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IMPROVING CLIENT VALUE FROM MICROINSURANCE: INSIGHTS FROM INDIA, KENYA, AND THE PHILIPPINES

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PREFACE

The primary goal of the International Labour Organization (ILO) is to contribute with member States to achieve full and productive employment and decent work for all. The Decent Work Agenda comprises four interrelated areas: respect for fundamental worker's rights and international labour standards, employment promotion, social protection and social dialogue. Broadening the employment and social protection opportunities of poor people through financial markets is an urgent undertaking.

Housed at the ILO's Social Finance Programme, the Microinsurance Innovation Facility seeks to increase the availability of quality insurance for the developing world's low-income families to help them guard against risk and overcome poverty. The Facility, launched in 2008 with the support of a grant from the Bill & Melinda Gates Foundation, supports the Global Employment Agenda implemented by the ILO's Employment Sector.

Research on microinsurance is still at an embryonic stage, with many questions to be asked and options to be tried before solutions on how to protect significant numbers of the world's poor against risk begin to emerge. The Microinsurance Innovation Facility's research programme provides an opportunity to explore the potential and challenges of microinsurance.

The Facility's *Microinsurance Papers* series aims to document and disseminate key learnings from our partners' research activities. More knowledge is definitely needed to tackle key challenges and foster innovation in microinsurance. The *Microinsurance Papers* cover wide range of topics on demand, supply and impact of microinsurance that are relevant for both practitioners and policymakers. The views expressed are the responsibility of the author(s) and do not necessarily represent those of the ILO.

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CONTENTS

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We are heavily indebted to the staff of organisations that participated in the PACE tool testing for taking their time, sharing data and providing useful comments on the final analysis. We would like to thank Denis Garand, Craig Churchill and the rest of the Facility team for useful guidance in developing the PACE framework and tool. We are grateful for comments on the first draft from Liz McGuiness, Michael J. McCord, Barbara Magnoni, Rick Coven, Pranav Prashad, Peter Wrede and Denis Garand. Aparna Dalal edited the final version of the paper and contributed substantially to improve its presentation.

EXECUTIVE SUMMARY

As microinsurance providers, governments and donors try to provide better value to clients, they are faced with the same questions: are clients benefiting from microinsurance? How do we measure those benefits? How do we improve the value proposition for the clients?

This paper contributes to this discussion by focusing on *improving* client value rather than *proving* it. It presents results from the analysis of 15 microinsurance schemes using the ILO's client value assessment tool called PACE (Product, Access, Cost and Experience). The PACE tool looks at the added value for clients from insurance products by comparing them to each other and to alternative means of offering protection from similar risks (including informal mechanisms and social security schemes). Informal mechanisms and social security schemes provide a benchmark to assess the value of microinsurance in the context of other risk management options.

Using PACE to identify value creation opportunities

The tool is structured into the following main dimensions:

Product: describes appropriateness by reviewing coverage, benefit level, eligibility criteria and availability of value-added services

Access: focuses on accessibility and simplicity by investigating choice, enrolment, information, education, premium payment method and proximity

Cost: measures both affordability and value for money, while looking at additional costs to keep down overall costs of delivery

Experience: assesses responsiveness and simplicity by looking at claims procedures and processing time, policy administration, product tangibility and customer care

One key aspect that differentiates PACE from other client value assessment tools is that PACE looks at both product specifications and related processes. Often, the problem with microinsurance schemes is that processes to enable access or to service claims are poorly designed and undermine the value of the products. By evaluating current processes from the client perspective, PACE can identify improvement opportunities.

Consider the claims settlement process. Settling a claim is when insurance becomes tangible for clients, and it provides an opportunity for insurers to build trust and increase loyalty. For the composite products reviewed in Kenya, the PACE analysis found that the list of required documents for some of the products reviewed products is often too long; and it is not clear whether the additional paperwork makes any contribution to the insurer's controls, but it definitely deteriorates the clients' experience. These processes can be simplified, as illustrated by MicroEnsure, by reducing documentation requirements for verification and allowing for the use of village head certificates and affidavits. In the Philippines, the PACE analysis points to several good examples of client value enhancements. Providers like CLIMBS and CARD pay the funeral benefit component of the policy within 24 hours, while the rest of the life benefit is paid slightly later and is subject to more documentation.

Results from the PACE analysis in Kenya, India and the Philippines

The results from the PACE analysis of 15 microinsurance schemes in Kenya, India and the Philippines show that there is a place for microinsurance to add value on the top of informal risk-sharing practices and existing social security schemes to protect low-income populations against life and health risks.

The analysis points to the correlation between client value and maturity of markets. In the Philippines, where for more than a decade microinsurers have been continuously improving life products, there seems to be no question about the value of all the reviewed products. In Kenya, where innovations in composite products, such as health and life, have just started, the client value of most offerings is under question as they are not much better than informal mechanisms nor do they complement the social security scheme. Indian health microinsurance products seem to be half way in their journey to delivering client value with interesting dynamics between valuable offerings by community-based and private schemes and the growing importance of government sponsored initiatives.

Using PACE to balance client value and strategic business choices

It is possible to integrate results of the PACE analysis into the strategic planning process. The PACE results can form an input to the planning that also considers the broader economic environment and institutional factors. Providers can repeat a PACE exercise regularly to provide inputs during the product review and repositioning process.

The PACE analysis shows that client value enhancements need to be strategic. There are intrinsic trade-offs between client value and business considerations. A balanced value approach across all four dimensions of PACE makes sense for a client, but it might not be the best choice for a microinsurer who wants to differentiate its offering in a competitive environment. There is often no simple answer to which business strategy makes the most sense, but what is obvious is that incorporating clients' feedback in strategic decisions is vital, especially with growing competition. PACE or other client value assessment tools can act as the medium to accomplish this.

In the ongoing value creation process, the competitive environment, market orientation and/or social commitment can lead to significant improvements. Often enhancements are small adjustments that make a significant difference for low-income consumers. There are many trade-offs in this process, but if improvements lead to greater efficiency, that might make a balance proposition possible.

The examples showcased in this paper are inspiring, but client value is contextual and not all ideas can travel across borders to markets with different client's preferences, social security set up, competitive landscape, and availability of technology or distribution channels. And yet, while context matters, some client value drivers seem sufficiently universal to be put on the global microinsurance agenda to further improve client value. This includes exploring:

- improvements in claims processing, customer care, consumer education and enrolment processes
- translation of efficiency gains (through process improvements and use of technology) into better client value
- value of mandatory versus voluntary product designs
- balance between simplicity and coverage (simple covers versus more comprehensive appropriate covers) in the context of marketing, demand and acquisition costs
- ways of structuring public-private partnerships for health and agriculture microinsurance
- opportunities to build on informal mechanisms and ensure better coexistence with microinsurance
- market segmentation and better product positioning for various segments.

1 > INTRODUCTION

In microinsurance, there is considerable emphasis on ensuring that the target market is receiving good value for their premiums. Microinsurance providers aim to improve their offerings to attract and retain their clients. Governments and donors search for effective ways to incorporate microinsurance into their development strategies. They all ask the same questions: are clients really benefiting from microinsurance? How do we measure those benefits? How do we improve the value proposition for the clients?

This paper contributes to this discussion by focusing on improving client value rather than proving it[1]. It presents results from the ILO's client value assessment tool called PACE (Product, Access, Cost and Experience). The PACE tool looks at the added value for clients from insurance products by comparing them to each other and to alternative means of offering protection from similar risks. The paper presents insights on value creation opportunities and the value of microinsurance in relation to informal mechanisms and social security initiatives in Kenya, India and the Philippines.

As summarized in Box 1, value creation is a complex process that can be analyzed at many stages and from different perspectives. The PACE client value assessment tool focuses mostly on the first stage of value creation, when the products are developed or refined (Figure 1). It caters to the needs of practitioners to help them develop a better value proposition to protect clients against specific risks. The PACE tool does not measure impact from microinsurance, nor does it attempt to assess client satisfaction or purchase decisions. It is not a substitute for rigorous impact studies, which are needed to measure the effect of microinsurance products on client well-being. The PACE tool provides an initial analysis of the product and processes that can be complemented by market research or impact studies. It provides actionable insights for practitioners and can help instil a client-centred approach to microinsurance, while simultaneously informing the design of more rigorous studies or policy debates.

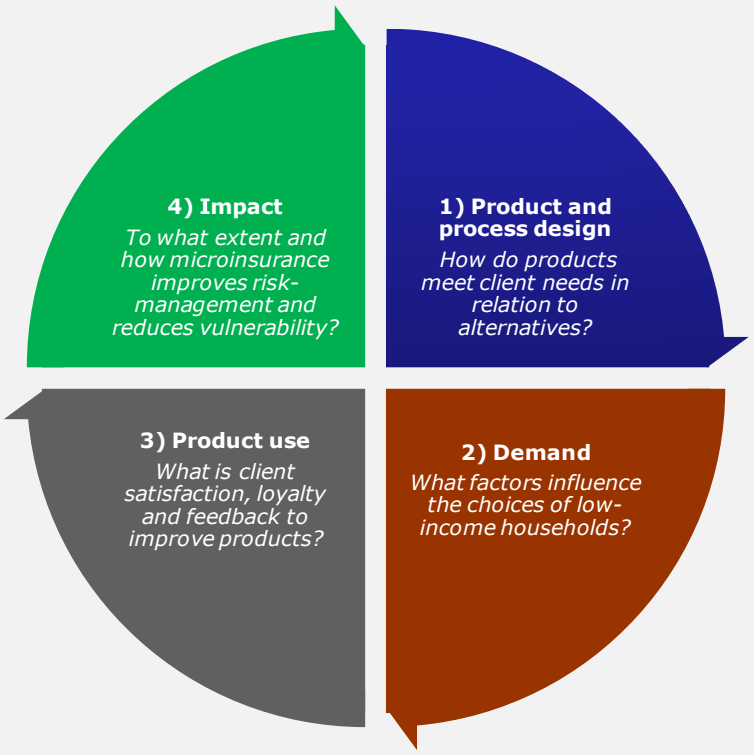
Box 1: Client value definition and value creation process

Client value is defined from the client's rather than the seller's perspective. The definition of client value used in this paper combines the viewpoints from the development and marketing literature (Sebstad and Cohen 2000, Dercon 2005, Woodruff 1997, Kotler 1994, Plaster and Alderman 2006). From a development perspective, the ultimate question is whether, and to what extent, microinsurance enhances the welfare of policyholders, their families and their communities. In the context of microinsurance, client value is about reducing vulnerability due to improved risk-management practices that then contribute to improved well-being – a key element of building assets is to protect assets. This client-focused approach is in line with a cornerstone of marketing: valuable products are a means to accomplish clients' goals and satisfy their essential needs. The marketing perspective brings into the picture the analysis of purchasing behaviours, product use and client satisfaction. No demand can mean a poor offering, but it can also mean that buyers have a misperception on the value offered.

Creation of value in microinsurance is a process that starts with developing a product and setting up its distribution. Value is created when clients use the product and are satisfied enough to renew their policies. Using the insurance product does not mean that clients need to make claims, as they can also get non-insurance or indirect benefits such as change of productive behaviour. The entire client value creation process is outlined in Figure 1. The steps are building blocks and by separately analysing each stage of the value chain it is easier to highlight value creation opportunities.

[1] See Dercon and Kirchberger (2008), Magnoni and Zimmerman (2011), Radermacher et al (forthcoming) for literature reviews on the impact of microinsurance.

Figure 1. Client value creation model



Source: Framework developed by the ILO's Microinsurance Innovation Facility and its partners.

The motivation to develop the PACE tool was driven by demand from the microinsurance industry for a holistic, yet simple approach to understand client value and provide real-time inputs for practitioners to improve offerings in a dynamic sector. The PACE analysis takes only few days to complete as the methodology relies on staff interviews, process reviews and secondary performance and other data. The analysis is similar to an audit and looks at product coverage, access, cost or value for money, and experience. The PACE analysis can be used by practitioners as well as governments, donors, regulators and investors to get a preliminarily understanding of client value and design interventions to improve specific markets.

This paper presents results from the PACE analysis of 15 microinsurance products in three markets. Section 2 presents the PACE tool and its components. Section 3 presents practical insights on value creation opportunities related to expanding product benefits, facilitating access, lowering costs and enhancing client experience. Often these small improvements can make big differences in the way clients perceive and respond to microinsurance offerings. Section 4 presents a country-level relative value analysis that shows the importance of product and market maturity. Section 5 provides thoughts on the intersection between client value and business viability, and more specifically on how to integrate client value into strategic business planning. These insights demonstrate how applying a client-centric perspective can help improve microinsurance products and develop markets.

2 > CLIENT VALUE ASSESSMENT FRAMEWORK AND TOOL

This section presents the client value assessment tool PACE and its four main dimensions (Product, Access, Cost, Experience).[2] It explains how products are scored in relation to alternatives and compares the PACE tool to other client value assessment approaches.

