementing agency (AIC) and any claim exceeding beyond 100 to 150% of premium (depending upon the crop type) will be borne by a corpus fund which is being created to meet catastrophe losses with equal contribution from state and central government of India.

Relative frequency of the different types of risks covered

According to the results of the inventories of micro-insurance schemes conducted in 2003/2004 in Africa (11 countries), India, Bangladesh, Nepal and the Philippines:

- ✓ Health micro-insurance is predominant in Africa (100% of investigated mutuals) and the Philippines (70% of investigated schemes provide - among others - health insurance benefits); it ranks second in India (56% of schemes), Nepal (52%) and is less important in Bangladesh (39%).
- ✓ Life micro-insurance is most important in Bangladesh (72% of investigated schemes provide - among others – life insurance), the Philippines (66%) and India (60%). It seems less important in Nepal (38%). Although this inventory did not capture information on life micro-insurance in African countries, we know that in some of them (e.g., Cape Verde) there exist burial societies whose concept is close to that of life micro-insurance.

✓ Examples of crops micro-insurance merely exist in India (two schemes in 2004, only one left in 2005). Pension schemes are to be found merely in India (4% of investigated schemes provide old age insurance) and the Philippines (24%).



4. Distribution of micro-insurance schemes in 15 countries by risks covered

89% of schemes cover health, 60% cover life, etc.

Source: ILO/STEP: 2003/2004. Consolidated database of the inventories of micro-insurance schemes.

Health figure includes data from Africa (11 countries), India, Bangladesh, Philippines, Nepal

Other figures (life, accidents, etc.) merely include data from India, Bangladesh, Philippines, Nepal

❖ Diversity of micro-insurance delivery models

Running micro-insurance is a complex business involving the following main functions:

- Product design and pricing
- Product sales and distribution, including marketing and monitoring clients' satisfaction
- Technical management (membership, premiums, claims) including monitoring
- Financial management
- Management of agreements with health care providers (accreditation, contracting, follow-up)
- Risk bearing (insurance, financial consolidation)

In some cases all the functions are managed by one organization; in other cases, they are shared by two or more organizations (example: partner-agent agreements).

All the functions are managed by one organization

Under this category, one may find in particular:

(1) Pre-existing civil society organizations (MFIs, NGOs, Health care providers, trade union, etc.) that add to their activities the provision of micro-insurance. Most often, the civil society organization provides insurance services together with other products and services (e.g. emergency loans, health funds, savings products, linkages to government programs, health cooperatives). They implement all insurance tasks and assume the (financial) risks. Although the design and operations of the insurance scheme is usually done in participation with the potential policyholders, the micro-insurance remains in the ownership of the implementing

organization. When health care providers offer health insurance to their patients (integrated system / sub-model), it is with two objectives: (1) increase patients' access to health care services; (2) secure the health care provider's revenues and return on investments (new equipments). Health care providers hold all the statistics on episodes of illness (frequencies, costs) among the target population, which is useful in order to calculate the premiums.

(2) Community based organizations that are settled for the sole purpose of providing a micro-insurance coverage, such as mutual benefit associations. The system is owned and managed by the insured groups themselves, and relies on active solidarity mechanisms. The insurance coverage provided usually responds to (at least some of) the members' needs and to their capacity of contribution. Many of these schemes offer also supplementary activities such as prevention of risks.

(3) Commercial insurers that sell insurance products to excluded groups.

Several organizations involved in the operation of the scheme

This second category includes partnerships between organizations aiming at providing insurance services to excluded groups. Under these partnerships one finds among others Partner-Agent agreements and outsourcing of management functions (such as in arrangements with TPAs).

In partner-agent agreements the partner is an insurance provider (usually a regulated insurer, occasionally a Government institution or a national agency such as Phil Health in the Philippines), and the agent is a civil society organization (e.g., NGO, MFI). In exchange for a commission, the agent sells the insurance products of the partner to its target population (members and/or non-members) and offers its infrastructure for product servicing such as marketing of the product, premium collection, and assisting in claims management. The insurance provider is usually responsible for the designing and pricing of the product, the final claims management, investment of reserves, and absorbs all the insurance risks.

Vimo SEWA (India) has a long history of partnering with a variety of different insurance companies. After having changed several times partner insurers, Aviva became the life insurer starting in 2005 as it permitted Vimo SEWA to pay the life claims, reducing reimbursement time to 1 week. For health and asset insurance, the private, non-life insurer ICICI Lombard became the partner in 2003, providing improved conditions, such as a fund to reimburse claims. This partnership has continued to date. Vimo SEWA has MoUs (Memorandum of understanding) with Aviva and ICICI Lombard outlining the duties of each party and the term of the agreement. These agreements delegate distribution, premium collection, record-keeping and claims payment to Vimo SEWA, with the insurer bearing the risk [Garand, 2005].

“Third party administrators” (TPAs) are service providers that may take over several functions: the accreditation of health care providers and the monitoring of these agreements, claims management, etc.

In the Yeshasvini rural micro insurance scheme in India, a TPA called Family Health Plan Limited (FHPL) is responsible for most of the day-to-day administration functions of the scheme, among others: it has the task of maintaining the membership and claims data bases, of accrediting hospitals, training hospital staff on the Yeshasvini plan, auditing service agreements with network hospitals, approving treatment of beneficiaries, monitoring claims to prevent over-utilisation, process reimbursement to network hospitals and collect feedback from members. The FHPL is paid a fee for its services at the rate of 5,5% of the contributions received from the members.

	Product design and pricing	Product sales and distribution	Technical and financial management	Agreements HC providers	Risk bearing
MFI, NGO providing micro-insurance, "mutuals"	+	+	+	+	+
HC providers providing micro-insurance	+	+	+		+
Partner-agent agreements					
NGO		+	+	+	

Insurer	+		+	+	+
Outsourcing of management functions (e.g. TPA model)					
Micro-insurance organization	+	+	+		+

TPA			+	+	

5. Diversity of micro-insurance delivery models : sharing functions

Some of the advantages and challenges of the various delivery models

When all the functions are managed by a civil society organization already active in the informal economy or a community based organization, the main advantage is a relative vicinity between the organization and the members which enables to better take into account the needs and demands of the potential insured persons in the product design (which is in some cases participatory) and the operating rules and procedures; to reduce the administrative and transaction costs (no intermediate structure, volunteer work); to reduce some risks like frauds ; and to reduce delays (e.g. in claims settlement). Share of resources (equipment, staff) that contribute to limit the overhead costs may also be possible. The main challenge relies in the difficulty to manage all by oneself a whole business whose complexity is intensified by the fact that needed resources are scarce or even non existent in many developing countries, that access to financial markets and to consolidation mechanisms such as reinsurance or guarantee funds is limited, that membership is relatively small and geographically concentrated, that it is difficult to collect premiums and build up reserves when members have a low ability to pay.

When several organizations are involved simultaneously in the operation of the scheme, the main advantage is that all partner organizations may focus on their core business and expertise. One of the challenges is that there may be a gap between the supply of insurance (products marketed by commercial insurers for instance) and the demand (needs of the target population). Another limitation is that such a model is not replicable anywhere; in some Western African countries where commercial insurers are not (until now) interested in the micro-insurance "market", partner-agent arrangements are not feasible; the outsourcing of management functions to third party administrators (or external management cells) are only feasible if such structures do exist, which is the case in very few countries today.

❖ *The need for reinsurance, coinsurance (syndicate insurance) and other financial mechanisms*

Reinsurance and coinsurance (syndicate insurance)

These arrangements enable micro-insurance schemes to share the risks with insurers or re-insurers. Reinsurance allows for diversifying risks and redistributing them over a broader base. It contributes to reduce the micro-insurer's risk of loss when the risks are not sufficiently independent and broken up. It is a mechanism through which an insurer (or a micro-insurer) secures insurance from a third party (the re-insurer) for part of the risks it has undertaken to cover, in exchange for the payment of a premium. The reinsurance contract may be thought of as the micro-insurer's insurance coverage, or second-degree insurance. There are two types of reinsurance: (1) Proportional reinsurance where the micro-insurer cedes a predetermined share of each premium to the re-insurer which promises to pay the same share of claims. (2) Non proportional reinsurance where the micro-insurer cedes a predetermined share of each premium to the re-insurer which promises to pay claims exceeding a certain amount. Reinsurance arrangements are particularly important to prevent the risk of catastrophic events.

Coinsurance (syndicate insurance) allows for dividing risks and redistributing them among several micro-insurers with an aim to reduce individual micro-insurer's risk of loss. Each micro-insurer bears a share of the risk, receives the same share of premium and will pay the same share of claims were the risk to occur. There is no solidarity between co-insurers; each of them remains responsible for the share of risks it bears.

Although the need for these mechanisms is important, micro-insurance schemes have still little access to them.

The insurance scheme 'Yasiru' in Sri Lanka may be seen as an exception. It signed a reinsurance agreement with a Dutch Insurance Company, known as Interpolis Re. The Interpolis Re - working together with Rabobank foundation - developed a combined financing and reinsurance model along the following lines. All benefits paid out by 'Yasiru' for death and disability risks are fully compensated by reinsurance up to a set maximum per event (SLRs 120 000 per risk) and per annum (the annual limit is of five times the reinsurance premium). 'Yasiru' pays 20% of the total annual gross premium per year to Interpolis Re under this reinsurance agreement. Interpolis Re deducts only 5% of the reinsurance premium for their administrative costs and 95% of the reinsurance premiums is paid back to 'Yasiru' as a commission. This special facility is offered by Interpolis Re to build up adequate reserves for the 'Yasiru' scheme.