2.1 BUILDING ON RISK-MANAGEMENT PREFERENCES OF LOW-INCOME HOUSEHOLDS

The PACE client value assessment tool is anchored in the current knowledge available on low-income households' preferences for insurance products. Cohen and Sebstad (2005) list key issues that need to be considered when developing risk management solutions for the poor. The underlying assumption behind the PACE analysis is that products can deliver value only if they are:

- **Appropriate**: match the most important risk management needs of the target population.
- **Accessible**: provide easy access, and products are explained in a simple language and delivered in the vicinity of the target groups.
- **Affordable**: provide good value for money at a price that the target clientele, with limited capacities to pay, can afford.
- **Responsive**: provide a timely response to shocks through prompt claims settlement and accurate answers to client queries so that the poor do not need to resort to expensive but reliable coping mechanisms such as borrowing from moneylenders.
- **Simple**: are simple to understand and use; this is an overarching principle given the low literacy levels of the target population.

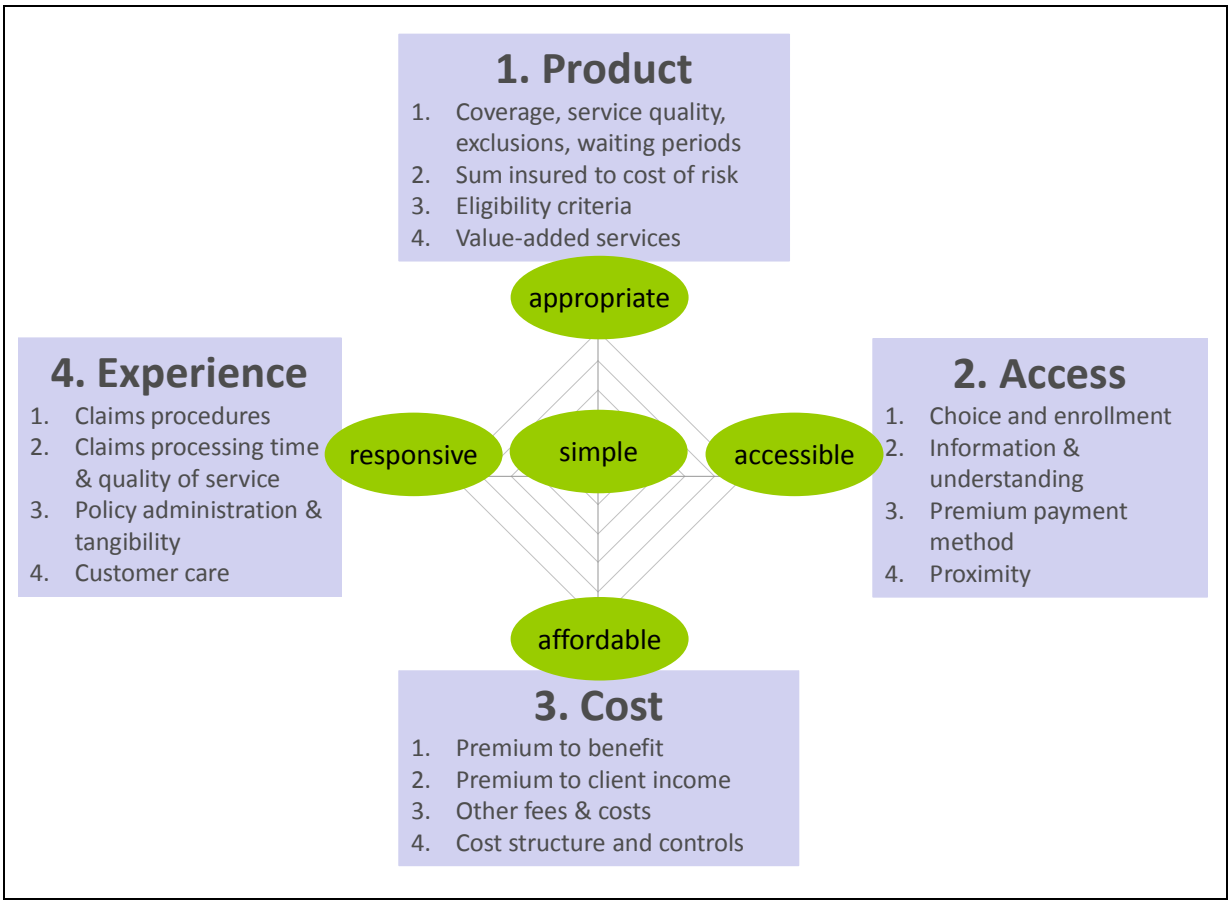
2.2 USING A HOLISTIC FRAMEWORK WITH A CLIENT'S LENS

The PACE framework is designed around the five principles mentioned above and is structured into four main dimensions. As illustrated in Figure 2, simplicity is a cross-cutting characteristic that is relevant for all dimensions:

- **Product**: describes appropriateness by reviewing coverage, benefit level, eligibility criteria and availability of value-added services
- **Access:** focuses on accessibility and simplicity by investigating choice, enrolment, information, education, premium payment method and proximity
- **Cost:** measures both affordability and value for money, while looking at additional costs to keep down overall costs of delivery
- **Experience:** assesses responsiveness and simplicity by looking at claims procedures and processing time, policy administration, product tangibility and customer care

[2] This paper focuses on the results of the PACE analysis. For more on the design and implementation of the PACE tool see the PACE Technical Guide, forthcoming.

Figure 2: PACE added value analysis framework



2.3 SCORING VARIOUS DIMENSIONS IN RELATION TO ALTERNATIVES

Although all four dimensions are important for clients, it can be argued that under certain circumstances some dimensions are more important than others for a specific market segment. However, from the client's perspective what is ideal is a balanced value proposition, a product that scores well on all four dimensions. Given this assumption and for the sake of simplicity, the dimensions are treated equally. Moreover, while PACE is assessed from the clients' perspective, it assumes that reviewed products are either financially viable or have a clear strategy to achieve viability. Unsustainable products provide bad value to clients in the long-term.

The scoring uses a five-point scale and criteria on all 16 sub-dimensions listed in Figure 3. This analysis is appropriate for one product but provides greater insight when it is done comparatively with a benchmark and compared to similar offerings (see Section 4 for the relative analysis). This is because client value cannot be analysed in isolation, as microinsurance often complements existing risk management mechanisms such as informal savings and credit groups or tax-funded government safety nets.

While it is plausible to assume that all four dimensions are almost equally important, not all the 16 sub-dimensions carry the same level of importance. For example, one cannot compare relative weight of claims processing with policy administration. Therefore, under each main dimension, two sub-dimensions are allocated higher importance and contribute to 70 per cent of the total score for the dimension, while the two other sub-dimensions contribute to the remaining 30 per cent.

Figure 3: PACE scoring criteria and sub-category weights

Dimension	Weight	Detailed criteria *(positive ranking if the product…)*[3]
1. PRODUCT		
1.1 Coverage, quality of service, exclusions and waiting periods	0.35	Covers appropriate risks from a client perspective Integrates appropriate riders to main cover Provides adequate service quality (for health) Offers simple cover without many exclusions Provides limited waiting period
1.2 Sum insured in relation to cost of risk	0.35	Pays out adequate amount in relation to cost of risk Does not put many sub-limits on specific covers
1.3 Eligibility criteria	0.15	Is inclusive, does not exclude groups of people
1.4 Value-added services	0.15	Offers non-insurance benefits Offers preventive health services (for health) Offers value-added agriculture services Triggers positive behaviour changes
2. ACCESS		
2.1 Choice and enrolment	0.35	Is voluntary Offers choices in benefit levels or additional riders Provides options to opt out Has simple enrolment process Does not require many documents Provides enrolment in convenient times Has efficient way to remind clients to renew policies
2.2 Information and understanding in relation to complexity	0.35	Provides clear information about the product, its benefits and limitations Establishes a channel to update the information Does checks if clients understand the product Educates clients on broader insurance issues
2.3 Premium payment method	0.15	Makes it possible for clients to pay in small instalments Offers premium financing options at fair price Offers premium subsidies Offers an option to automatically deduct premiums Offers a way to pay from savings accounts
2.4 Proximity	0.15	Offers a close PoS Does not require frequent travels to PoS Offers close network of health care providers
3. COST		
3.1 Premium in relation to benefit	0.35	Offers good value for money coverage (calculated as a ratio of monthly premium per insured member divided by the score on 1.1 coverage and 1 all benefits)
3.2 Premium in relation to client income	0.35	Offers affordable access, <2% of client income (calculated as a ratio of monthly premium for a household divided by average monthly household income)[4]
3.3 Other costs	0.15	Limits travel costs Reduces opportunity costs Limits co-payments Does not have any additional fees
3.4 Cost structure and controls	0.15	Prices fairly Has claims ratio in a range of 50-90% Has lean cost structure, explains use of intermediaries and other commissions Has strong cost controls Has mechanisms in place to control fraud, adverse selection and moral hazard
4. EXPERIENCE		
4.1 Claim processing procedures	0.35	Has simple and easy claims procedures Requires limited documentation to file a claim Provides a cashless access to health services with a clear authorization process
4.2 Claim processing time and service quality	0.35	Has sound practice of rejecting (fraudulent) claims Offers quick payments of primary benefits (eg<10 days) Offers quick turnaround time on other payouts (eg<3 weeks) Provides cashless access to quality health services
4.3 Policy administration and tangibility	0.15	Issues policies on the spot or within 2 weeks Offers a clear policy document Provides a tangible insurance card
4.4 Customer care	0.15	Has mechanisms to collect feedback from clients Has clear first contact information Provides access to call centre Is offered by competent sales staff Has a Client Relationship Management system Introduces bonuses for loyal clients Has a systematic approach to build trust Establishes a clear grievance mechanism

[3] Not all the criteria should be met by a specific product. PACE grid is adapted to the context. More details on measurement criteria can be found in the Annexes. The Facility will also continue testing and improving the PACE tool to arrive at more robust measurement system.

[4] The affordability threshold will need to be adapted for different microinsurance products.

The PACE analysis can be done relatively quickly as it relies just on available secondary data and a limited number of staff interviews. Key data sources are: product specifications, performance data, manuals and process flowcharts, reports and staff feedback (see Annex A for more on client data sources for the analysis done in this paper). The data collection approach is similar to one of an audit, for which answers to specific questions are validated based on data from different sources. The more data on clients that is available the better. If the client data is not available, then the accuracy of the PACE analysis is undermined. Collecting primary data directly from clients increases significantly the cost of the PACE analysis, but is definitely an option for those organisations who are serious about serving the low-income market.

2.4 USING PACE TO COMPLEMENT OTHER CLIENT VALUE APPROACHES

PACE is just one approach to assess client value. As shown in Figure 4, other approaches have different objectives, cater to the needs of different audiences, vary in terms of the type and scope of analysis, as well as in terms of complexity and costs. The PACE tool fills a gap in the middle-range approach that lies between key performance indicators that only signal successes or problems, and full-fledged client studies that can be expensive and time consuming.

One key aspect that differentiates PACE from other approaches is that PACE looks at both product specifications and related processes. By evaluating current processes from the client perspective, PACE can identify improvement opportunities. As discussed later, part of the problem with some microinsurance offerings is that processes to enable access or to service claims are often poorly designed and undermine the value of the products.

Figure 4: PACE in relation to other client value assessment approaches

	*Key performance indicators**	*PACE*	*Market study*	*Client satisfaction study*	*MILK client math***	*Impact study*
Rationale	Raise red flags about current client value performance; Help set priorities for improvement	Identify value creation opportunities; Explore strengths and weaknesses of current design in relation to alternatives	Understand needs and preferences of target population	Understand client satisfaction, renewal behaviours and client loyalty	Understand the financial value at the time of a claim of products in comparison to alternatives	Assess outcomes/ impacts on indicators related to behaviour change or wellbeing of households / communities
Key audience	Practitioners	Practitioners and enablers	Practitioners and enablers	Practitioners	Practitioners, and enablers	Enablers
Type	Ongoing monitoring	Ad-hoc audit	Ad-hoc study	Ad-hoc study, ongoing monitoring	Ad-hoc study	Ad-hoc, longitudinal study
Stage	After product launch	Product development or refinement	Product development	Product refinement	For more mature products	For more mature products
Data source	MIS	Secondary data on current design and clients	Primary and secondary data on current and prospective clients	Primary and secondary data on current clients, MIS	Primary client interviews and MIS data	Primary and secondary data, at least two rounds of data collection
Complexity/costs	Low	Low to medium	Medium to high	Medium	Medium	High

** See http://www.microfact.org/microinsurance-tools/ for more on KPIs.*

*** See www.microinsurancecentre.org for more on MILK client math methodology.*

3 > VALUE CREATION OPPORTUNITIES

This section is on the application of the PACE tool in India, Kenya and the Philippines to analyse 15 microinsurance providers. It provides preliminary insights into efforts to enhance value under each of the four PACE dimensions. The main criteria for the selection of case studies were similarity in the offerings within a country and the maturity of the microinsurance markets. In each country, analysts considered similar business lines – life products in the Philippines, health products in India, and health and composite products in Kenya (see Figure 5). Consequently the list of value creation opportunities presented below is based on the experience of these insurers and does not cover innovations in other microinsurance product lines.[5]

*Figure 5: Offerings considered for client value assessment tool testing**

Country	Provider, product name	Product type**	Delivery model***	Start date	Outreach (lives)
Kenya	NHIF, informal sector cover	IP health	Government	2007	na
	CIC, Bima ya Jamii	IP health, AD&D, funeral	PPP, partner-agent	2007	8,300
	Pioneer, Pioneer Faulu Afya	IP&OP health, term life, AD&D, funeral	Partner-agent	2010	11,000
	Britak, Kinga ya Mkulima	Whole life, IP health	Partner-agent, broker	2007	78,000
	Jamii Bora Trust, Jamii Bora health	IP health	Community based	2001	600,000
India	Government of India, RSBY	IP health	PPP, government	2009	45 million
	ICICI Lombard, Health Insurance Scheme (HIS) for weavers	IP&OP health	PPP	2005	5.5 million
	Yeshasvini	IP health	PPP	2007	2.7 million
	Bharti Axa, PWDS	IP health	Partner-agent	2010	16,000
	VimoSEWA, Sukhi Parivar and Swastha Parivar	IP health	Partner-agent	1992	100,000
	Uplift Mutuals, Uplift Health	IP health	Community based	2003	100,000
Philippines	FICCO, MBA	Term life, AD&D	Regulated MBA	2007	330,000
	CARD, MBA	Term life, AD&D	Regulated MBA	1994	4 million
	CLIMBS, Microbiz Family Protector	Term life, AD&D, funeral and fire	Partner-agent	2004	135,000
	Microensure, Family Life with TSKI	Term life, AD&D, funeral	Partner agent, broker	2007	1 million

** More details on the products and their performance are in Section 4 and Annexes B, C and D*
***IP in-patient; OP out-patient; AD&D accidental death and disability*
**** MBA- Mutual Benefits Association, PPP – Public-Private Partnership*

3.1 IMPROVING PRODUCT FEATURES TO EXPAND MEMBER BENEFITS

Life insurance is the most developed microinsurance product and ways to make it more valuable are well documented. Churchill et al (2003) and Wipf et al (2011) argue that to make the products more attractive to potential clients it is important to extend benefits beyond basic credit life and to include death cover for additional family members and/or other benefits. As presented further in Section 4, the reviewed life products in the Philippines provide an example of how, in a mature market, providers have incorporated best practices to deliver value to their clients.

One of the few remaining issues with the value of life microinsurance is with **accidental death and disability** (AD&D) covers. Often the client value from those covers is questionable due to inadequate pricing (high premiums for a very

[5] See Rusconi (2011) for innovations in savings-linked or endowment products, IFAD/WFP (2010) and Carter (forthcoming) on index agriculture products, Hougaard and Chamberlain (2011) on funeral products, Wipf et al (2011) on credit life products, and Leatherman et al (2010) for more on health products.

low frequency risk), exclusions and long waiting periods, which, in principle, are not necessary to control adverse selection for accidental covers.

Given low-income households' high exposure to accidents and their challenges in coping with unexpected expenses, it is important to continue to improve the value of AD&D products. Some providers in the Philippines, like CLIMBS, simplified the list of exclusions and introduced no waiting periods for accidental covers. Similarly, CARD and Microensure provide accidental cover soon after enrolment, while natural death benefits increase incrementally over time. Another good feature of the CARD product is to pay out disability benefits in monthly instalments rather than as a lump sum; this is similar to getting a monthly wage and should instil better financial discipline among the beneficiaries.

Designing valuable and sustainable **health microinsurance** products is inherently more complex than other types of microinsurance (Leatherman et al, 2010). The first wave of innovation in health microinsurance limited coverage to catastrophic risks – low-frequency, unpredictable, high-cost services (in-patient care). These events are more easily insurable than routine healthcare needs, and the products are more affordable. However, providers have struggled to reach scale because they often experience low renewal rates. Clients would perhaps see more value in coverage for high-frequency, predictable and often low-cost services (such as out-patient care) if the product could be designed so that it was affordable. Most of these primary or secondary care services, however, are difficult and expensive to insure. A third approach is to provide preventive health services or discounts for outpatients services, while only covering in-patient services. Box 2 gives two examples of SEWA and Uplift that integrate preventive health care services with their hospitalisation products to boost value and lower hospitalisation claims costs.

Box 2: Expanding member benefits in health microinsurance in India

Established in 2003, Uplift Health Mutual Fund currently serves more than 100,000 members in urban and peri-urban slums of Pune, Mumbai and rural Maharashtra. While the core product is a hospitalisation cover, the scheme provides tangible benefits through array of broad benefits that it delivers through its strong community structures that market products and manage insurance funds and claims. Benefits include include monthly health camps, health clinics and a 24-hour hotline staffed by qualified doctors who assist in navigating the complex healthcare system (Dimovska et al 2009, Ruchismita and Virani 2009).

A similar approach is practiced by VimoSEWA, the national cooperative promoted by SEWA, which provides standalone health products and composite health, life, and property products to more than 100,000 self-employed women and their family members. VimoSEWA strives to integrate preventive health programmes into its provision of health insurance because it discovered that one-third of hospitalisation claims were for highly preventable illnesses such as malaria, gastroenteritis and other water-borne diseases. Leaving diseases like these untreated increases the vulnerability of poor communities, and drives up claims rates, which affect the viability of the insurance scheme.

Another relatively easy way to enhance benefits is a hospital-cash feature, or a cover for loss of income due to hospitalisation. This can be useful when clients need to pay (informally) for drugs or for services due to under-financed public health systems. In addition, it can also provide protection for informal workers who are not compensated for loss of income by social security systems. For example, CIC in Kenya pays out KES 2,000 (US$ 22) per week for up to 25 weeks during the hospitalisation period. In India, SEWA health workers come to the hospital on the first or second day of hospitalisation to provide an advance on a claim that is reimbursed in full later on.

Lastly, eligibility criteria and mechanisms to choose additional members or appoint beneficiaries for health and life products require careful monitoring. As noted by Banthia et al (2009) and observed for some products in India and the Philippines, letting the principal member select other members for health policies can lead to gender discrimination, as it may result in much lower enrolment for female family members. Consequently, products that cover the whole family tend to be preferred, and have the corresponding benefit of lowering adverse selection.

3.2 FACILITATING ACCESS

CHOICE AND ENROLMENT

Intuitively, offering a choice between products or specific features should be beneficial. However, too much choice can complicate decisions, and discourage clients from buying an otherwise valuable product (Dalal and Morduch 2010). Also, mandatory products, that offer no choice, are usually less expensive as they enable insurers to reach scale faster and avoid adverse selection. The merits and downsides of mandatory versus voluntary products are better discussed when all client value dimensions are considered at once (see the Kenyan examples in Section 4).

Some providers are experimenting with hybrid approaches. In the Philippines, Microensure offers a mandatory life insurance product to borrowers of the microfinance institution, Taykay Sa Kauswagan, Inc. (TSKI), with an opt-in feature for clients who want to continue coverage after their loans as many clients also save with TSKI. The basic idea is to control adverse selection through a mandatory offering delivered with superior service that allows clients to appreciate the product, and buy it voluntarily or upgrade to a higher option in the future.

Clients' needs are not all alike, yet many products are standardized to reduce transaction costs. Although too much customization might be expensive to administer, giving some choice to clients seems to be a valid solution. Among the insurers reviewed, only Pioneer Assurance and VimoSEWA offer such choice. As insurance literacy levels increase, it should be possible to let clients choose from a limited set of riders or even decide on a combination of composite products offering protection for health, life or property risks in one product. For the moment, the composite offerings available to low-income clients are rigid and expensive to deliver (see Kenya experience in Section 4).

The enrolment process matters, especially the timing and length of the enrolment period. VimoSEWA enrols after harvest in rural areas to overcome liquidity constraints and reach farmers when they are flush with funds from the harvest. Some Indian health schemes include a single, short enrolment window during the year. While a one-week enrolment period may mitigate adverse selection and reduce marketing cost, it is not enough to capture all interested households and it can create major operational challenges.

INFORMATION AND UNDERSTANDING

Low levels of insurance literacy make it difficult for clients to understand policies and use them properly. Addressing this challenge requires transferring information about the product in an accessible way and educating clients on how to use the product within a range of other available risk management solutions. The latter usually involves broad financial education and requires use of various channels to relay educational messages to change consumer behaviours. Dror et al (2010) outline various strategies and tools used by practitioners, including providers like Microensure, VimoSEWA and Uplift, which run systematic educational programmes on risk management concepts that go beyond basic information transfer. Microensure's education programme, for instance, is based on three pillars: 1) financial literacy on savings versus insurance through comic books and CDs, 2) explanation of product benefits and logistics, and 3) education to MFI staff on the same issues with an emphasis on claims administration. These comprehensive efforts are worth evaluating further, but given the costs it is unlikely that providers can deploy such broad programmes on their own without support from donors, government or industry bodies. Hence, providing clear information about the product is a good start for microinsurers. FICCO in the Philippines and ICICI Lombard in India provide useful examples, with the former providing a very simple policy document that conveys key benefits and logistics of the policy, and the latter including a list of exclusions provided on the back of the insurance card. In general, the providers studied in the Philippines outperform their counterparts in India and Kenya with the simplicity of forms and clarity of language used during the enrolment process.

Education seems more important when clients either do not decide to buy the product themselves (mandatory offerings) or pay little for subsidized offerings. In these circumstances, use by clients is often lower than expected (or claims rejection rates are higher) because clients do not fully understand what they are entitled to. More education is

required for complex products, which probably explains why Microensure conducts the broad educational programme and Britak in Kenya limits itself to information transfer.

PREMIUM PAYMENT

Collins et al (2009) draw a detailed picture of how poor people all over the world live on small and irregular incomes. Paying for insurance is a challenge when low-income households are struggling to meet a multitude of needs with scarce resources. Microinsurers recognize this as a problem hampering access to microinsurance, and are trying different ways to overcome it.

Greater flexibility in premium payment is required. Low-income households appreciate paying in small instalments (irregular, if possible) at their doorstep and to have their payments spread out over time. Mobile payments, albeit not practiced by the reviewed schemes, can provide a breakthrough, provided transaction costs are affordable. Reasonable grace periods to avoid policy lapses are also desirable. Adding flexibility is not always possible though, as insurance regulations often limit possibilities to introduce more flexibility into certain product lines. For example, for health policies, often annual premiums paid in lump sum are required.

In developed countries, automatic deductions from a salary provide an easy, client-friendly option. This option is rare in the context of microinsurance as low-income households often work in the informal economy and are unbanked. Among the reviewed products, only Britak in Kenya, which works with the Kenyan Tea Development Authority, offered automatic deductions to small-scale tea growers who were paid a regular monthly wage and an annual bonus.

Another solution to make payments more convenient involves linking microinsurance to other financial services. For example, of CIC's Bima ya Jamii policies, almost 90 per cent are bought with loan financing from Savings and Credit Cooperative Organisations (SACCOs). This is also practiced by other providers in Kenya. The issue is delicate as there is a fine line between increasing client value and cross-selling credit services, which might lead to excessive debt or to an increase in the premium level.

For this reason, using savings and remittances to finance premiums should provide better client value but such solutions still need to be developed.[6] VimoSEWA had mixed results on two savings-linked premium payment mechanisms that were tested. Automatic deduction from savings accounts proved difficult when the account balance was insufficient, and it was challenging to educate clients properly given the mandatory nature of the product. Now, VimoSEWA clients have an option to make a deposit into a special SEWA bank account, and instead of earning interest, they receive coverage. While this mechanism reduces transaction costs, it does not overcome liquidity constraints as clients need to make a deposit that is twenty times higher than the annual premium. Previously, a quarter of SEWA members used the fixed deposit payment method but this proportion has been declining steadily (McCord et al 2006).

PROXIMITY

Given the limited and often expensive transport options, low-income households need an accessible point-of-sale network to enrol in insurance and avail the benefits. This requirement is embraced by most of the insurers reviewed, especially VimoSEWA, Uplift and PWDS, whose staff is present in the communities for the enrolment process. It is also the case for life insurers in the Philippines that invest significant resources in training the front-line staff of delivery channels who are situated close to the clients, as well as developing a network of their own agents to support the delivery channels.

[6] Powers et al (2011) confirm that remittance-linked schemes are in nascent stage of development.

3.3 LOWERING COSTS

VALUE FOR MONEY

Value for money can be measured by the ratio of all insurance and non-insurance benefits compared to the total premium paid. Of the reviewed schemes, it is not surprising that the subsidized products provide the best value for money. Products with many value-added benefits, such as Uplift or VimoSEWA, also score well on this dimension. Interestingly, in the Philippines, where there is a mature market for life products, all products provide similar value for money.