Guarantee funds and investment funds

A guarantee fund is a fund that a health micro-insurance scheme can call upon in the event of financial difficulties. Generally speaking, the assistance provided by the guarantee fund takes the form of a loan. The circumstances in which the guarantee fund may be used are usually specified in detail. The fund's assistance may be made conditional upon changes in the operation of the health micro-insurance scheme. Guarantee funds may be financed by member schemes, the State, financing institutions or support organizations.

Some micro-insurance schemes (PREM, Vimo SEWA [ILO-STEP, 2001a]) are granted an initial seed fund from partner organizations of the scheme (Plan-International in the case of PREM, GTZ in case of Vimo SEWA). Investment earnings help to support and stabilize the scheme (in case of Vimo SEWA, investment earnings are covering administrative expenses).

2- Some factors for success and challenges

Prior to establishing a micro-insurance scheme the following factors for success and challenges shall be taken into consideration.

❖ *Setting up and operating a micro-insurance scheme is a long process*

Setting up micro-insurance is time consuming and requires high investment in terms of human and financial capital. The length of the setting up process depends on the risks covered, on the model chosen and other factors (e.g., experience of the implementing organization, familiarity with insurance in the country, financial and technical resources, either internal or external).

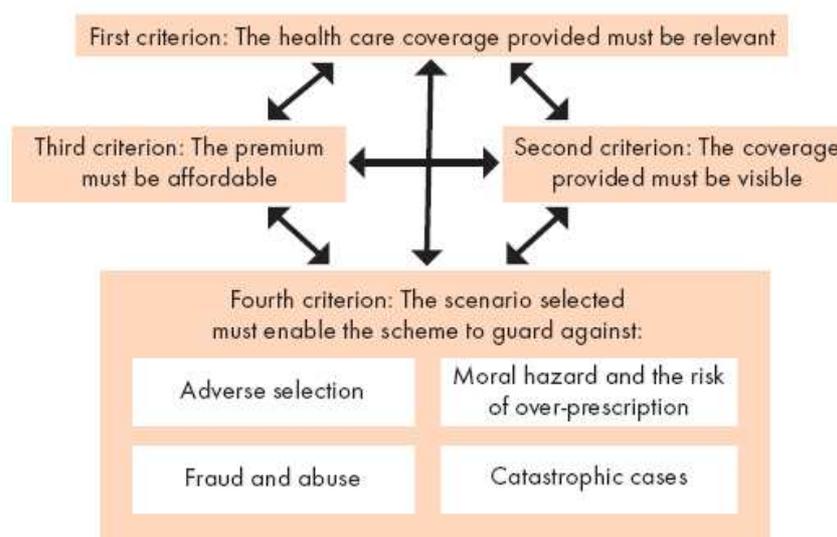
Yielding the benefits of being insured is a long time process, except for health micro-insurance. This is even more relevant for certain life micro-insurance products (long term life, endowments, annuities) that can be materialized after 15 years or even later. This implies a stable and professional structure of the implementing organisation with a long term vision and ability to survive internal and external challenges in order to fulfil its commitments towards its insured members (and the insurance provider in case of a partner-agent model).

❖ *Setting up a micro-insurance scheme requires specialized skills*

At the product design stage

Product design is a real challenge since it is difficult to design a customized benefits package that both responds to the numerous coverage needs of the target population and is affordable to them. Problems of design of the benefit package may result in low population penetration rates, particularly when membership is voluntary.

The design of a health micro-insurance benefits package needs to take into account several criteria:



1- The health care coverage provided must be relevant: the health services to be covered must effectively correspond to situations that members perceive to be a risk.

2- The coverage provided must be visible: a health micro-insurance scheme that chooses to cover only health services that are used rarely, such as emergency hospitalizations or surgery, runs the risk of not being very lively and attractive. A scheme that covers minor risks, on the other hand, will be very active, and therefore very visible, but will require members to pay a high premium, no doubt rendering the scheme less accessible.

3- The premium must be affordable. A premium that is too high will be prohibitive for the vast majority of the scheme's members.

4- The scenario selected must enable the scheme to guard against insurance-related risks: adverse selection, opportunistic behaviours, moral hazard, risk of over-prescription, catastrophic cases.
Source: ILO/STEP. 2005. Health Micro-Insurance Schemes: Feasibility Study Guide.

In terms of technical management

Technical management is highly complex and includes: management of membership, premium collection, claims management, assessment of customer satisfaction for better renewal rates, monitoring and evaluation, prevention and fight against risks inherent to insurance (moral hazard, adverse selection, etc.).

“Inherent risks” to insurance may jeopardize the scheme’s financial viability

Moral hazard is a phenomenon according to which insured persons change their behaviours because they know they are insured. For instance, their utilization of health care exceeds the standard used as an input for determining premiums. Crop and health micro-insurance are particularly prone to moral hazard: a farmer may reduce its efforts of prevention (e.g., fail to use pesticides) as he/she knows that its crop is insured. A patient may use more expensive health services as his/her health care expenses are covered by insurance.

Over-prescription is a form of moral hazard but specific to health (micro-)insurance. It occurs when health providers raise their prescriptions to exploit the maximum level of patients insurance benefits while patients do not oppose to the practice.

Adverse selection is a phenomenon according to which persons with a greater-than-average risk enrol in a micro-insurance scheme in a higher proportion than that of their share of the target population and/or choose the highest levels of coverage. Disability micro-insurance covering blindness caused by cataracts could face an adverse selection problem. Because blindness from cataracts is progressive, somebody who was recently diagnosed could join the scheme and later get the benefit of the payout (in case of blindness) or even obtain a loan with the knowledge that they will become blind and have their debt written off.

Catastrophic risks are contingencies that affect a large segment of the covered population, such as epidemics, major floods, earthquakes, climatic risks and/or those for which the unit costs are high, such as very costly hospitalisations.

The complexity increases when periodic claims reimbursements are necessary such as for health insurance or when the payment of the premium is based on monthly instalments. The acceptance of micro-insurance depends to a significant extent on rapid claims settlement. This calls for experience in verifying claims and assisting policyholders in completing the necessary documentation. The lack of adequate and computerized management information system (MIS) may also prevent many schemes from monitoring properly their operations, particularly memberships, premium collection and claims.

ILO/STEP has developed two management and monitoring software in French. MAS Gestion is a management software aimed at micro-insurance schemes managers. It provides day-to-day management devices (membership, premiums and claims), a simplified accountancy module and a set of indicators that are useful to monitor the development of the scheme. MAS Pilote is a monitoring software aimed at supporting structures of micro-insurance schemes. It can be used to monitor the development of one or more schemes. These software are distributed free of charge. For further information, please contact ILO/STEP office in Senegal: step_afr@sentoo.sn

Among micro-insurance schemes, health micro-insurance schemes face an additional challenge, that of the relationship with health-care providers: implementation and follow-up of agreements on quality of care, on the tariffs, on the payment procedures.

In terms of communication and awareness building

Since micro-insurance is a relatively new concept, the target population lacks the comprehension of this risk management instrument. It is often misinterpreted with micro-finance causing difficulties in selling insurance policies and low renewal rates, particularly from insured persons that have not had a claim (“intangibility” of insurance). Often, policy documents (contracts, statutes, internal regulation) are too complicated for the members, most of whom are illiterate. In a partner-agent model, the partner (a commercial insurer) may have

a poor image among low-income communities, being seen as quick to sell and slow to pay. It is therefore necessary to invest into IEC (Information – Education – Communication) and training of field staff.

Dealing with this complexity requires specialized skills and knowledge

Operating a micro-insurance scheme therefore requires specialized skills and knowledge in various fields (accountancy, management, marketing, underwriting¹³, communication, etc.) and sufficient staff members. However it is in some contexts more cost-effective to outsource selected management functions to specialized agencies than keeping these functions in house. This presupposes that such agencies do exist.

In India some schemes outsource the relationships with health care providers and the management of some technical functions (e.g., claims settlement) to the so-called Third Party Administrators (TPAs).

This complexity differs from one field of micro-insurance to the other

On the whole, the complexity of the setting up process and operation of micro-insurance varies from one field of (micro-)insurance to the other.

<i>Field / product</i>	Protection provided	Complexity
Crop	Financial compensation in case of crop failure generated by uncontrollable adverse events	
Health care	Compensation of the health care expenses in case of illness, childbirth and/or physical injuries	
Life/old age: Annuities, Endowment	Financial compensation in case of the death of the breadwinner and / or survival (old age)	
Property and asset	Financial compensation of the damage or loss (destruction, theft) of assets, work premises and tools	
Disability	Financial compensation in case of disability of the breadwinner	
Term Life	Financial compensation in case of the death of the breadwinner + compensation of the burial costs	
Credit Disability	On-going loan payments if borrower becomes disabled	
Credit Life	Loan principal and interest paid on death of borrower	

6. Relative complexity of the different fields of (micro-)insurance

Amended from: “Preliminary Donor Guidelines for Supporting Microinsurance”, CGAP Working Group on Microinsurance, October 2003

¹³ Underwriting is the entire process of designing and pricing of the product including terms and conditions such as waiting periods, avoiding adverse selection, etc.