The value for money analysis helps to identify if products are overpriced to compensate for inefficient processes. For example, in Kenya neither a relatively cheap product by Britak nor the most comprehensive scheme by Pioneer Assurance seem to provide the best value for money. Both products have claims ratios[7] between 80 to 120 per cent, which means that members get more for their premiums. But a ratio that high is also a sign of a problem with the programme, which ultimately can be bad for both the provider and the client. It seems that other Kenyan providers have more efficient processes or better cost controls because even with lower claims ratios they offer better financial value to clients.

AFFORDABILITY

Many of the reviewed products seem to be affordable, especially in the Philippines where all the products are within a range of PHP20 to PHP 30 (US$0.44 to US$0.66) per year; according to Rimansi (2002) low-income households are willing to pay for life insurance. Dror et al (2006) estimates that low-income households in India are willing to pay about 1.35 per cent of their income for health insurance, which is similar to what clients are paying for in three of the reviewed schemes in India. As argued in Section 4, the only products that do not comply with the Affordability dimension are composite products in Kenya by CIC and Pioneer Assurance, which might explain their slow growth.

Again, a subsidy can be a good tool to overcome affordability issues as long as it is permanent or designed in a way that does not undermine the market outlook of a specific product. This is becoming more prevalent in countries with sound government policies, especially for health and agriculture insurance products. Three of the reviewed health schemes in India are subsidized either by central or state governments.

OTHER COSTS

In most of the reviewed cases, products do not require clients to pay extra costs. However, travel costs to avail health care benefits and for families to visit a sick person are still an issue, especially in rural areas. Schemes like RSBY provide a travel allowance, which removes barriers and should significantly improve the value of insurance in rural areas.

Many health schemes have co-payments of 10 to 20 per cent. As the PWDS example illustrates in Box 3, when members are given a choice, they often intuitively select an option with co-payment and thus lower premiums. This is in line with the high discount rate that is often reported for low-income households; a notion that households value cash-in-hand rather than in the future (Dalal and Morduch 2010). Some of the Indian schemes offer co-payments on expensive surgical procedures or accidental hospitalisation cases. This kind of co-payment should have limited impact on controlling moral hazard but can significantly increase vulnerability for those who are exposed to the catastrophic

[7] As noted by Denis Garand on 28th May 2011 at discussion forums at the Facility Knowledge Centre: 'A higher claims ratio by itself does not measure client value. However a claims ratio is an overall measure of value to the broader community. If there was a choice of a product with a 25 per cent claim ratio and one with a 75 per cent claim ratio, assuming they are the same benefit. It is likely that the second has a lower premium. In the insurance industry in general there are real examples of insurers with higher claims ratio, with similar products having greater market participation. A consistent low claims ratio demonstrates a lack a value over the long run, and if competitors are present that low paying organisation will diminish in size.'

risks. It seems like client value can be increased if co-payments are eliminated for rare but expensive events, while still used for more frequent, low-cost incidences.

Box 3: Preferences for higher co-payments (and lower premium) at PWDS in India

PWDS, an NGO operating in Tamil Nadu in India, offers in-patient health insurance in collaboration with two insurers to its self-help groups. PWDS wanted to involve community groups during the development of an in-patient health insurance product to understand communities' requirements and gain early buy-in. Two product options were discussed during product development meetings - one with full payment of the claim and a higher premium, and the other with a 20 per cent co-payment from the insured and a lower premium. When the product was rolled out, four out of five community federations opted for the co-payment option. Members felt that requiring a co-payment would reduce false and excessive claims since a portion of the claim cost had to be borne by the claimant. Their decision to opt for the co-pay option was probably driven by the lower price but also illustrated that they understood the requirement for self-regulation and were willing to try it.

Source: Emerging Insight #8, Microinsurance Innovation Facility based on a market study by Centre for Insurance and Risk Management.

COST STRUCTURE AND CONTROLS

As already signalled in the 'value for money' analysis above, effective cost controls should result in better value products that will provide access to services in the long term. Cost structure and efficiency matter in the same respect because consumers do not want to pay for providers' inefficiencies. Detailed analysis on cost structure and controls goes beyond the scope of this paper, but it is interesting to see various cost reduction strategies among the participating organisations: eliminating intermediaries (MBAs in the Philippines), leveraging staff from delivery channels (CLIMBS, Pioneer Assurance), involving specialized brokers (Microensure) or TPAs, limiting adverse selection, fraud controls as well as monitoring cost at health care providers (Jamii Bora Trust, Uplift, RSBY). Lastly, technological advances should result in efficiency gains and subsequently premium reductions, though these cases do not yet offer enough insights on this issue.

3.4 ENHANCING EXPERIENCE

CLAIMS PROCESSES AND TIMELINESS

Settling a claim is when insurance becomes tangible for clients, and it provides an opportunity for insurers to build trust and increase loyalty. Claims procedures need to be convenient and claims need to be paid in a timely manner to provide a service that is better than the informal ways (e.g. sales of assets) in which low-income households manage risks.

Quick payouts on funeral riders of the life policies in the Philippines are good examples of client value enhancements. CLIMBS, CARD (Box 4), and Microensure pay the funeral benefit component of the policy within 24 hours, while the rest of the life benefit is paid slightly later and is subject to more documentation.

Health microinsurance providers are increasingly offering a solution for instantaneous claims payment, so called 'cashless' claims (Le Roy and Holtz 2011). Instead of advancing their own money and being reimbursed later by an insurer, a member can access healthcare services for free. This limits the chance that clients will postpone treatment and makes the entire system more attractive and easier to understand. Most health microinsurance players, including ICICI Lombard, RSBY, PWDS, CIC, NHIF, Pioneer Assurance, Jamii Bora Trust, Britak, have moved to 'cashless' solutions, however, the approach has its critics. Uplift strongly believes that a reimbursement basis creates a stronger sense of ownership amongst clients and avoids inflated costs (because of unnecessary treatment, for example) from health care providers. Uplift believes that a reimbursement system is more efficient in keeping overall claims costs

down.[8] VimoSEWA practices something in between, by advancing part of the payout when the client is still in the hospital and paying the rest after the documentation is submitted.

Box 4: CARD 1-3-5 claims settlement model

CARD the *1-3-5-day procedure* for life claims settlement is set in place to ensure good experience with claims processing. Verified by the CARD branch manager or CARD MBA staff, claims are settled:
Within 24 hours upon notification, claim for indemnity must be settled if the dead body is not yet buried at the time of validation.
Within three days upon notification and with complete documents, claim for indemnity must be settled if the dead body is already buried at the time of validation.
Within five days upon notification, difficult claims will be given action with finality.

Source: CARD MBA website.

Despite these positive examples, many microinsurers can improve how they handle claims. The process can be cumbersome, especially for AD&D and some non-cashless health covers. Turn-around times of more than a month undermine value as beneficiaries may resort to costly alternatives to generate the needed lump sum. High rejection rates for some schemes suggest that claims procedures are not clear or well communicated. The list of required documents for some products, especially in Kenya, is too long. It is an open question whether the additional paperwork makes any contribution to the insurer's controls, but it definitely deteriorates the clients' experience. MicroEnsure's common sense approach to accident and death certificates is an example of a small change that improves the clients' experience (see Box 5).

POLICY ADMINSTRATION AND TANGIBILITY

Policy administration is less of an issue than claims handling because most of the insurers reviewed, especially FICCO, CARD and CLIMBS, excel at quickly delivering policy certificates or insurance cards to their members. RSBY issues membership cards on the spot during its enrolment campaigns with the use of new technology. However, in many other cases clients wait three to four weeks to get the cards. Many providers do not give any policy document or tangible proof of being insured. It is hard to defend the cost reduction arguments as the insurance proof can be as simple as the card used by ICICI Lombard with some key policy information on the back.

For clients to have a positive experience, it is also important to make insurance tangible for the vast majority who were fortunate enough not to make a claim. Efforts by Uplift and VimoSEWA described in Box 2 are good examples of providing value to non-claimants, but providing additional services might be costly and for product lines other than health insurance might have less direct benefits to insurers. Providing tangibility can be as simple as offering a membership card and sending follow-up text messages with information related to the insurance policy.

CUSTOMER CARE

As products and distribution models become complex, the role of customer care in microinsurance has become more important. In the past, this consideration has been largely neglected and many microinsurers had not provided clients with a way to contact them in case of a problem or information request. Recently, however, insurers are making a greater effort to provide support to clients before, during, and after a sale.

With advancements in mobile telecommunications, call centres are being tested in microinsurance and the clients of some reviewed schemes (CIC, Pioneer, ICICI, RSBY, Uplift) have access to a toll-free number. It enables clients to

[8] Uplift tested cashless solutions and argues that health care providers almost doubled the rates when approached for cashless compared to rates practicing with cash clients.

understand the basic features of the product at the time of purchase, establishes a feedback and grievance mechanism, and allows them to check their policy status.

Customer care goes beyond call centres and just being close to the client. It is about having an institutionalized process to satisfactorily answer clients' queries, mechanisms for responding to grievances and a system to monitor and act on individual requests and complaints. For example, CLIMBS, CIC, Uplift and VimoSEWA, among others, made an effort to provide structures for customer care. This is often not the case with many community-based or partner-agent schemes, which assume that being close to the client is sufficient.

3.5 BALANCING TRADE-OFFS IN A CONTINUOUS IMPROVEMENT PROCESS

Many of the products include value enhancing elements, however, it is rare that one product scores well on all the client value dimensions as there is often a trade-off between affordability and enhancements in product benefits, access and experience. Client value improvements, however, do not always require an increase in premium. They can also be achieved through efficiency gains as many processes can be streamlined. In fact, continuous improvement of client value was observed in several schemes, including Uplift and Microensure (see Box 5).

Client value enhancements should be strategic. There are intrinsic trade-offs between client value and business considerations. A 'balanced' value approach across all four dimensions of PACE makes perfect sense for a client, but as further discussed in Section 5 this might not be the best choice for a microinsurer who wants to differentiate its offering in a competitive environment.

Lastly, client value is contextual. Not all the enhancements that work in one country can be replicated or are needed in another. Clients' preferences might be different, availability of technology or distribution partners vary, and the landscape of informal mechanisms, national security schemes and microinsurance providers might require finding a niche for a specific microinsurance offering. The next section compares various offerings at the country level and illustrates the importance of looking at a product in relation to its alternatives.

Box 5: Process of improving client value at Uplift and Microensure

Uplift Mutuals started its operations in 2003 with a maximum coverage of INR 5,000 (US$ 111) for an annual premium of INR 50 (US$ 1.11) per person. The cover at that time included full reimbursement for in-patient treatments at the public hospitals and 80 at the private providers. In 2007, out-patient discounts on consultations and medicines were added and day-care procedures and accidents were included in the cover while pre-existing conditions were excluded for two years (previously only one year), fully dedicated field staff was recruited and premium increased to INR 60 (US$ 1.33) per person as an adjustment. In 2009, Uplift increased the sum insured to INR 15,000 (US$ 333) for a premium of INR 100 (US$ 2.22) per individual.

Uplift had to address three issues during the first years of operation: a high rejection ratio, an increase in cost of claims and an increase out of pocket expense by clients. Due to lack of awareness, claims submitted were for excluded cases. Small network of empanelled providers did not enable Uplift to monitor (compare) costs and offer proximity to its members. Uplift realised that its members value access to and information on health services as much as they value the financial benefit of insurance. To improve access, Uplift painstakingly developed a network of more than 300 quality health providers offering price discounts of 10-50 per cent, and instituted a 24/7 helpline and referral system to point members to an appropriate health provider. Uplift also expanded its health initiatives (e.g., out-patient drug discounts, monthly health camps, free monthly check-ups, health education to prevent seasonal illnesses) to increase value for all members, even those with no hospitalisation claims.

Uplift's efforts to improve client value seem to be paying off. As of early 2011, the scheme covers more than 100,000 people, the rejection ratio is as low as 2 per cent, the loss ratio has increased to 47 per cent[9], services ratio (proportion of members accessing outpatient or inpatient health services) was 56 per cent in 2010, out of pocket spending decreased by 22 per cent, and the renewal ratio increased from 48 per cent in 2008 to over 60 per cent in 2010. Uplift is currently not fully sustainable. Premiums are enough to cover insurance operations but are not sufficient to sustain all the value-added benefits (access to health initiative), which are subsidized by a donor. Uplift management argues that tripling the current outreach should generate enough economies of scale to sustain the full programme.

Microensure started its partnership with the microfinance institution Taytay Sa Kauswagan Inc. (TSKI) in 2007, in the Visayas region of the Philippines. TSKI already was self-administering a life insurance product to cover its members. This product was used as a starting point in the design of an added-value life insurance product for the low-income families, in the framework of a partner-agent model with product development, marketing and claims administration support from Microensure. Different features have been modified over time.