❖ *Operating a micro-insurance scheme requires stable sources of funding*

During the first years of operation, micro-insurance may incur losses due to the limited number of insured and fixed overhead costs. Unless the scheme is highly subsidized or benefits from infrastructure and staff of the implementing organization, it may face a dilemma between the intention of fostering its own expansion and at the same time the need to limit overheads. In any cases, long-term revenues will have to be funded through premiums, commissions of insurance providers (in the case of the partner-agent model), government budget allocations and external funding, if any. Funding assistance provided either by government or external donors may be aimed at covering the administrative expenses of the scheme (e.g., staff's salaries); it may also be aimed at subsidizing the premiums of some specific categories of members (e.g., subsidy of the premiums for the poorest households). The first type of funding should not last longer than the necessary start-up period aiming at sustainability of the micro-insurance product. On the opposite redistribution mechanisms should be encouraged as long as they are financed through sustainable arrangements (*See part IV for further details*).

❖ *Conducive social and economic environment*

Confidence in the implementing organization

Micro-insurance presupposes the regular payment and pooling of premiums. The target population cannot easily be persuaded to pool its premiums when it lacks full confidence in the promoters and the other persons/institutions involved in the project, nor when its experience with "collective" projects (service cooperatives, savings and loan associations, etc.) consists of projects that ended in failure.

Existence of interest for insurable risks

Setting up a micro-insurance scheme is worthwhile only if the insured risk is perceived as important by the target population. Some workers in the informal economy may for instance be more concerned by the risks of illness or death of the breadwinner than by the financial risk linked with old age.

Existence of mutual assistance

Since insurance is based on the concept of mutualisation (resource pooling and risk sharing) the understanding and acceptance of the insurance mechanism is enhanced when traditions of mutual aid exist within the target population. This spirit of mutual aid may arise from a number of situations such as being members of a saving & credit group, a cooperative or workers of an enterprise, residents of the same neighbourhood, or members of a social movement.

A dynamic of socio-economic development has been initiated

It is difficult for households to make regular premium payments when they have other priority needs that strain their budgets, such as food and housing. It is also difficult in a context of sluggish monetary circulation and seasonal cash-flow. Conversely it is easier to agree to regular premium payments when a dynamic of economic development has been initiated. However, in order to facilitate access to micro-insurance it is important to design and implement an appropriate payment method. Examples include: instalments designed to suit the disrupted cash-flow; interests earned on the savings which may be used for the premium payment; deduction of the premium from the amount of a loan taken by the member, which is

not causing the burden of additional premium payment but taking the money when the member has money at hand. Furthermore, by reducing vulnerability and insecurity, micro-insurance may contribute to developing increased economic activity, which in turn facilitates the payment of premiums.

❖ *Conducive political environment*

Regulatory requirements

Insurance regulations are meant for protecting insured persons against misleading selling practices as well as the financial viability of the micro-insurance schemes. If organizations intend to establish an independent insurance business high capital requirements can obstruct the provision of insurance products to low-income groups. Small premiums cause obstacles to accumulate the required capital for receiving a licence as a formal insurer.

However, in an increasing number of countries, specific regulations which are adapted to micro-insurance organizations are being designed and implemented.

In India the Insurance Regulatory and Development Authority (Micro-Insurance) Regulations, 2005 [Official Gazette, 2005] officially recognizes and regulates the agreements between micro-insurance agents (NGOs, Self Help Groups, MFIs) and formal insurance companies (partner-agent model). For instance it specifies the list of functions that the micro-insurance agent could be authorized to perform through the agreement. It indicates also that “a micro-insurance agent shall not work for more than one insurer carrying on life insurance business and one insurer carrying on general insurance business”. It also stipulates the maximum amount (expressed in percentage of premium) of remuneration paid by the insurer to the agent for all the functions rendered including commission.

Commitment towards social protection

Micro-insurance cannot be in a position to reduce all major risks of low-income groups and poor sections of the society. The effectiveness of micro-insurance schemes is strengthened when it is integrated in national strategies of extension of social protection and risk management (see part IV).

3- Mechanisms that may supplement micro-insurance

❖ *The need for a multilevel and integrated strategy of social protection*

Taking the potential of micro-insurance into account and realizing the advantages and gaps of other existing risk management mechanisms (see part II) the need for a multilevel strategy is obvious. Such an approach combines mechanisms complementing each other at various levels. Ideally an integrated strategy of social protection should be implemented in collaboration with the government, public institutions (such as statutory social security schemes), the private sector, organizations of civil society, and self-help groups or other community-based networks (see part IV).

❖ *The linkages between micro-insurance and other risk management instruments*

Beside micro-insurance, civil society organizations support a large range of risk management instruments in order to protect their members or target groups against adverse events. These instruments include: prevention and precautionary measures, savings & emergency credit programs, and emergency & solidarity funds. These instruments are essential in order to supplement micro-insurance risk coverage, increase its impact, and reduce the future expenses (claim reimbursements) of the micro-insurance scheme.

Linkages between micro-insurance and preventive & precautionary measures

As elaborated in part II, preventive actions and precautionary measures are all the more important as low-income groups have a limited access to risks related information and are more exposed to risks than others. Although most of the preventive actions and precautionary measures cannot eliminate the risks, they can reduce their chances of occurrence or their severity. These measures are useful to micro-insurance schemes by reducing future claims and thereby the scheme's expenses.

When individuals get immunized and apply basic hygiene principles the risk of falling ill is reduced. If they undergo regular check-ups the chances of diagnosing a disease in a early stage are increased thereby reducing the cost of the necessary treatment. With lower risks and lower costs of treatment, the insurance scheme's expenses (claims) will be reduced.

Linkages between preventive and precautionary measures and micro-insurance schemes are of various natures:

- **Information dissemination**

In-service trainings like watershed management can improve the quality and quantity of crops. This does not only increase the income but also reduces the chances of crop failure, thus leading to lower premium as the number of claims can be reduced.

- **Advocacy and networking**

Improving the working conditions of the target population has a positive effect on safety at work and reduces the number and severity of accidents. Establishing cooperative networks with the aim of selling generic drugs at low price to the members may contribute to better health status and reduce the scheme's expenses.

- **Conditioning the insurance coverage to the respect of preventive and precautionary measures**

In an insurance contract against theft, the micro-insurer may require that the insured accommodations be secure enough (e.g., presence of security locks). In a disability insurance group contract, the micro-insurer may require that the director of the client factory fit the machineries with safety devices.

Linkages between micro-insurance and savings & emergency credit programs

Savings and emergency credit programs may be provided to members of the micro-insurance scheme in order to supplement the protection offered by micro-insurance, that is:

- To provide a protection against risks which are not covered by micro-insurance. Savings and emergency credit programs are particularly appropriate for minor risks that entail moderate expense and have a high probability of occurrence. These risks could consequently be taken out from the insurance plan thereby contributing to reduce the insurance premium.

The protection against health risks would include health savings for minor risks (e.g., consultation with a general practitioner, the purchase of generic drugs) and health insurance for major risks (e.g., hospitalization and complicated delivery).

- To provide a supplementary protection when adverse events financial consequences are only partially covered by micro-insurance.

In most asset micro-insurance products, the loss or damage of e.g. huts due to fire or natural disasters is not fully covered. Savings and/or emergency loans may provide the additional funds for rebuilding the hut.

Although medical savings accounts may raise problems of equity (since they limit risk sharing between the healthy and the sick, and do not provide for redistribution between the rich and the poor) and may not be an appropriate protection device for major risks (that have a low occurrence and entail high expenses), this mechanism may be a useful supplementary mechanism to insurance, particularly in case

of benefits with high co-payments (deductibles for instance). In fact, co-payments are an effective means of combating moral hazard, but, when too high, they may have the effect of limiting the accessibility of health care. Moreover, MSAs promote individual responsibility in health spending [Hanvoravongchai, 2002].

- To pre-finance expenses covered by micro-insurance in the absence of a third-party payer mechanism. After the occurrence of the adverse event the policyholder may need money for paying his/her loss immediately. If claims settlement takes too long, the insured person may need to avail a loan for bridging the time until he/she received the reimbursement from the micro-insurance. If it can benefit from a loan at a low interest rate, it brings more financial protection than going to money lenders or selling assets [Chatterjee & Ranson, 2006].
- To finance premiums payments on a regular basis. For instance, the annual interest generated on savings may be used to pay the premium.

Vimo SEWA, India has implemented two ways of paying the premium. The original method is by annual payment. Since 1993, members have had the option of payment through the fixed deposit arrangement. The deposit, which can be paid at any time of the year, must be paid in cash into the member's account in SEWA Bank, where it remains. The annual interest is used to pay the annual premium. The deposit is paid back to the woman when she reaches the age of 58. The fixed deposit arrangement brought greater security in the scheme's management since it was assured of a known size of membership and avoided problems of collecting premiums.

Linkages between micro-insurance and emergency & solidarity funds

Emergency & solidarity funds may supplement micro-insurance products notably by providing a financial compensation for benefits not provided by the schemes. They may also be useful to meet the specific protection needs of potential members with high risks such as the Elderly, the disabled, chronic ill persons or to provide coverage to the extreme poor that do not have the financial means to pay the premiums for micro-insurance.

❖ The linkages to other social protection components: social security schemes, social assistance schemes and special health programs

Civil society organizations involved in micro-insurance may assist their members to access social protection programs supported by the government or welfare funds operated by employers and employee organizations (even in the informal economy). They may for instance facilitate the access of their members to public schemes and programmes through information on these programs and the procedures of enrolment, or through the provision of assistance in registration of entitled individuals and households. They may also channel social assistance to those members that are eligible and play the role of an intermediary between the State and the recipients; they may receive public subsidies aiming at covering full or part of the contributions of the poorest members. Civil society organizations may also lobby for improved public social programs and services. They may finally participate in the design of new programs and services, in the improvement of the delivery channels of existing public funds and schemes (e.g., emergency assistance after natural disasters), in the monitoring of existing public schemes & programs with an aim to improve the quality and efficiency of the services provided (e.g., health care centres, food assistance programs, disability programs, residential dwellings and/or minimum income programs for the poor).

❖ Synthesis table of examples of measures and programs that may supplement micro-insurance coverage or increase its impact

Risk management measures and programs that may supplement micro-insurance coverage or increase its impact

	Prevention & precaution	Savings & emergency credit	Solidarity funds	Access to public programs
Life risks	Awareness raising for old-age pension	Savings Asset building Premiums payments	Burial association	Social assistance minimum pension schemes
Disability risks	Advocacy for safety at work	Savings Emergency loans	Solidarity fund for the disabled	Public assistance for disabled
Livestock risks	Training Cattle rearing Fencing cattle	Savings Productive loans		Participation in public works programs
Health risks	IEC* Immunization	Health savings Emergency loans Prepayment	Solidarity fund for HIV/AIDS	Social health insurance Public health programs

**IEC : Information – Education - Communication*

7. Examples of supplementary measures and programmes

PART IV. MICRO-INSURANCE: A COMPONENT OF SOCIAL PROTECTION

Some micro-insurance schemes (certain types of organizations covering certain types of risks or contingencies) are not only risk management instruments, but have the potential to actively contribute to the extension of social protection to excluded groups and furthermore to facilitate and improve the governance of the social protection sector and raise supplementary resources (financial means, human resources, etc.) that benefit to the social protection sector as a whole. This is particularly the case in contexts of low financial and institutional capacity of the State (low income countries).

Considering micro-insurance schemes as components of the national social protection systems has several implications, among which:

✓ Micro-insurance schemes may take over some of the social protection functions such as redistribution, with internal cross-subsidies or through the channeling of external subsidies to their members (public subsidies).

✓ Micro-insurance schemes should not only be evaluated on technical aspects (financial viability, etc.) but also on their capacity to reach social protection expected outcomes (financial protection in case of a shock, access to a minimum, efficient and relevant health package, etc.); more generally the socio-economic impact of these schemes on their members and on the non-members should be taken into consideration. A non-regulated market may fail in providing an efficient benefit package to the poor.

✓ Micro-insurance schemes have an important role to play in the promotion of empowerment and participation of their members, which has implications in terms of the design of the products, the choice of the most appropriate benefit / premium combinations, the organization of the schemes (participative decision making).

However stand-alone, self-financed micro-insurance schemes have strong limitations to become sustainable and efficient social protection mechanisms able to reach large segments of the excluded populations. Their potential as tools to extend social protection is increased when the governments recognize their interest and include them as a key dimension in their national strategies of extension of social protection, linking them to other components of the social protection systems in order to create a progressively more coherent, efficient and equitable system of social protection for all.

In any case, the decision to implement or support micro-insurance schemes is not only driven by a risk analysis but also by political considerations: on priority contingencies to cover, on populations to be targeted, on the relevance of this mechanism as compared to others, on its comparative advantages, on the possibility to link it to other mechanisms and other social protection components, in order to improve each others efficiency, to increase coverage and to progressively create more coherent and equitable systems of social protection.

Because they have a specific role, micro-insurance schemes in the context of social protection should be considered in a different way from other micro-insurance schemes (e.g., property micro-insurance (assets, livestock, housing), or credit life micro-insurance securing the reimbursement of loans) regarding in particular use of public subsidies, design of the benefit package and regulation

1- What is social security? What is social protection?

❖ Definition, objectives and key functions of social security and social protection

Social security has always been a core mandate of the ILO since its creation in 1919 and a first series of conventions and recommendations on social security were adopted before 1939.

The Declaration of Philadelphia, adopted in 1944, requires the ILO "to further among the nations of the world programmes which will achieve the extension of social security measures to provide a basic income to all in need of such protection and comprehensive medical care". The objective of implementing everywhere in the World social security schemes aiming at universal coverage was established.

According to the ILO [ILO, 2000a], social security is the protection which society provides for its members through a series of public measures:

- To offset the absence or substantial reduction of income from work resulting from various contingencies (notably sickness, maternity, employment injury, unemployment, invalidity, old age and death of the breadwinner);
- To provide people with health care; and
- To provide benefits for families with children.

Social protection is defined to include not only public social security schemes but also private or non-statutory schemes with a similar objective, such as mutual benefit societies and occupational pension schemes, provided that the contributions to these schemes are not wholly determined by market forces.

ILO's approach to social security and to social protection is set out, among other places, in the decent work strategy [ILO, 1999], which states that all men and women must be able "to obtain decent and productive work in conditions of freedom, equity, security and human dignity". One of the aims of decent work is to strengthen and extend social protection for everyone.

ILO's definition of social protection is one among a large range of approaches. Other organizations such as the World Bank and the Asian Development Bank claim more holistic conceptions of social protection, with a larger range of contingencies addressed as long as they affect individuals' income security, with various overlaps with other sector policies such as education or labour market policies (e.g., enforcement of labour standards, elimination of child labour), with not only protecting mechanisms but also promotional interventions aiming at increasing the levels of asset base or economic opportunities for the households (such as microfinance programmes, price supports or commodity subsidies).

GTZ's definition of social protection (to be written by GTZ)

Through the attainment of the core objectives mentioned previously, social protection can have also other functions.

Social protection is an important tool to prevent poverty, and strengthen the capacity to go out of poverty. The absence of social protection leads to greater chances of falling into poverty or remaining stuck in a poverty trap. Some social protection measures consisting of direct transfer of funds to the poorer (e.g., social assistance benefits that are means tested) have a direct and at least temporary effect on the level of poverty.

Social protection also contributes to poverty reduction through its positive impact on economic performance and productivity. It can be seen as a productive factor [ILO, 2005] & [ILO, 2001a], for three main reasons.

- Firstly, social protection helps people to cope with important life risks and loss of income. In doing so, it can enhance and maintain the productivity of workers and creates possibilities for new employment. For instance, health-care systems help to maintain workers in good health and to cure those who become sick. Other example, work injury schemes are playing an important role in preventing work-related accidents and sickness and in rehabilitating workers who fall victim to these.
- Secondly, social protection can be a critical tool in managing change in the economy and the labour market. For instance unemployment insurance creates a feeling of

security among the workforce which facilitates structural and technological changes and encourages individuals to undertake riskier initiatives in the production and labour market spheres, that can result in a higher return for them and for the economy overall.

- Thirdly, social protection can stabilize the economy by providing replacement income that smoothes consumption in recessions and thus prevents a deepening of recessions due to collapsing consumer confidence and its negative effects on domestic demand. For instance, unemployment benefits and old age pensions help to maintain the purchasing power of workers after they lost their job or retired.

Social protection can enhance principles such as solidarity, dignity and equality.

- Solidarity within a social protection scheme arises when every one contributes to a common pot according to its capacity and draws from this pot according to its needs (within the limits fixed by the internal rules of the scheme). Solidarity can materialize through public subsidies and redistribution of funds raised through taxes. The level of solidarity depends on the nature of the financing instruments that are being used: unlike income tax or income-related contributions that are usually progressive, consumption taxes or flat-rate premiums entail the risk of being regressive.
- Social protection is linked with the principle of dignity since it gives people the right to live a decent life whatever the adverse events. Contrary to charity, social protection integrates individuals in a process of exchange where individuals have the right to receive and the obligation to give. Giving people the possibility to give (or contribute) is fully recognizing their dignity.
- Social protection is also linked with the principle of equality (including gender equality) and non-discrimination when equal rights are given to people exposed to the same risks or supporting the same burdens without discrimination of any kind, such as race, colour, sex, ethnicity, etc.

According to the New Consensus [ILO, 2001b], “Social security should promote and be based on the principle of gender equality. However, this implies not only equal treatment for men and women in the same or similar situations, but also measures to ensure equitable outcomes for women. Society derives great benefit from the unpaid care which women in particular provide to children, parents and infirm family members. Women should not be systemically disadvantaged later in life because they made this contribution during their working years.”

The application of the principles of solidarity, dignity and equality within social protection may help to foster social cohesion, social inclusion and social peace, which are in turn prerequisites for stable long-term economic growth.

Social protection can play an ‘integrative’ role and assist in bringing back into the mainstream individuals or groups that have been excluded, by providing support in getting back into employment and becoming an active (and possibly tax-paying) member of society once again. Social protection can be justified on the basis of social inclusion related to equal citizenship. It is also a strategy for responding to social exclusion and a way of promoting greater social cohesion [Piron, 2004].

Social protection can finally be a tool to promote empowerment and participation through the representation of workers (within formal statutory social protection schemes) and that of mutual benefit associations’ members (within community based social protection schemes, mutual benefit associations). This participation is one way of enhancing democracy.

The Declaration of Philadelphia stipulates “the collaboration of workers and employers in the preparation and application of social and economic measures” (§III-e) [ILO, 1944]. The new consensus on social security [ILO, 2001b] stipulates that “In order to be effective, initiatives to establish or extend social security require social dialogue.” (§16) and states that the ILO’s technical cooperation should include a wide range of measures, in particular: “ supporting and training the social partners to participate in policy development and to serve effectively on joint or tripartite governing bodies of social security institutions” (§19).