As a first step, the sum insured was increased from PHP100,000 to PHP120,000 (US$ 2,222 to US$ 2,666) so that loan amount (on average PHP30,000, US$ 666) and funeral costs would be fully covered and an additional amount would remain for the family of the insured. Benefits between Life and Burial were separated and pre-existing disease were included in the burial benefits, resulting in quicker benefit payments. In order to simplify the cost structure and improve understanding by the client, a community-rate was introduced, thus not differentiating premium amount by age group anymore. The enrolment of family members then became compulsory and a family rate was introduced, insuring all members were protected, although at different benefits levels. The definition of dependents was also reviewed several times in order to adapt the policy to the current family situations in the Philippines: school attendance released, increased age limit definition, parents as dependent if insured is single.

In order to simplify the payments of claims, Microensure made the MFI a trustee on the policy, avoiding complex legal situations for families. The documentation required for the claim process was reduced, including the possible use of village head certificate and affidavits. Furthermore, an increasing-with-time benefit table was introduced in order to limit verifications linked to exclusions and pre-existing conditions. Thanks to these adaptations, the turn-around-time decreased from three months to 44 days as of November 2010, which is a significant decrease but can still be improved.

Source: Data collected from Uplift and Microensure during the PACE tool testing; Emerging Insight #19, Microinsurance Innovation Facility.

[9] Uplift reports 78 per cent loss ratio. It was adjusted as Uplift calculates it on 60 per cent of premium received that goes to the insurance fund.

4 > RELATIVE VALUE FROM PRODUCTS AT THE COUNTRY-LEVEL

This section presents country-level analysis and argues that there is a case for market-based microinsurance that is fulfilled differently in the three market studies: life microinsurance in the Philippines, health microinsurance in India, and composite health and life products in Kenya. It shows the importance of a client value assessment of a microinsurance product in relation to alternatives in the same market.

4.1 SETTING BENCHMARKS: INFORMAL MECHANISMS AND SOCIAL SECURITY SCHEMES

Informal mechanisms and social security schemes provide a benchmark to assess the value of microinsurance in the context of other risk management options.

Low-income households use a multitude of informal group mechanisms such as burial societies, savings or self-help groups to manage life, health and property risks. Through group risk-sharing mechanisms, households participate in an important social function nested within well-defined communities that allow risk pooling without much fraud, moral hazard or adverse selection. However, as described by Dercon (2005) and Morduch (1999) they have many weaknesses. They can only handle idiosyncratic risks, not those that affect entire communities (e.g. flood). They are best suited for small disbursements for frequent events. Responding to larger losses is only possible by well-structured groups, often managed by a remunerated committee, which is rare and happens mostly in urban areas. Low-income households tend to patch various strategies together because none can provide enough funds on their own to cover large losses. Households compensate by participating in multiple group schemes, or in the case of emergencies they deplete their savings, sell assets at low prices, or take one or more small loans from moneylenders or MFIs. These activities often involve high transaction costs (Cohen and Sebstad 2005, Collins et al 2009).

The PACE client value assessment in Kenya (see Box 6 and Annex B) on the use of informal risk-management arrangements in response to health and life risks confirms that they offer partial coverage for an expensive price. Informal risk sharing mechanisms in Kenya score low on Product benefits and Cost, high on Access, and medium on Experience.

Box 6: Client value from informal risk sharing mechanisms in Kenya

In Kenya, 'welfare groups' that consist of 20 to 60 members are a popular, self-managed way to respond to life and to certain extent major health risks. They are better organized in urban areas where members contribute regularly approximately KES 200 to KES 400 (US$2.2 to US$ 4.4) per month to receive a KES 20,000 to KES 50,000 (US$222 to US$555) payout in case of death of the member or a family member. In case of major illness, members are requested to contribute ex-post from KES 100 to KES 500 (US$ 1.1 to US$ 5.5), which usually results in lump sums of KES 5,000 to KES 30,000 (US$55 to US$ 333) to cover health bills. In rural areas the ex-ante collections are rare, members of welfare groups are requested to contribute during the funeral and sometimes organize special fundraising events to collect funds to help other members in the group to respond to major health shocks (Cohen et al 2003, Smith et al 2010, Simba 2002).

Given that costs of funeral vary from KES 150,000 to KES 200,000 (US$ 1,666 to US$ 2,222), risk coverage from one welfare group is not enough. Many people belong to two to five welfare groups at the same time or need to patch together multiple other strategies such as borrowing or selling assets to generate the required amount. So even if regular contributions to one group may seem affordable (and are close to premiums collected for similar microinsurance offerings) the cost to benefit ratio is low. Moreover, each membership incurs transaction costs in the form of time, fees, and in-kind contributions; relying on several informal group-based mechanisms can be a very

costly strategy for coping with shocks. Lastly, those groups do not have any 'stop-loss' arrangement in case of excessive claims from their members so are vulnerable in themselves.

The welfare groups in Kenya are accessible but seem to provide poor service to their members. Johnson (2004) reports that 40 per cent of households in one rural area belonged to at least one group. In most cases rules are simple, groups are within the close community and have convenient ways to collect member contributions in frequent but small instalments. Claims settlement procedures are also easy and quite flexible. But seem to work only for ex-ante schemes that provide good service in urban areas for life risks. In case of a funeral, groups usually pay the family instantly the life benefit that is based on regular contributions. It is rarely the case in rural areas and in general for health risks. There is some evidence to reckon that ex-post contributions are provided with long delays, if at all. Simba (2002) says that collecting contributions from members can take many weeks after a funeral.

The other useful benchmark for analysing client value for microinsurance is social security schemes. Despite the emergence of social security schemes that go beyond protecting the formal sector, their outreach is still low and they rarely offer comprehensive protection, most often cater to health shocks or catastrophic events or aim at reducing vulnerability of children and elderly people (ILO 2008).

The National Health Insurance Fund (NHIF) in Kenya is a good example of a government effort to protect a poorer stratum of the population. Originally available for formal sector employees and funded by their contributions, in 2007 the NHIF scheme was opened to include informal sector workers for an annual premium of KES 1,920 (US$21) for the whole family, which is approximately 0.8 to 1.2 per cent of a low-income household income. The cover can be bought by anybody at NHIF offices, but given the limited public awareness, few people have enrolled. It offers close to full hospitalisation cover at government hospitals and limited reimbursements for services from private health facilities. This is a reasonable coverage at the price, thus NHIF cover scores well on the Cost dimension, moderately on the Product and Experience dimensions, mostly because of the low service quality at government hospitals, and poorly on the Access dimension (see Annex B for more details). Government schemes in India (see Annex C) obtained similar scores to the Kenyan case, which suggests that while social security schemes might solve the cost problem (mostly through subsidies), better solutions are needed to enhance awareness, establish efficient processes and control quality of care.

As shown in Figure 6, in Kenya, in the broader risk management picture it seems as though there is an opportunity for microinsurance products to add value. To do so, microinsurance should mimic informal ways to provide access and complement the benefits of social security schemes, while offering superior service.

4.2 UNVEILING WEAKNESSES OF COMPOSITE PRODUCTS IN KENYA

Low-income households in Kenya rank risks to health and life as their biggest concerns (Cohen et al, 2003), and this demand perspective is consistent with the supply of informal risk management arrangements and microinsurance schemes that often cover both health and life risks. The Kenyan PACE analysis compares three composite products by CIC, Pioneer Assurance and Britak, and two in-patient health products by Jamii Bora Trust and NHIF (see Figure 7 and Annex B for more details).[10] One may argue that this is comparing apples to oranges. However, as health risks are a great concern for low-income households, a comparison of a health and life product to a health only product is a valid exercise from the clients' perspective as both address their highest priorities. Additionally, the products are comparable as they target broadly similar market segments; CIC and Britak serve the same populations in rural areas, CIC and Pioneer Assurance in urban areas, and Jamii Bora Trust targets the slightly lower market of urban slum dwellers. None of the reviewed Kenyan schemes, however, have a business case at this point.

[10] CIC product sells NHIF in-patient cover and bundles it with life benefits underwritten by CIC.

Figure 6: PACE evaluation of informal risk-management mechanisms and NHIF in Kenya

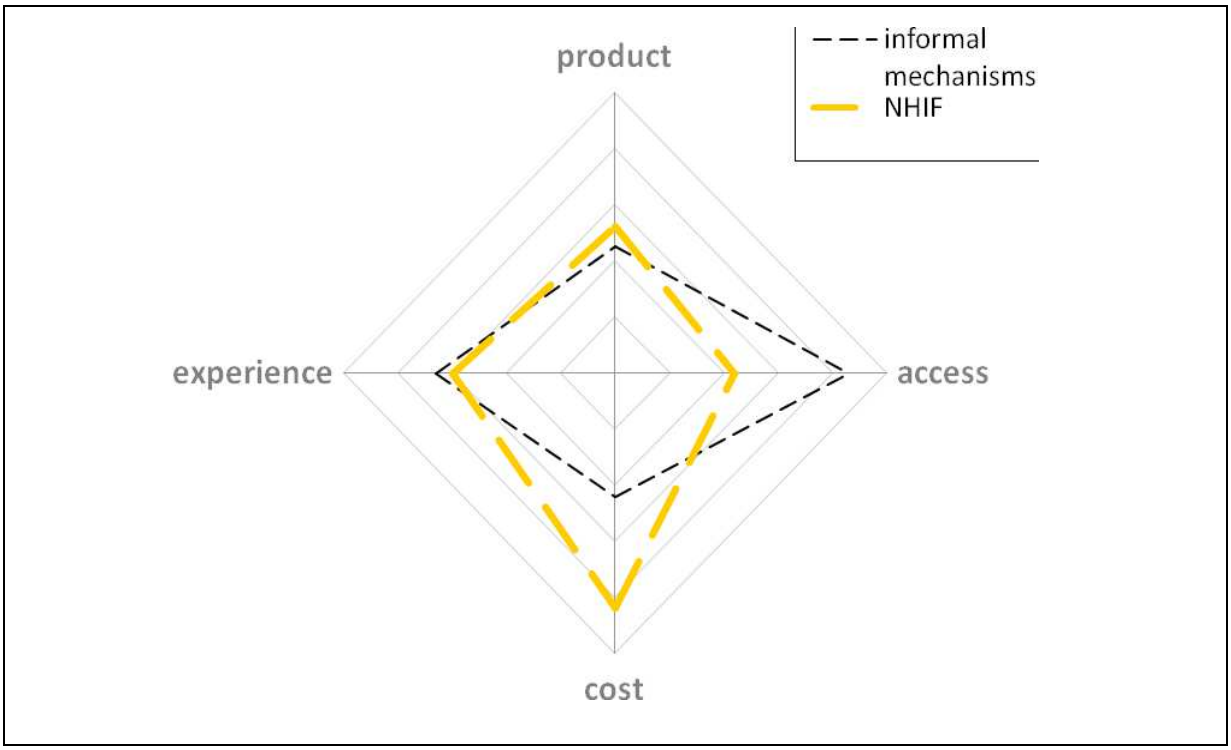


Figure 7: Considered offerings for the PACE assessment, Kenya.

	CIC, Bima ya Jamii	Pioneer Assurance, Faulu Afya	Britak, Kinga ya Mkulima	Jamii Bora Trust
Start date	2007	2010	2007	2001
Product type*	IP health, AD&D, funeral Voluntary, standalone	IP&OP health, term life, AD&D Voluntary, standalone	Whole life, IP health Voluntary, standalone	IP health, credit life Mandatory, credit-linked
Coverage	KES 340,000 (IP), KES 50,000 (hospital cash), KES 100,000 (AD&D), KES 30,000 (funeral)	KES 200,000 (IP), unlimited OP, KES 100,000 (life), Disability on tables	KES 100,000 (life), including 20% for IP health	Unlimited IP, outstanding loan cover
Yearly premium**	KES 3,650 for family	KES 6,995 for family	KES 1,860 for member and spouse	KES 2,400 for family
Distribution	SACCOs and MFIs	MFI	Employer (KTDA)	MFI
Targeted segment***	SACCO members and MFI clients KES 10-15,000 (rural) KES 15-30,000 (urban)	Urban micro entrepreneurs KES 15-30,000	Small-scale tea growers KES 10-15,000	Urban slum dwellers KES 10-20,000
Performance	8,300 lives (06.2010) 40% claims ratio for life; 120% for health 25% renewals ratio	11,000 lives (09.2010) > 100% claims ratio	78,000 lives (10.2010) 80-100% claims ratio 1% lapse rate	600,000 lives (10.2010) 80-120% claims ratio

Data sources in Annex A; more details on product specifications and performance in Annex B.