ILO’s conception of social protection (definition, functions) is shared by many institutions worldwide. Recently, the most important international federations and organizations

representing the cooperative and mutual insurance sector and the ILO have formed the International Alliance for the extension of social protection (www.social-protection.org)¹⁴. Their shared vision, values and principles are exposed in the “Geneva consensus”, 2005. This consensus recognizes that “*Social security is a fundamental and universal human right.*” and that “*The International Labour Standards of the ILO in the area (particularly Convention 102) are the basis of reference.*” This consensus also enumerates basic principles and values regarding social protection, such as: solidarity, redistribution, role in economic and social development, importance of efficiency, relevance, good governance and financial viability, and suggests that values held by the cooperative and mutualist movement be valued (e.g., social justice, absence of exclusion and discrimination, etc.).

❖ *Right to social security*

Several international instruments affirm that every human being has the right to social security. These include: the Universal Declaration of Human Rights¹⁵, the International Covenant on Economic, Social and Cultural Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, the European Social Charter, the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights.

Universal Declaration of Human Rights: the right to social security

Art 22: Everyone, as a member of society, has the right to social security and is entitled to realization through national effort and international cooperation and in accordance with the organisation and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Art 23 (3) : Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.

Art 25 (1) : Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

One of social security areas (provision of health care) is related to a specific human right: the right to health care. Similarly this right is recognized in numerous international and regional human rights instruments. According to the Economic and social council [Economic and social council, 2000], the right to health includes notably the right to a system of health protection, which provides equality of opportunity for people to enjoy the highest attainable level of health.

¹⁴ ISSA (The International Social Security Association), AIM (The Association Internationale de la Mutualité), ICA (The International Cooperative Alliance), ICMIF (The International Co-operative and Mutual Insurance Federation), IHCO (The International Health Co-operative Organization), WIEGO (Women in Informal Employment: Globalizing and Organizing)

¹⁵ The Universal Declaration of Human Rights: articles 22 and 25.1

The International Covenant on Economic, Social and Cultural Rights: article 9

The International Convention on the Elimination of All Forms of Racial Discrimination: article 5

The Convention on the Elimination of All Forms of Discrimination against Women: article 11

The Convention on the Rights of the Child: article 26

The European Social Charter: articles 12 and 13

The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights: article 9.

In line with these international and regional human rights instruments, the Declaration of Philadelphia adopted in 1944 by the International Labour Conference assumes that “all human beings, irrespective of race, creed or sex, have the right to pursue both their material well-being and their spiritual development in conditions of freedom and dignity, of economic security and equal opportunity” (§II-a). This definition of social security as a human right is reasserted by the International Labour Conference in its 89th session, 2001: “Social security is very important for the well-being of workers, their families and the entire community. It is a basic human right (...)” (§2).

ILO’s social security conventions constitute technical extensions dealing with the practical implementation of this right [Reynaud, 2005]. The most important of these conventions is the Social Security (Minimum Standards) Convention, 1952 (No. 102). It defines nine branches of social security and the corresponding contingencies covered: medical care, sickness benefit, unemployment benefit, old-age benefit, employment injury benefit, family benefit, maternity benefit, invalidity benefit and survivors’ benefit. In addition, it introduces the idea of a general social security minimum level that must be achieved by all member States.

Convention No 102 has been subsequently completed by a series of conventions and recommendations:

- Equality of Treatment (Social Security) Convention, 1962 (No. 118)
- Employment Injury Benefits Convention, 1964 (No.121)
- Invalidity, Old-Age and Survivors’ Benefits Convention, 1967 (No.128)
- Medical Care and Sickness Benefits Convention, 1969 (No.130)
- Maintenance of Social Security Rights Convention, 1982 (No. 157)
- Employment Promotion and Protection against Unemployment Convention, 1988 (No.168)
- Maternity Protection Convention, 2000 (No.183)

To take into account the different national situations, most of these norms contain flexibility clauses in terms of the population covered as well as the scope and level of benefits provided. They also give to the States full scope on the organisation of their social security scheme. In other words, these conventions derive from the international instruments that affirm the right of everyone to social security, but at the same time they recognize the major practical difficulties in actually implementing this right in the various social realities that prevail worldwide.

Definition of social security as a human right starts from the principles of universality and equality: every human being is equally entitled to social security, which has two major implications.

First implication: States have some kind of obligation regarding the right to social security / social protection [Maastricht Guidelines, 1997] ¹⁶. They have the obligation to fulfill this right i.e. they have to take appropriate legislative, administrative, budgetary, judicial or other measures to ensure the full realization of the right. Social protection schemes to provide minimum social security to all would come under this obligation – though the obligation does not necessarily mean that the State has to directly provide social protection; it can facilitate or encourage actions of third parties.

¹⁶ Other elements than the conception of social protection as a basic human right may require State’s intervention in the delivery, financing and regulation of social protection mechanisms. Some of these mechanisms are public goods, that cannot be efficiently delivered without State’s intervention. Among social protection areas, State’s intervention is above all required to provide access to health care, since health is being recognized as populations priority need (Source : Millenium poll, United Nations, New York, 2000), is one of the components of Human Development and therefore one of the ultimate goals of development (Source : UNDP Human Development report 2003), and is included in four of the Millenium Development goals (namely MDGs n° 1, 4, 5 and 6) that have been adopted by 189 States in september 2000.

- Obligation can be of conduct: States have to take the necessary steps to realise a particular right. This would include an obligation to take steps towards ensuring the realization of social security and more broadly developing a social protection strategy. Other actors of society (e.g., local communities, health professionals, intergovernmental organizations, civil society organizations, as well as the private business sector) may also play a part in the progressive implementation of this right or the denunciation of its violation, although they are not ultimately responsible for its realization.
- Obligation can also be of result: States have to achieve specific targets to satisfy a specific standard. In this case, States are obligated to actually ensure social protection in line with the policy and legislative framework they have adopted.

In addition, there is some sort of, but so far unofficially recognized, obligation of the international community to support States with insufficient resources for the realization of human rights standards, including right to social security. This is in line with the idea behind the Global Fund for Malaria, Tuberculosis and HIV.

Second implication: everybody is entitled to a minimum of social protection, without exception or discrimination. This claims for an equitable access to social protection, independently of individuals age, sex, health status, location, type of occupation or level of income. This entitlement to a minimum of social protection is often put forward in order to justify the design and implementation of equity subsidies between the rich and the poor.

❖ *Gaps between right and reality*

In many developing countries, however, social protection coverage is dramatically low: it reaches a very limited proportion of the population and provides protection against only a limited range of risks [Reynaud, 2002]. In sub-Saharan Africa and South Asia it is estimated that only 5 to 10 percent of the active population is covered by a statutory social security scheme, most of these being old-age pension schemes, in some cases providing also access to health care. Although the situation is less dramatic in other parts of the world, it can be taken that worldwide only 20 per cent of workers enjoy adequate social protection. In some cases the percentage of covered population is even shrinking, in particular as a result of structural adjustment policies, privatisation and the development of the informal economy. Although some excluded people work in the formal sector (e.g., in Cape Verde: members of liberal professions, employees in civil engineering firms), the large majority is active in the informal economy: employees in small workplaces, self-employed workers.

Until the last decade, social protection strategies were in fact designed with the idea that the formal economy would progressively gain ground on the traditional economy and therefore that social security systems would progressively cover a larger proportion of the working force. But this trend did not come true since in many developing countries, and particularly in Latin America and Africa, most of the jobs created during the last decade have been in the informal economy [ILO, 2002a]. Today, informal employment comprises one half to three-quarter of non-agricultural employment in developing countries: 48 per cent in North Africa, 51 per cent in Latin America, 65 per cent in Asia and 72 per cent in sub-Saharan Africa (78 per cent if South Africa is excluded). If informal employment in agriculture is included in the estimates, the proportion of informal employment increases significantly: from 83 per cent to 93 per cent in India, from 55 percent to 62 per cent in Mexico and from 23 per cent to 34 per cent in South Africa [ILO, 2002b]. Statutory social security schemes' attempts to extend coverage did exist in some countries, but remained insufficient.

❖ *Priority to extend social protection coverage and possible strategies*

It is therefore necessary to find supplementary ways to translate the right to social protection into appropriate operational, organizational and institutional arrangements. This priority to extend coverage ensues from the principles of universality and equality mentioned before and was reaffirmed by the International Labour Conference in its 89th session, 2001, where governments, employers' and workers' organizations agreed that "Of highest priority are policies and initiatives which can bring social security to those who are not covered by existing systems." (§5) [ILO, 2001b]. The ILC 2001 proposes several ways of extending coverage: "When coverage cannot be immediately provided to these groups, insurance — where appropriate on a voluntary basis — or other measures such as social assistance could be introduced and extended and integrated into the social security system at a later stage when the value of the benefits has been demonstrated and it is economically sustainable to do so. Certain groups have different needs and some have very low contributory capacity. The successful extension of social security requires that these differences be taken into account. The potential of micro-insurance should also be rigorously explored: even if it cannot be the basis of a comprehensive social security system, it could be a useful first step, particularly in responding to people's urgent need for improved access to health care. Policies and initiatives on the extension of coverage should be taken within the context of an integrated national social security strategy." At the suggestion of the Conference, the ILO launched in 2003 the "Global Campaign on Social Security and Coverage for All".

Facing present situation where a large (and growing) number of persons are excluded from social protection and where existing social protection schemes provide most of the time insufficient levels and scope of coverage, it is necessary to conduct proactive strategies to extend social protection. These strategies aim at increasing the number of persons covered and at improving the level and the scope of existing social protection benefits. There is a large range of mechanisms that can be used to implement these strategies.

- Social insurance schemes can extend existing or modified benefits to previously excluded groups or contingencies, either on a compulsory or voluntary basis. They may also enhance their effectiveness through improved governance and design.
- Special social insurance schemes can be set up for excluded groups.
- Universal benefits covering the whole target population without any condition or income test (for instance, those over a certain age) can be implemented.
- Social assistance programs targeting specific vulnerable groups can also be implemented: waivers, social pensions / cash benefits, conditional cash transfers (for instance on school attendance).
- A complementary option is to encourage and support the development of micro-insurance and innovative decentralized social security schemes to provide social protection through communities, social partners or civil society organizations.

Following examples illustrate part of the variety of paths that can be followed and the multiplicity of actors involved.

Some countries managed to include new categories of workers within compulsory health insurance schemes. It is the case of the Republic of Korea [Kwon, 2002] which has gradually extended compulsory health insurance to all workers over a period of 12 years (from 1977 to 1989): wage earners of large corporations with more than 500 workers were first to be covered, government employees and teachers came next, followed gradually by workers in increasingly small enterprises. Extension to the self-employed began through pilot programmes before being generalized.

Extension of social insurance on a voluntary basis goes not very often gain much success. In Senegal [Fall, 2003] a special social protection scheme for the workers in the informal economy was implemented in 1996, ie at the inception of the health mutual benefit associations movement in this country providing coverage of various social risks but living workers free to seek coverage for one or several risks. The contributions were not based on

the actual income of the workers (for difficulties of assessment) but on a flat rate. Insufficient information and communication on the programme, and a too high level of requested contributions (compared to the willingness to pay of the target population) explain that the programme did not gain much success (1,000 workers had joined in 2000).

Some others chose to develop special public schemes for excluded groups. In Uruguay [Reynaud, 2002], precise understanding of the characteristics of different excluded categories of workers in the informal economy, namely construction workers, domestic servants and the self-employed, led to the design of specific arrangements for each category: one scheme covering construction workers for old-age pensions, sickness, family and employment injury benefits; a health insurance scheme for domestic servants; and coverage for the self-employed by the country's main social security institution for old age pensions, survivors, invalidity and sickness benefits.

Welfare funds represent one of the models developed in India for providing social protection to workers in the informal economy. They are occupation based and financed by levying a cess on the production, export or sale of specific goods, or by collecting contributions from various sources including employers and employees. These funds have been promoted and implemented by Central government and State governments. The Beedi workers¹⁷ Welfare Fund was created in 1976 by the Central government; it is financed by a cess in the nature of an excise duty on manufactured beedis. The benefits provided include among others: scholarships, coverage of cost of treatment in dispensaries and hospitals, maternity benefits.

When these special schemes are to include very poor households, it is usually necessary that subsidies of the contributions be implemented. These subsidies may be financed from the fiscal budget and/or through transfers of the active contributors to the social insurance system, such as in Colombia (Régimen Subsidiado de Salud), see further § 3 section *The development of linkages*.

In Brazil [Swarzer; Querino, 2002] the health care services have been transferred in the mid-1980s from social insurance to the Health Ministry and eventually decentralized in the 1990s to States and municipalities. The services were transferred into a universal basic health care system, which offers primary, secondary and tertiary health care, in principle for any person without charge.

Some developing countries, particularly in Latin America, have set up tax-financed cash benefit schemes that provide basic income security for those in need. They are generally targeted to categorical groups (elderly people, widows and children) who have few or no potential links with the labour market. Benefit levels are frequently lower than the poverty line, but they appear to be a welcome supplement to family income and encourage the integration of children and elderly into the household [Van Ginneken, 2003].

Among these programmes, conditional cash transfers provide money to poor families contingent upon a certain verifiable actions, such as sending children to school or bringing them to health centres on a regular basis. CCT programs have been successfully implemented on a large scale in several middle-income, high inequality countries such as Brazil, Chile, Colombia, Ecuador, Jamaica, Mexico, South Africa and Turkey [Rawlings; de la Brière, 2006]. Examples include the so-called PROGRESA (Programa de Salud y Educacion) in Mexico and Bolsa Familia in Brazil. The CCT programmes in Latin America have had reasonable success in meeting their basic welfare objectives, namely reducing short-term poverty through increased total and food expenditures, decreased malnutrition among young children, higher educational enrolment, lower dropout and repetition, and reduced child labour. The cost of these programs does not usually exceed 0.5% of GDP (0.32% in Mexico, 0.36% in Brazil).

In addition, various forms of linkages can be developed between the different schemes and other public policies, including a wide range of public-private or public-third sector partnerships.¹⁸

BOX PPP to be written by GTZ

¹⁷ Beedi workers are cigarettes rollers.

¹⁸ For a typology of the different possibilities, see [Kannan, 2004].

2- What are the current potentials and limitations of micro-insurance as a mechanism of extension of social protection?

As said previously, ILO considers that it is the States' responsibility to define their own social protection policy and to design the organization of their social security schemes. Some of them may consider micro-insurance to be a tool for the extension of social protection, and may include this mechanism in their strategies of extension.

❖ *Types of micro-insurance schemes concerned*

It is necessary to precise that not all micro-insurance schemes may play a role in the extension of social protection. The importance of some micro-insurance products is recognized and supported, although these products are not strictly speaking providing social protection coverage. It is the case of assets, livestock, housing, car accidents micro-insurance. It is also the case of credit life and credit disability micro-insurance that merely consist in covering the repayment of the outstanding balance of the loan in case of death / disability of the borrower, although life and disability are part of the contingencies listed in ILO Convention 102. On the contrary some micro-insurance products such as health micro-insurance (hospitalisation, primary health care, maternity, etc.), life, old age pensions, disability and loss of income are entering into C 102's list of contingencies, and may thereby play a role in the extension of social protection.

❖ *Positive contribution of micro-insurance in the extension of social protection*

In a context of low financial and institutional capacity of the State (low income countries) micro-insurance schemes may raise supplementary resources (financial means, human resources, etc.) that benefit to the social protection sector as a whole and contribute to facilitate and improve the governance of the social protection sector.

More specifically, health micro-insurance schemes contribute to improve access to health care: utilization of health services is facilitated through the reduction of the financial barriers that delay access, in some cases quality of care is improved when the scheme signs agreements with health care providers on the quality of delivery (availability of medicines, effective presence of the health care staff, effective use of treatment protocols, etc.). Contracting with health care providers also contributes to increase transparency in billing and invoicing practices and thereby to improve the way the health sector is managed.

Micro-insurance has also several positive effects in terms of participation of civil society, empowerment of socio-occupational groups including women. Since many schemes are being set up and operated by women's associations they may contribute to strengthen women's capacity to meet their health needs including those linked with their reproductive role.

Moreover, micro-insurance as a mechanism of extension has several added values or comparative advantages as compared to classical social security schemes.

1- Micro-insurance has a good capacity to reach groups excluded from statutory social insurance, such as most categories of the workers in the informal economy and rural workers.

2- The transaction costs necessary to reach these populations are reduced, since micro-insurance schemes are often operated by decentralized civil society organizations that are usually implemented in the vicinity of their target populations; their staff includes social workers that are used to work and communicate with these populations; etc.

3- Micro-insurance benefits package are most often designed in close partnership with the target population. This participation is highest in mutual benefit associations where the choice of the package is the result of a voting in the general assembly. In other types of micro-insurance schemes, less participative, the target groups are usually consulted for instance

through households surveys. As a result, the benefits package is often customized i.e. responding to the coverage needs of the target population with affordable contributions.

4- Small community-based micro-insurance schemes usually record less problems of frauds and abuses than centralized systems of social protection since members often know each other, belong to the same community and share the same interests. This social vicinity may help also in the distribution of the product. However it raises the problem of the sustainability of small scale schemes and that of the weak social pressure to pay contributions on a regular basis resulting in high levels of drop out. Some schemes manage this issue of drop out (law renewal / repayment rates) through the implementation of group insurance contracts with organized occupational groups (such as cooperatives).

❖ Current limitations of micro-insurance as a mechanism of extension of social protection

The development of micro-insurance is ongoing, with a kind of proliferation of new schemes. This shows that these schemes respond to a real demand and that they manage, at least at the local level, to solve a certain number of issues.

India's 2003/2004 inventory published in 2005 [ILO-STEP, 2005b] found 60 micro-insurance schemes covering 5 200 000 people. The inventory is being updated ; the current (beginning 2006) number of scheme stands at 71 covering more than 6 800 000 people.
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It seems however that this development faces problems that limit micro-insurance schemes' contribution to the extension of social protection:

1- The total population covered in most countries is far from reaching the target (populations excluded from legal social protection schemes). In fact, many of these schemes (particularly in Africa) have great difficulties in extending their geographic or socio-occupational outreach and in increasing the size of their membership.

2- Many micro-insurance schemes have poor viability and sustainability.

These 2 points are linked (particularly in Africa) with poor management skills (not enough financial resources in order to hire professional staff) and information systems (difficulties to produce information and monitor the scheme's operations).

3- Members' ability to pay is most often very low, which leads also to a very limited coverage in the absence of subsidies.

4- Most of these schemes do not take over the functions that are usually played by statutory social security schemes such as redistribution / solidarity between richer and poorer segments of the population (since contributions in such schemes are very often flat rate), and do not reach the poorest segments of the excluded groups (those that cannot contribute).

5- In many countries the legislative framework and regulations are not adapted to these schemes and do not facilitate their extension.