** IP = in-patient; OP = out-patient; AD&D = accidental death and disability*

*** Premiums do not include cost of taking a loan to purchase insurance, which is very common for all the reviewed offerings but Britak one.*

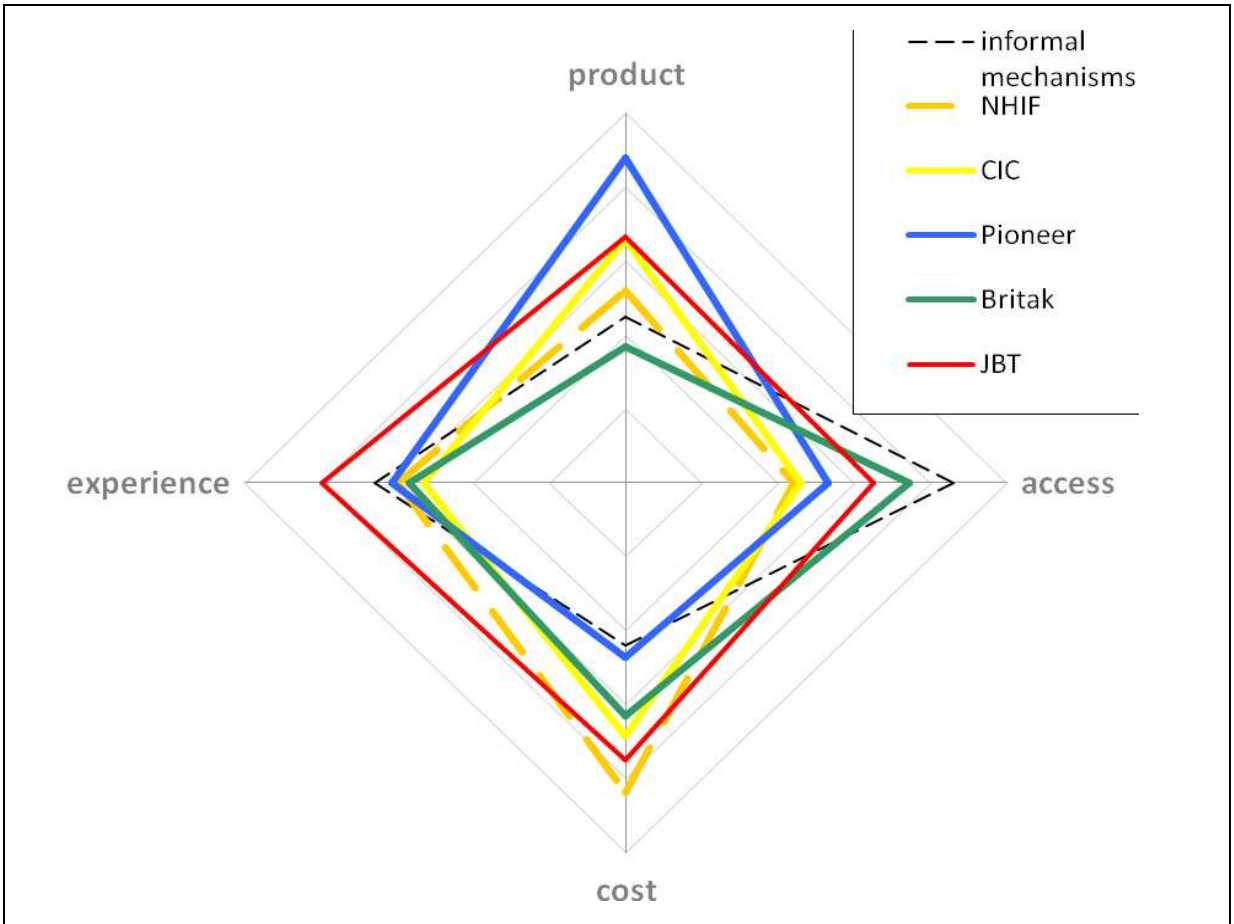
**** Average monthly household income based on estimations of the providers, ongoing impact study of the CIC product conducted by EUDN and Oxford University and Ana Klincic's study on Jamii Bora Trust clients.*

According to the PACE analysis, Jamii Bora Trust's microinsurance product is the only product that significantly adds value (Figure 8 and Annex B). This product mimics informal mechanisms in terms of access, fulfils social functions and provides superior service, while at the same time providing more comprehensive cover than NHIF for a similar price. The relatively good value for money stems from the fact that adverse selection is limited due to the mandatory nature

of the product, and adequate controls are put in place to reduce fraud and moral hazard by health care providers. The mandatory, credit-linked feature lowers the ranking for access as clients do not have any choice and in most of the cases finance premiums through loans. However, this is counterbalanced by product simplicity and the proximity of Jamii Bora branches. Giving the members more choice is now being discussed, but it seems that making the product voluntary to all Jamii Bora Trust members might reduce value for money as adverse selection and administration costs will increase significantly.

Britak's is the most accessible product because of its simplicity and its very convenient delivery channel that allows automatic premium deduction from monthly wages. However, the relatively small benefits undermine its development potential. Moreover, the slightly lower value for money puts this product at risk when markets become more educated and less fragmented. Britak is now discussing an enhancement that might significantly improve the product benefits but at a price that might not be affordable for this market segment (see Section 5 for more details).

Figure 8: Client value PACE assessment, Kenya.



	informal mechanisms	NHIF	CIC	Pioneer	Britak	JBT
product	2.3	2.6	3.3	4.4	1.9	3.3
access	4.3	2.2	2.3	2.7	3.7	3.3
cost	2.2	4.2	3.4	2.4	3.2	3.8
experience	3.3	3.0	2.7	3.1	2.9	4.0

Bima ya Jamii has been a sound attempt by CIC to enable access to NHIF cover, while at the same time improving coverage and service at a reasonable price. However, it has not worked very well in practice and requires readjustment as NHIF announced in 2010 the intention to include out-patient services in their cover, which will result in a substantial increase in the premium (2.3 per cent of monthly income). Therefore, CIC and NHIF are contemplating

whether to stop offering the product in its current form. Despite improvements on proximity and client awareness, CIC and NHIF have encountered difficulties in streamlining the enrolment process, document requirements, and synchronizing their information systems. CIC was also obliged by regulation to collect an annual premium upfront (while for directly bought NHIF cover monthly instalments are possible), which created affordability challenges and inhibited access.

Pioneer Assurance's product received a low ranking for different reasons. On one hand, it is the most comprehensive offering on the market and as such merits attention, but it is hard to explain to clients and difficult to maintain high service standards for a multiple cover, resulting in lower scores for Access and Experience dimensions. Moreover, the product struggles with adverse selection and there is a need to improve administrative processes to better manage the providers' network. Lastly, low-income markets are sensitive to price; a premium equivalent to 2.9 per cent of monthly income puts the Pioneer product at the limit of affordability. Yet, it is the least mature of all the reviewed products and its value proposition is likely to improve over time.

The jury is still out on the client value from Kenyan microinsurance offerings as many of them are new: with their limited maturity, there is room for improvement. The PACE analysis raises a question about the client value from composite products, at least in a rigid form as they are presented in Kenya. In theory, there are strong arguments in favour of composite products given the high acquisition costs in microinsurance. However, one needs to be conscious of their drawbacks. Inherent complexity makes it difficult to explain benefits to clients, expensive to administer, and difficult to maintain high quality service, resulting in barely affordable products. From the client value perspective, the lack of choice is an issue as it is tricky to assume that one-size solutions fit all. All these factors have resulted in low take-up.

4.3 COMPARING VARIOUS MODELS FOR HEALTH INSURANCE IN INDIA

Over the last decade, a number of health microinsurance products have been developed in India making it the most mature market for the provision of health cover to low-income households. As shown in Figure 9, the PACE analysis captures this diversity by looking at five hospitalisation products bundled with additional benefits. These products are delivered by a community-based scheme (Uplift Mutual), by NGOs in partnership with insurers (PWDS, VimoSEWA), by an insurance company in collaboration with the Ministry of Textiles (ICICI Lombard), by a state government in collaboration with cooperatives (Yeshasvini) and by the government with various private insurers to below the poverty line population (RSBY)[11]. The RSBY and weavers' schemes are subsidized and the latter is the only one offering full out-patient cover. It may seem unfair to compare subsidized schemes to market-priced ones, but these comparisons make sense from the clients' perspective, which is the essence of the PACE assessment. The products serve similar target groups, but are sold in different locations with the exception of RSBY, which has been rolled out in many states across India.

[11] Various insurers deliver RSBY; premiums vary slightly but the product design and core processes remain the same. For the PACE analysis, the RSBY delivered in collaboration with ICICI Lombard is taken as a reference.

Figure 9: Considered offerings for PACE analysis, India

	RSBY	ICICI Lombard, HIS scheme for weavers	Yeshasvini	Bharti-Axa/ PWDS	VimoSEWA, Sukhi Parivar and Swastha Parivar	Uplift
Start date	2009	2005	2007	2010	1992	2003
Product type*	IP health, voluntary, individual, standalone	IP and OP health, voluntary, group, standalone	IP health, voluntary, group, standalone	IP health, voluntary, group, standalone	IP health, voluntary, group, often linked	IP health, mandatory, group, credit-linked
Distribution	Mass	Cooperatives	Cooperatives	SHGs	SHGs	MFIs
Coverage	INR 30,000 no sub-limits, pre and post IP, full maternity, transport allowance, OP discounts	INR 15,000no sub-limits, comprehensive cover	INR 200,000 IP but limited to one incidence per person per year; mostly surgeries	INR 30,000 no sub-limits, full maternity,	INR 2,000-6,000 for composite products; INR 10,000 for the standalone product	INR 15,000 for IP, sub-limits pre and post IP, OPD discounts, preventive health services
Monthly premium per family	INR 2.5	INR 12.5	INR 50	INR 59	INR 50	INR 33
Targeted segment**	India's BPL* population in both urban and rural settings Monthly household income: INR 1500 (rural) and INR 2000 (urban)	Weavers and other textile industry workers Semi-Urban and mostly Rural (in 29 states of India) Mostly BPL members Monthly household income: INR 2000 (rural) and INR 2500 (urban)	Members of the Registered Cooperative Societies in rural Karnataka Upper poor, some BPL members INR 3000 (rural) and INR 3500 (urban)	Members of SHG's in 7 Federations in 3 southern districts of Tamil Nadu Rural only Upper poor INR 3500 (rural)	Members of SEWA and other NGO beneficiaries, mostly in Gujarat. Informal sector, rural (60%) and urban (40%) Poor, some BPL members INR 2500 (rural) and INR 3000 (urban)	Mostly urban population, Pune and Mumbai, slum dwellers, microcredit clients Poor, some BPL members INR 2500 (rural) and INR 3000 (urban)
Performance	22.5 million cards issued so far Average 2.5 lives per card enrolled	1.7-1.8 million policies, 5-6 million lives (12.2010); 90% coverage ratio 50-90% claims ratio; low claims rejection ratio 95-100% renewals ratio	2.7 million lives (11.2010) 70-100% claims ratio 70% renewals ratio	6,500 policies, 16,000 lives (12.2010) 140-160% claims ratio	60,000 policies, 100-125,000 lives (12.2010); 8% of SEWA members 60-90% claims ratio, 15% claims rejection ratio 60% renewals ratio	100,000 lives 47% claims ratio, 2% rejection ratio 70% renewals ratio (02.2011)

Data sources in Annex A; more details on product specifications and performance in Annex C.