6- Micro-insurance schemes are most often self-governing organizations. They may pursue objectives that are not in line with government's strategy of social protection and their promoters may be unwilling to participate in the design and set up of national systems of social protection for this participation would challenge the schemes' autonomy.

3- How can micro-insurance be used to achieve the extension of social protection?

An increasing number of States consider micro-insurance to be a tool for the extension of social protection, and include this mechanism in their strategies of extension. In several countries micro-insurance schemes are already part of the process of designing and

implementing progressively more coherent and integrated social protection systems: in India the partner-agent model contributes to increase the formal acceptance of these schemes; in Senegal micro-insurance schemes are mentioned in the national social protection strategy as key mechanism to extend social protection; in Rwanda and Ghana, the State implements nation wide social protection schemes in health that are built on district and community based mutual organizations.

To overcome the limitations mentioned above one suggest three pathways (developed in following paragraphs): First that the further development of micro-insurance be enhanced and accelerated (in terms of population covered, scope of the benefits package, technical and financial capacities of the schemes, etc.); Second that linkages be developed¹⁹ with other actors and institutions (e.g., outsourcing of management functions) as well as other components of social protection and the health sector (contracting with health care providers at local level but also defining contractual frameworks at national level); Third that micro-insurance be further integrated in coherent and equitable national systems of social protection.

❖ *The further development of micro-insurance*

This further development has implications for various actors, particularly the State and the promoters / operators of micro-insurance schemes.

The State may support this development through increased efforts of promotion of micro-insurance and sensitization of the public opinion (particularly the target populations). It may also support this development through the improvement of design management and monitoring of micro-insurance schemes. The State could for instance support structures aiming at providing technical support and training to micro-insurance schemes' operators. It could facilitate the share of experiences between actors (e.g., development of networks) and the access to information and knowledge, also to make sure that isolated experiences can be replicated to other groups or geographic areas. Governments could more specifically (such as in Cambodia's Master Plan) formulate recommendations on design: benefits package, affiliation, administration, payment methods of health care providers; they could implement mechanisms aiming at strengthening the viability of the schemes (management information systems) and their financial capacities (e.g., reinsurance mechanism, guarantee funds); they could also set up structures able to produce information (statistics, indicators) on these schemes and to monitor the performance of micro-insurance schemes. The State could finally promote public-private partnerships (see further, paragraph on linkages).

In Cambodia the Master Plan for Social Health Insurance in Cambodia recommends the set up of Community Based Health Insurance schemes that respond to certain characteristics in terms of levels of contributions (flat rate corresponding to not more that 4% of the family income), type of affiliation (all the members registered in the family book are registered in the CBHI), benefit packages (list of services to be covered), payment methods with health care providers (capitation mode of payment), etc. [WHO Cambodia, 2003].

For promoters and operators of micro-insurance schemes this further development may in some cases mean altering the way the schemes currently operate: making their management become more professional which goes hand in hand with challenges (e.g., increased complexity) that many promoters and operators of micro-insurance are not yet ready to face; outsourcing some of their management functions to other more specialize organizations (see next paragraph on linkages). It may also mean setting up new schemes targeting the members of already large organizations (trade unions, cooperatives, occupational associations, etc.). In fact, schemes with larger membership are in a position to provide more comprehensive

¹⁹ Note: This second pathway may contribute both to the development of micro-insurance and to its integration in national systems of social protection.

coverage to their members (particularly against major risks like hospitalization) and are often more sustainable (for instance, they can more easily build up financial reserves).

❖ *The development of linkages*

Linkages are all sorts of relations that may be developed between a micro-insurance scheme and other organizations, institution or systems. They may be classified according to the types of mechanisms used and to the actors (or partners of micro-insurance schemes). Following typology is not exhaustive.

Mechanisms	Actors / partners
Subsidies (local, national, international)	Other micro-insurance schemes, Federations of schemes
Contracting with health care providers	Civil society organizations, MFIs, trade unions, networks of cooperatives ...
Outsourcing management functions	Health care providers
Technical advise	Service providers: TPAs ...
Financial consolidation (reinsurance, guarantee funds)	Private sector, pharmaceutical industry
Distribution of insurance products	Central and local governments
Distribution of public goods (immunization, social assistance)	Public health programs
Bargaining	Social assistance programs
Exchange of information, practices	Social security schemes, Private or public insurers
Regulation, control	International cooperation

Linkages aiming at improving the functioning of the schemes

The sharing of functions / responsibilities according to each others core competences and scope of activities (with other schemes or with service providers such as TPAs) may create economies of scale and make the micro-insurance schemes become more efficient. Examples of linkages include: outsourcing management functions to Third Party Administrators (TPAs) in India, distribution of formal insurance companies' products in the Indian partner-agent model, creation of economies of scale and of a bargaining power through the grouping of micro-insurance schemes (such as emerging African federations).

Functional linkages may also be established with other components of social protection; they contribute to improve the coherence of the national system of social protection. Examples of linkages include: channeling social assistance and social services to eligible members; distribution of social insurance services. These linkages have to be defined in national master plans.

In the Philippines, Philippine Health Insurance Corporation (PHIC), or "PhilHealth", has a mandate to achieve universal coverage by 2012 [GTZ-ILO-WHO, 2005]. One of the paramount challenges is to provide health insurance coverage to workers in the informal economy which is estimated at 19.6 to 21.7 million workers or approximately 70% to 78% of employed population. In response to this challenge, PhilHealth approved the Board Resolution No. 569 (PBR 569) in June 2003 which allowed partnerships with organized groups on a pilot basis. The partnership, called PhilHealth Organized Group Interface (POGI1), is seen as an innovative approach to reach out to workers in the informal economy through micro-credit cooperatives. The initiative is being tested with six (6) cooperatives in Cavite and five (5) cooperatives in Southern Leyte agreeing to enter into a partnership with PhilHealth. The cooperatives act as marketing and premium collection agents for PhilHealth.

As far as health micro-insurance schemes are concerned, the decentralization of the health care sector and the design and implementation of a contractual framework between micro-insurance schemes and health care providers as well as a set of tools may facilitate the establishment of contractual arrangements with health care providers.

In Senegal most of the mutual health organizations sign contractual agreements with health care providers but the relation is often unbalanced (information asymmetry) and the mutual has no real means to compel the health care provider to respect its commitments. To face this problem the Ministry of health recognized the necessity to design a contracting framework that gives guidelines and concrete tools to facilitate the contracting process: stages in the design of an agreement, minimum content of an agreement, commitments of both parties (including financial aspects, invoicing and payment methods), monitoring tools and procedures, State's role and implication. A working group has been created in 2006 in order to design a first draft of this framework that will next be presented to the actors involved (mutual health organizations and their federations, ministry of health, health care providers, support structures, social partners, etc.).

Linkages for redistribution

Micro-insurance schemes can constitute mechanisms of redistribution of public subsidies (e.g., premiums subsidies coming from the statutory social insurance system or equity funds) that can help to provide poorer households or individuals with low contributive capacity and / or high social risks (e.g., the Elderly, the chronic ill, some occupational groups) with a package of social protection. Such mechanisms are legitimate as far as they aim to provide an equitable access to social protection (independently of individuals' characteristics and financial capacity). Beside their redistribution role these subsidies also make the beneficiary micro-insurance schemes more attractive and contribute to increase their membership.

Within the reform of the health care system in Colombia [Pérez, 1999] in the 1990s, a special scheme (Régimen Subsidiado de Salud) was introduced to finance health care for the poor and vulnerable groups (including their families) who are unable to pay contributions to the general insurance scheme. The funds are raised through a solidarity contribution collected under the contributory social insurance scheme (50%) and a State subsidy (50%). They are then channelled to several institutions (including 8 mutual benefit associations and several private insurance institutions) that are managing the scheme. Today this subsidized scheme covers 8 million people.

The mission of the GLOBAL SOCIAL TRUST Network is to systematically reduce poverty in developing countries through a partnership that invests in and sponsors the development of sustainable national social protection schemes for people and groups which have been excluded from the economic benefits of development. The basic idea is to request people in the richer countries, i.e. OECD countries, to contribute on a voluntary basis a rather modest monthly amount (say €5 per month or about 0.2 per cent of their monthly income) to a GLOBAL SOCIAL TRUST which will be organized in the form of a global network of National Social TRUSTs supported by the ILO, which will then: invest these resources to build up basic social protection schemes in developing countries; and sponsor concrete benefits for a defined initial period until the basic social protection schemes become self-supporting.

For more detailed information:

<http://www.ilo.org/public/english/protection/socfas/research/global/global.htm> [2006]

❖ *The integration in coherent and equitable national systems of social protection*

Providing social security to citizens remains a central obligation of a society as a whole. Government has to organise the access to and level of services through legislative and regulatory means. This does not mean that all social security schemes have to be operated by public or semi-public institutions. Governments can delegate its responsibility to various institutions and organisations in the public, private, co-operative and non-profits sectors. What is needed, however, is a clear legal definition of the role of the different players in the provision of social security to all members of a society. The definition of these roles should be complementary while achieving the highest possible level of protection and coverage. A government could develop a social security development plan that defines the scope and coverage of public provision of services through government agencies, social insurance, private insurance, employers and micro-insurance schemes. It is therefore desirable that governments and social partners explicitly recognise micro-insurance as a tool for the extension of social protection, which implies that micro-insurance be integrated in national

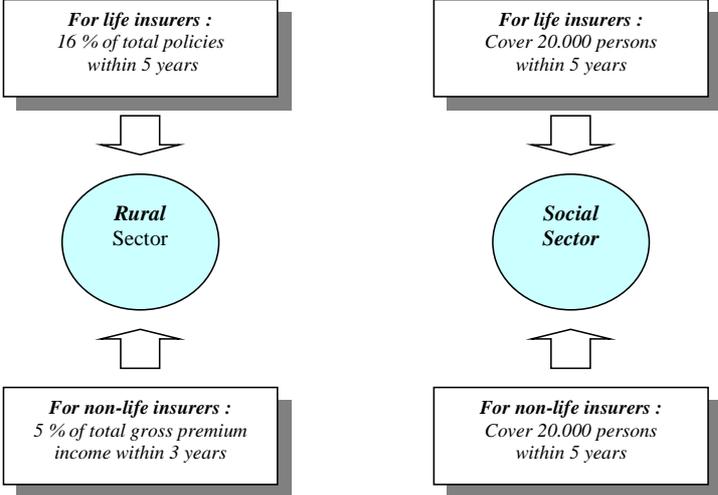
strategies of extension of social protection, health development and poverty reduction (e.g., PRSPs). The role of *health* micro-insurance in an overall health financing policy coordinated by the State should be as well recognized. The overall aim of such a policy is universal access to health, based on pluralistic financing structures.

In Cambodia the government recognizes the potential of social health insurance as a major health care financing method in the future. Cambodia’s Master Plan for Social Health Insurance recommends – in order to reach universal health insurance coverage - to follow a parallel and pluralistic approach which comprises: (1) Compulsory social health insurance through a social security framework for the public and private salaried sector workers and their dependants; (2) Voluntary insurance through the development of community based health insurance schemes (CBHI) and (3) Social assistance through the use of equity funds and later government funds to purchase health insurance for non-economically active and indigent populations [WHO Cambodia, 2003].

The design and adoption of appropriate legal frameworks is a key step towards this integration. Such a framework may specify – among others - the role of micro-insurance in the national system of social protection and introduce a set of rules and institutions for the supervision of the operations of micro-insurance schemes: regulatory body (e.g. ministry in charge), procedures of agreement, etc. Legislative frameworks may moreover be a strong factor of development of these schemes. On the opposite, frameworks with too high financial requirements or a too strong supervision from the public authorities may restrain this development.

ILO / STEP supports the construction of a regional framework for the development of health mutual benefit organizations in several UEMOA countries (Benin, Burkina Faso, Mali, Niger, Senegal) and, within this framework, the design and implementation of national legislations that will regulate mutual benefit organizations and support their development.

In India the Insurance Regulatory and Development Authority (IRDA) adopted in 2002 regulations aiming to extend the insurance coverage to the rural sector (cultivators, agricultural labourers, workers in livestock, forestry, fishing, etc.) and social sector (unorganised sector, informal sector, economically vulnerable or backward classes both in rural and urban areas) [ILO-STEP, 2005c].



The insurance companies falling into the scope of the IRDA regulations will have to comply to the following obligations:

- life insurers have to sell 16% of total policies within 5 years in the rural sector, and cover 20 000 persons within 5 years in the social sector;
- non-life insurers have to earn 5% of total gross premium income within 3 years in the rural sector and cover 20 000 persons within 5 years in the social sector.

This development is further strengthened through the Insurance and Development Authority (micro-insurance) Regulations, 2005 which officially recognizes the micro-insurance partner-agent model [Official Gazette, 2005].

8. IRDA regulations

The supervision of micro-insurance schemes’ internal regulation, operations and financial statements, are moreover useful to check that these schemes effectively contribute to an equitable access to social protection and are accountable for the efficient use of public funds (e.g. tax financed funds channeled to subsidize the premiums of the poorest members of these schemes).

For the promoters of micro-insurance, the integration in national systems of social protection has various implications. The benefits package that they provide should include an insurance

coverage against one or more social protection contingencies (Cf. those listed in C 102). Moreover, when a minimum guaranteed package of social protection has been defined by the legislation, these schemes should provide this minimum coverage to all their members. Micro-insurance schemes' internal regulations should abide by the principles of equity defined by legislation (if any). Rules such as the exclusion of members over a certain age or calculation of premiums based on individuals' risks may not be in line with such principles. If micro-insurance schemes are to receive public financial support (such as equity subsidies) they should be accountable for the efficient use of these public funds. This implies that strict rules of management and accountancy be enforced and that micro-insurance schemes' operation and management be more professional. Micro-insurance schemes should also agree that their financial statements be supervised by a public or independent regulatory body.

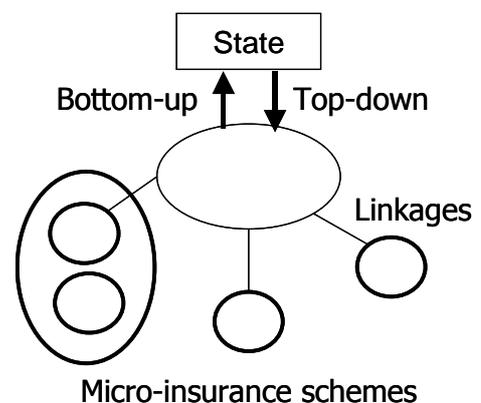
More generally it is important that promoters and operators of micro-insurance be involved - either directly or indirectly (through groupings and federations of schemes representing their interests) - in national consultations and negotiations with the State and other stakeholders (social partners, legal/statutory social security schemes) on social protection issues, such as the design and implementation of national strategies of social protection.

Such integration needs that a climate of trust and confidence be created between operators of schemes, networks and federations of schemes, other civil society organizations representing the populations covered by these schemes (trade unions, cooperatives, etc.) and the government.

❖ *The dynamic of extension using micro-insurance*

The dynamic of extension of social protection may be fed by:

- ✓ Bottom-up initiatives: further development of micro-insurance, advocacy, sensitisation of public opinion, policy makers, donors and development agencies as well as social partners, and other social protection components.
- ✓ The development of linkages: with other micro-insurance schemes, with health care providers, with service providers such as TPAs, with social security institutions, etc.
- ✓ Top-down efforts: recognition of the potential for micro-insurance by a number of actors including social partners, local and central governments, supporting structures and donors, etc.; willingness to organize coherent social protection systems including micro-insurance schemes.



9. Micro-insurance and the dynamic of extension of social protection

In Senegal, joined efforts of a large number of actors (civil society organizations, the State, local governments, social partners, support structures and donors, health care providers) have contributed to accelerate the process of extension. Several events have been significant:

- in 2003 : the law on mutual health organizations was adopted, a national concertation framework on the development of mutual health organizations was created, the national committee on social dialogue (Comité National du Dialogue Social, CNDS) in charge of the implementation of the national charter on social dialog was created as well.
- in 2004 : the global campaign on social security and coverage for all was launched in Senegal, the trade union of transport operators (Syndicat National des Travailleurs des Transports Routiers du Sénégal, SNTRRS) included in its claims platform social protection issues ; the Law on agriculture, forestry and breeding (Loi d'Orientation Agro-Sylvo Pastorale, LOASP) that plans the design and implementation of a social protection scheme for rural workers was adopted.

These events or elements have been integrated in the logical framework of the national strategy of extension of social protection and risk management (SNPS/GR) formulated in 2005 with the active participation of a large number of actors. This strategy aims at extending social protection from 20% to 50% of the population by 2015 through the design and set up of new schemes responding better to the priority needs of the informal economy workers.

These events and the national strategy formulation lead in 2006 to the conduct of feasibility studies aiming at the design and establishment of two nation-wide social protection schemes: one for the transport operators and their families (target population of 400 000 people) and the other for the rural workers and their families (target population of 5 000 000 people).

CONCLUSION

This guidelines starts with the statement of the need for protection against risks and enumerates the various mechanisms or options to deal with risk. One of these mechanisms, namely micro-insurance, may be useful to face risks.

Micro-insurance is a technical notion that encompasses a large diversity of organizations: mutual benefit organizations in western Africa, micro-insurance schemes set up and operated by health care providers, NGOs or MFIs providing an insurance service to their members in partnership with a public or private insurance company (partner-agent model), etc. These schemes may cover various risks or contingencies: health, life, assets, crops, etc. The decision to implement or support micro-insurance schemes should not be made without a thorough assessment on priority contingencies to cover, on the relevance of this mechanism as compared to others, on its comparative advantages, on the existence or absence of conducive conditions (internal / external factors for success), on the possibility to link micro-insurance to other mechanisms in order to improve each others' efficiency.

Some micro-insurance schemes (certain types of organizations covering certain types of risks or contingencies) are not only risk management instruments, but have the potential to actively contribute to the extension of social protection to excluded groups and furthermore to facilitate and improve the governance of the social protection sector and raise supplementary resources (financial means, human resources, etc.) that benefit to the social protection sector as a whole. This is particularly the case in contexts of low financial and institutional capacity of the State (low income countries). However stand-alone, self-financed micro-insurance schemes have strong limitations to become sustainable and efficient social protection mechanisms able to reach large segments of the excluded populations. Their potential as tools to extend social protection is increased when the governments recognize their interest and include them as a key dimension in their national strategies of extension of social protection, linking them to other components of the social protection systems in order to create a progressively more coherent, efficient and equitable system of social protection for all. Because they have a specific role, micro-insurance schemes in the context of social protection should be considered in a different way from other micro-insurance schemes (e.g., property micro-insurance or credit life micro-insurance securing the reimbursement of loans) regarding in particular use of public subsidies, design of the benefit package and regulation.

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