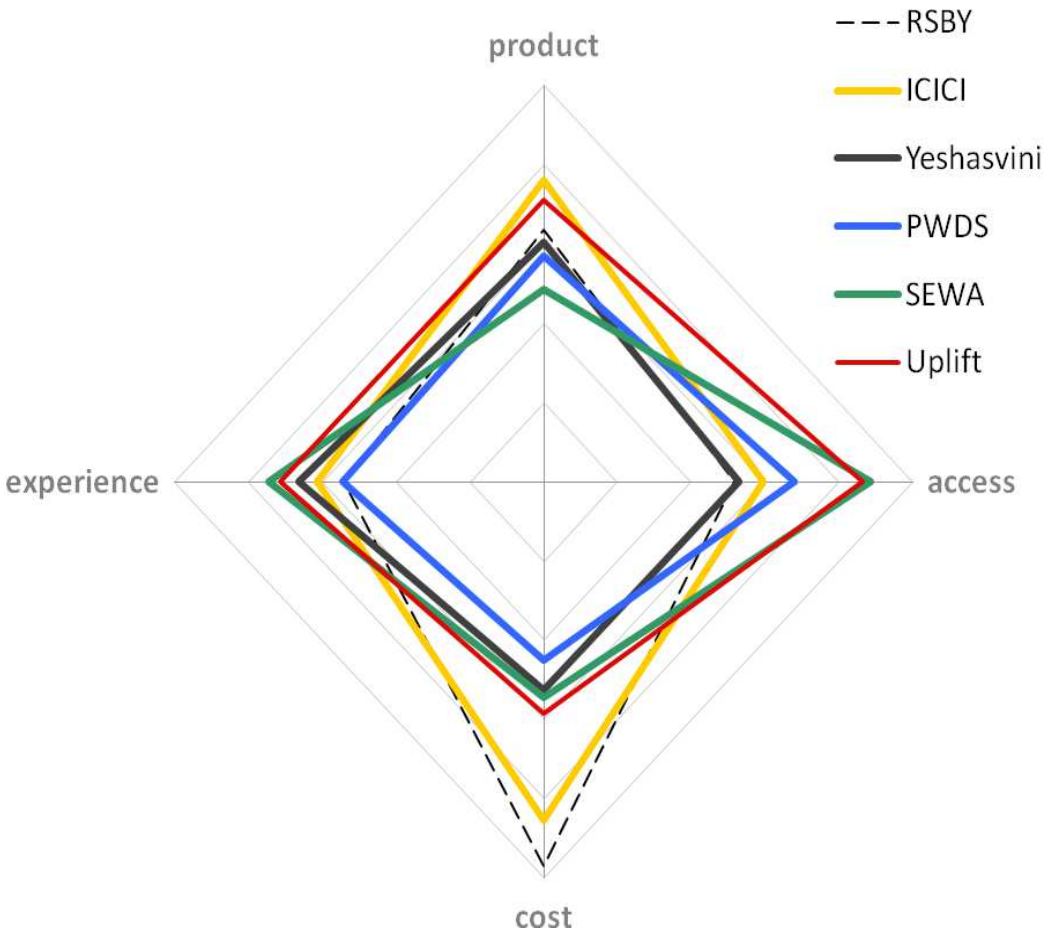
** IP in-patient; OP out-patient; BPL below the poverty line*

*** Client income estimations should be treated with caution as limited data was available. Amounts stated above are based on estimations of providers in relation to BPL level in India; for which threshold is set at approximately* INR *1,800 (rural) and* INR *2,300 (urban) monthly income for a family of four.*

As shown in Figure 10, the government-sponsored schemes in India score similarly to their Kenyan counterpart NHIF (see Figure 6). Although they can provide better products at a lower cost due to subsidies, as large-scale schemes, they underperform on both Access and Experience dimensions. For RSBY, access is limited to below the poverty line (BPL) population as identified by the ration card. More importantly, enrolment is often done within a specific window of time and all family members need to be present in person, which suppresses enrolment. Limited information to the public and limited effort to educate members are likely explanations for low usage rates. In the case of ICICI Lombard, access to its scheme is constrained by limited member education for a relatively complex product. Low usage rates

may suggest inadequate claims procedures, but an emerging 'cashless' system should improve service quality in the near future. The government of India and involved insurers are investing resources to make the RSBY and other government-sponsored schemes work for low-income populations.

Figure 10: Client value PACE analysis, India



	RSBY	ICICI	Yeshasvini	PWDS	SEWA	Uplift
product	3.2	3.8	3.0	2.9	2.4	3.6
access	2.6	3.0	2.7	3.4	4.4	4.3
cost	4.9	4.3	2.6	2.3	2.7	2.9
experience	2.7	3.1	3.3	2.7	3.7	3.6

Improvements in the Access and Experience dimensions might make it difficult for market-priced schemes to compete with RSBY and other government schemes, at the least for the poorest clients. Presently, it is still the case that some households are enrolled in RSBY and other health microinsurance schemes, but in the future, it seems that schemes will align with RSBY and reposition their products. Organisations like Uplift, VimoSEWA and PWDS can improve access to RSBY and make sure that their members benefit from the government system.

Interestingly, as with Kenya, the most 'balanced' client value is provided by a community-based scheme run by Uplift Mutuals. As described in detail in Section 3, Uplift scores well on the PACE framework mostly because of value-added services, quality care management, systematic client education efforts and outstanding customer care. VimoSEWA is very close to Uplift in several dimensions except for Product as benefits are the lowest offered among

the Indian schemes. At the same time, the VimoSEWA scheme has been financially viable for several years now[12], while Uplift is still dependent on donors[13], which might suggest that the value-added benefits provided by Uplift might not be realistic for a market-based scheme. Premium increases might be an option to improve viability as most of the reviewed schemes in India are below the willingness to pay threshold for health insurance of 1.35 per cent of income as estimated by Dror et al (2006).

Yeshasvini and PWDS offerings add slightly less value, however, they serve their captive markets and provide decent coverage at a fair price. Access seems to be an issue for Yeshasvini, while PWDS, the least mature of all the Indian schemes, needs to improve on claims administration and quality of service. If adverse selection and moral hazard problems are solved, there might be room for further improvement resulting in higher client value.

To summarize, the PACE analysis for India draws an interesting picture of the value delivered by different models. Each model has different strengths that can be leveraged to create better health insurance offerings for low-income households. Private sector players and NGOs should align their products with large public schemes (provided that service quality improves) through integration or by targeting different market segments.

4.4 ENHANCING VALUE FROM LIFE INSURANCE IN THE PHILIPPINES

As India is one of the most mature markets for health microinsurance, the Philippines is for life microinsurance. Compulsory life covers with disability and funeral benefits were selected for the PACE analysis. The different models represented include CARD and FICCO, which are large Mutual Benefit Associations (MBAs): CLIMBS, a regulated, cooperative insurer working in a partner-agent model with MFIs and cooperatives; and Microensure, a specialized broker that develops and administers products delivered in a partner-agent model.[14] The four products are similar and broadly target the same market segments (Figure 11), which makes the PACE analysis easier than in the case of Kenya and India where the presence of social security schemes and the complexity of health insurance made the comparisons more challenging.

Figure 11: Considered offerings for PACE analysis, Philippines.

	FICCO, MBA	CARD, MBA	CLIMBS, Micro-biz family protector	Microensure, Family Life with TSKI
Start date	2007	1994	2004	2007
Product type*	Term life, AD&D	Term life, AD&D	Term life, AD&D, funeral, fire	Term life, AD&D, funeral
Coverage	PHP 40,000 (natural death, principal), PHP 10,000 for others, same AD&D	PHP 50,000 (natural death, principal), PHP 10,000 for others, same AD, Disability up to 100,000 Php, 10,000 Php hospital cash due to motor vehicle accident	PHP 30,000 (natural death, principal), 10- PHP 15,000 for others, same AD&D, burial benefit PHP 2,500-10,000, PHP 40,000 for fire	PHP 90,000 (natural death, principal), PHP 15- 30,000 for others, PHP 70,000 (AD&D, principal), PHP 10-20,000 for others, benefit PHP 5,000-20,000
Monthly premium per family**	PHP 90	PHP 60	PHP 87	PHP 78
Distribution	FICCO MFI	CARD MFI	MFIs and cooperatives	TSKI MFI
Targeted segment***	Microentrepreneurs, fishermen, farmers and formal sector workers loans from PHP 13,000- 2M PHP 5-20,000 monthly average family income	Women microentrepreneurs, trade, services, agriculture PHP 5-20,000	Members of credit and savings cooperatives PHP 5-20,000	Women microentrepreneurs, working poor, mostly in rural areas PHP 5-20,000

[12] It is sustained and viable for VimoSEWA, which has not been validated with insurers carrying the risk for the scheme.
[13] Currently, Uplift covers costs of the insurance operations with the collected premiums. The part that is not sustainable is all the added value services (access to health initiative), which is funded by donors. According to Uplift management, the whole scheme can become sustainable with continuous improvements in systems and reaching economies of scale (at least tripling the current membership).
[14] Microensure product with TSKI is taken as a reference for the PACE assessment in the Philippines.

Performance****	85,000 members (330,000 lives insured) 30% claims ratio Retention rate >80%	1 million members (4 million lives insured) 15-25% claims ratio Retention rate >80%	135,000 lives	1 million lives 45% claims ratio

Data sources in Annex A; more details on product specifications and performance in Annex D.

** AD&D = accidental death and disability*

*** Half of the premium for MBAs goes to guarantee fund and is reimbursed to members when they decide to leave the scheme.*

****As all the schemes target population that is just below or just above the poverty line, the estimated income range for all schemes is PHP 5,000-20,000, with average monthly household income at PHP 11,000. These calculations are based on the following sources: 1) PhilHealth (2010): low-income threshold at Php 246,109 annually, approx PHP 20,000 monthly; average income in low-income group PHP 7,500. 2) NSCB (2011) official poverty statistic: monthly poverty threshold for a family of 5 at PHP 7,017.*

***** Claims ratio for MBAs is calculated on premiums collected. In reality, the ratio doubles as it should be based on the non-refundable portion only.*

All the schemes in the Philippines provide better value to low-income households than similar informal risk mechanisms (Figure 12), despite the fact, that in the Filipino culture, community support to help bereaved families is well established. The main limitation of informal risk-sharing mechanisms is that they only cover funeral costs, which still leaves families vulnerable when a breadwinner dies. Otherwise, informal mechanisms to deal with life risks are accessible, not costly and quite responsive, especially when compared to the same arrangements in Kenya. So the fact that the reviewed life microinsurance products add value in the Philippines merits attention, as it is hard to provide better value than the informal practice of Abuloy (see Box 7).

Box 7: Informal risk-sharing mechanisms in the Philippines

In the Philippines, informal risk sharing to deal with funeral costs is a widespread practice, especially in rural areas, where as many as 80 to 90 per cent of concerned households benefit from it. Within Damayan, a broader term for community support, relatives and friends contribute Abuloy (informal support for funeral) to a family who lost a member. The largest share is contributed by families who live abroad.

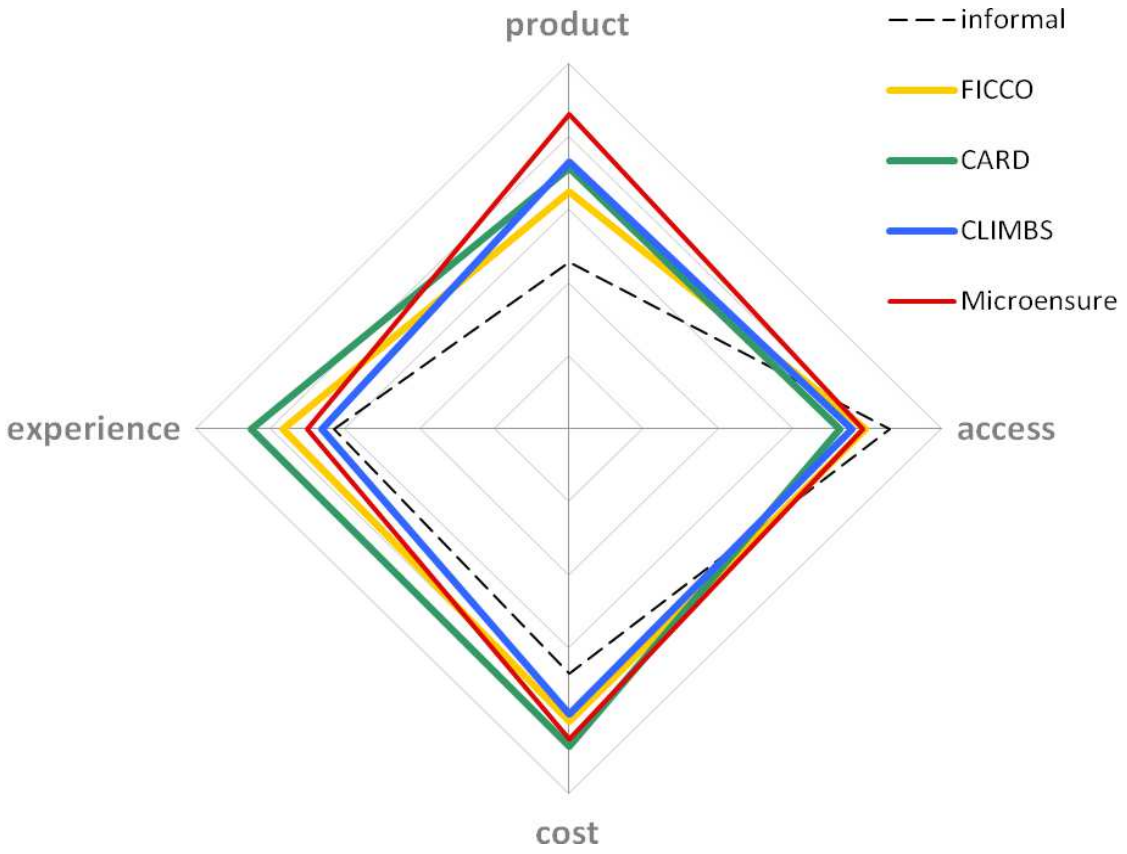
In most of the cases, contributions are made ex-post during a wake of nine days between death and funeral. Depending on wealth status of the concerned household, they range from 5 to 100 Php for more distant community members and as much as PHP1,000 (US$ 22) for close relatives or friends. The total amount collected for Abuloy ranges from PHP20 to PHP50,000 (US$ 444 to US$ 1111) but can be as high as PHP100,000 (US$2222). Funeral costs in most of the cases range from PHP50 to PHP90,000 (US$ 1111 to US$ 2000). It can be adjusted downwards to PHP10 to PHP30,000 (US$222 to US$ 666) but it rarely happens. Abuloy often covers just the funeral costs and rarely leaves the family with additional resources to readjust their income generating strategies.

Some cooperatives 'formalized' the practice of Abuloy and require their members to contribute ex-ante PHP 2 to PHP5 (US$ 0.04 US$ 0.11) per month for a death benefit of PHP20,000 to PHP35,000 (US$ 444 to US$ 777), which should be very close to the price people pay to be part in Abuloy. As regulated micro-MBAs emerged they built on those semi-formal schemes and fully formalized them. This resulted in some of the products reviewed during the PACE analysis (CARD and FICCO).

Interestingly, there are few if any similar systems that include risks other than life, forcing low-income households to patch together multiple strategies and resort to high-interest loans.

Source: Based mostly on exchange with Karlijn Morsink and on her research in the Philippines. Additional inputs obtained from John Wipf and staff of FICCO, CLIMBS and Microensure as well as Chua 1999, Llanto et al 2009 and Barbin et al (2003).

Figure 12: Client value PACE analysis, Philippines.



	informal	FICCO	CARD	CLIMBS	Microensure
product	2.3	3.3	3.6	3.7	4.3
access	4.3	4.0	3.6	3.8	4.0
cost	3.4	4.0	4.4	3.9	4.3
experience	3.2	3.8	4.3	3.3	3.5

All four products reviewed score almost the same on the four core dimensions of the PACE framework. As described in Section 3 and further detailed in Annex D, the products have various strengths and weaknesses, but offer good coverage and service for a reasonable price. According to Rimansi (2002) the price is within the willingness-to-pay range declared by low-income households. Concern over the value for money still remains a question, as all the products are very profitable, suggesting that there is an opportunity to raise benefits or reduce premium.

It is interesting to see such a convergence in an environment where there is not much competition since most of the insurers (especially those that are member-based associations) serve captive markets. However, with increased activity by CLIMBS and the recent entry of Microensure, competition has increased, and it seems like it has benefited the clients. The life products in the Philippines built on informal mechanisms and have continued improving their features to provide better value, providing evidence that maturity does matter and that client value improves over time. There are still improvements to be made and with increased competition there should be further benefit to the client.

5 > CLIENT VALUE AND STRATEGIC BUSINESS CHOICES

Understanding client value provides half the answer; striking the right balance between client value and business viability is the other half. As presented in this section, the PACE framework can help microinsurance providers make strategic choices in their pursuit of making microinsurance viable while improving client value.

5.1 PROVIDING CLIENT VALUE TO INCREASE BUSINESS VIABILITY

Marketing theory postulates that client loyalty and company profits are linked to value creation for clients (Woodruff 1997). Slater (1997) developed a value-based theory of the firm and suggested that client value should be the main purpose of organisations. Client value proposition influences purchasing decisions and product use by building client loyalty through on-going product improvements to achieve superior client value proposition, which in turn creates profits and growth. Organisations with a more comprehensive value creation strategy (greater breadth or depth of value creation) are likely to outperform competitors with less valuable offerings. Client value research can be used for describing marketing strategy, enhancing product concept specifications, identifying value creation opportunities and developing measures of customer value (Smith and Colgate 2007).

Marketing principles are more relevant for microinsurance markets, especially for mass, voluntary products, than for mainstream insurance markets, where corporate insurance is one of the main sources of business. In microinsurance, as in any other retail business, client value and business viability are interlinked. However, given the lack of maturity and competitiveness in markets, a mandatory, low client value product can sell well and bring profits as clients might not have other options or might not be adequately educated. A good client value product can sell poorly due to low insurance literacy and make losses due to inadequate pricing, cost structure or lack of economies of scale. In the short-term, business viability can be increased by reducing client value but this strategy is unlikely to work in the longer term, especially in a competitive market with educated consumers. The Philippines example presented in this paper proves that striking the right balance is possible as most of the reviewed life products are profitable and provide added value to clients compared to similar informal mechanisms. At the same time, some Kenyan products prove that a lose-lose scenario is also possible, especially during the experimentation process.

5.2 MAKING STRATEGIC CHOICES ABOUT CLIENT VALUE

The trick is to strike the right balance between client value that will pay off in the medium- or long-term for both the provider and the client. The importance of superior client value creation is central in most modern strategy models, e.g. Balanced Scorecard or Six Sigma (Kaplan and Norton 2004, Plaster and Alderman 2006). The PACE tool is based on the latter[15] and builds on the value disciplines framework[16], which includes operational excellence, product leadership and customer intimacy as the value disciplines. The model is widely used in marketing strategies and states, in a nutshell, that in competitive markets, a company cannot be all to everyone. It needs to find a niche; the niche could be price, benefits, or service or a combination of these.

It is possible to integrate results of the PACE analysis into the strategic planning process. The PACE results form an input to the planning that also considers the broader economic environment and institutional factors.[17] Providers can

[15] *Six Sigma* originated as a set of practices designed to improve manufacturing processes and eliminate defects, but its application was subsequently extended to other types of business processes and is often used as a reference model in strategic planning. Plaster and Alderman (2006) show how to go beyond *Six Sigma* to create value for customers and the enterprise. PACE framework is built on the four dimensions proposed by Plaster and Alderman.

[16] Treacy and Wiersema (1993) have modified Porter's (1980) three generic strategies to describe three basic "value disciplines" that can create customer value and provide a competitive advantage.

[17] This section presents initial thoughts on the broad framework on how to link PACE with management tools. Usage of PACE to inform marketing strategies is beyond the scope of the paper and still needs to be tested to provide further clarifications on how PACE can be better integrated with *Six Sigma*, *Balanced Scorecard*, *value disciplines*, *marketing 4P`s* and other relevant management frameworks.

repeat a PACE exercise regularly as an input into the initial product positioning process and also during the product review and repositioning process.

The Britak example from Kenya is a good illustration of how the PACE tool uses the value disciplines strategic marketing model. Britak is contemplating whether to refine its Kinga ya Mkulima product (see Figure 7 and Annex B) into a more comprehensive offering with higher health benefits, better service through localized agents and higher pricing that might make this product less affordable to the lowest segments of the microinsurance spectrum. These changes will make Britak a more balanced product in terms of client value, as shown on Figure 13. Britak will however need to leave its cost leadership position and move in the direction of higher benefits and better service (Figure 14). In a competitive market, which is not yet a case in Kenya, this would be considered as a risky endeavour. Differentiating products for various segments (providing the old product to the lower segment and the new product to the higher segment) would seem to be a more valid strategy.

Balanced client value concept makes sense from a client perspective, but providers might have valid reasons to excel at specific dimensions of client value to strategically position their products in the market. Business decisions need take into account their competitive edge and product positioning; resulting in a more nuanced `balanced' client value concept in competitive markets.

There is no simple answer to which business strategy makes the most sense but what is obvious is that incorporating clients' feedback in strategic decisions is vital, especially with growing competition. PACE and other client value assessment tools can act as the medium to accomplish this.

Figure 13: Achieving balanced client value through product refinement, Britak, Kenya.

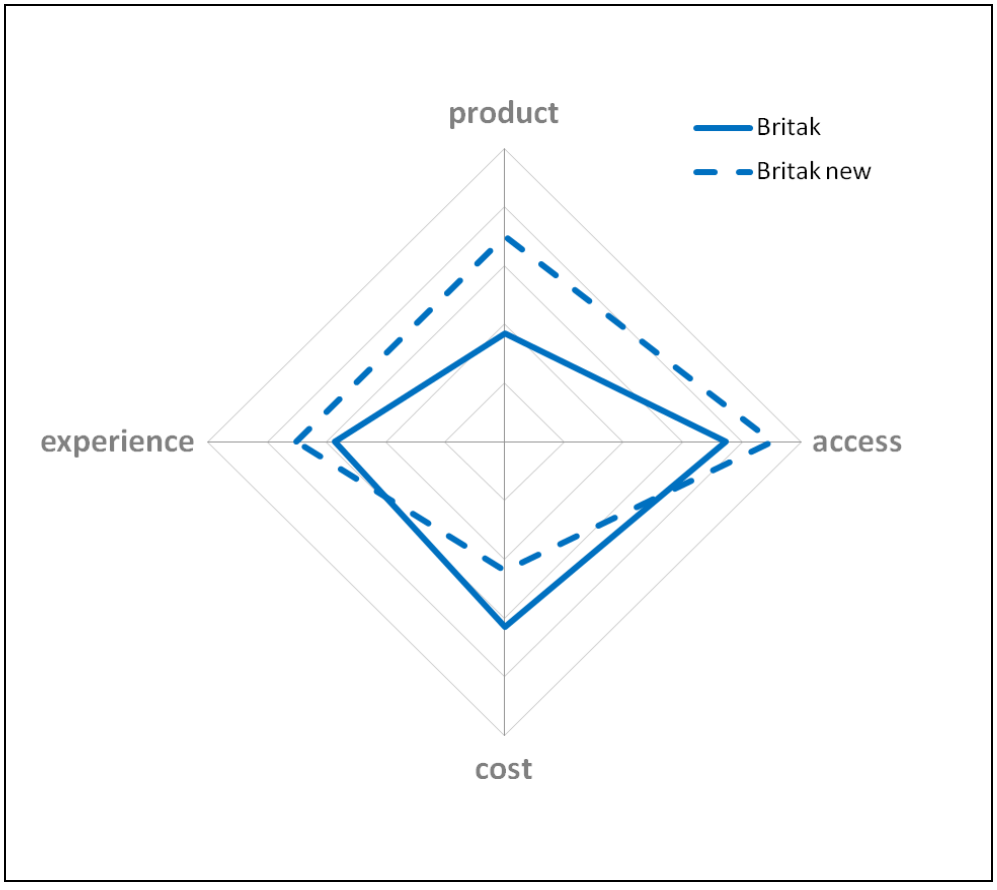
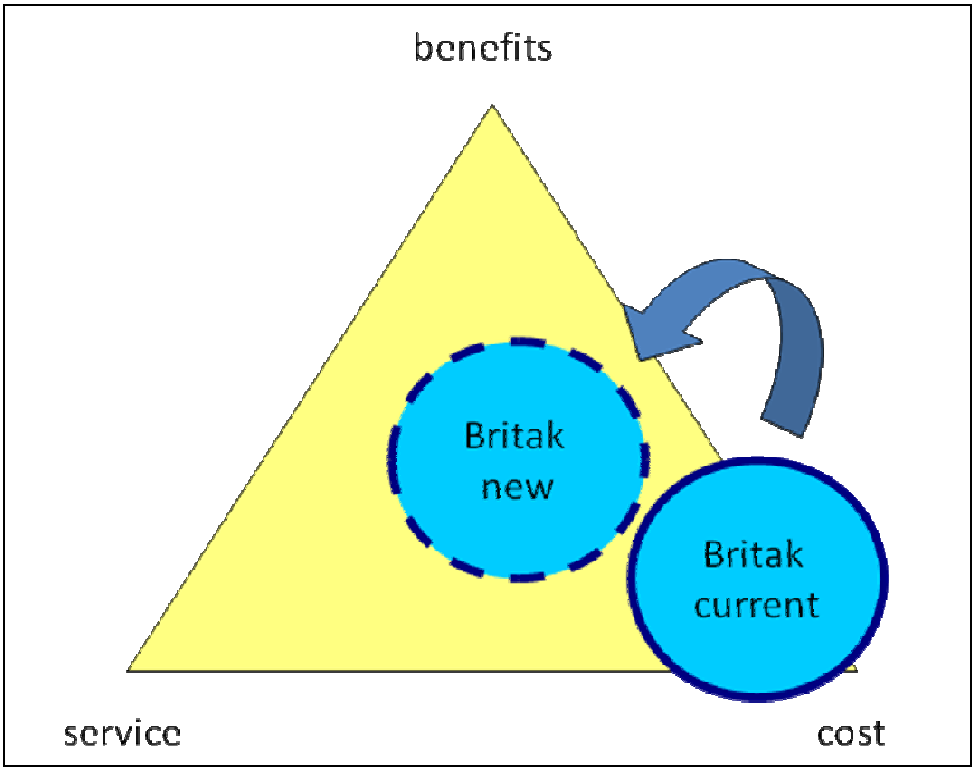


Figure 14: Product strategic positioning, Britak, Kenya.



6 > CONCLUSIONS

Client value is a complex issue, yet it is crucial to understand, and for practitioners to succeed in their business, and for other stakeholders to effectively support the development of microinsurance markets. Client value can be assessed using various methods and the PACE tool is just one approach. The PACE tool can be used to compare microinsurance to its alternatives through an audit-based system supported by secondary information sources. It fills a gap between key performance indicators, which can only signal successes or problems, and full-fledged client studies, which are expensive and longitudinal in nature. The PACE framework looks at products through the clients' lens in a holistic way by taking into consideration the dimensions that are important to consumers. Hence, it can be used by practitioners to improve value of their offerings and contribute to strategic management processes. The PACE results even seem enough to engage governments, donors and regulators in debates at the policy level.

The initial analysis in Kenya, India and the Philippines shows that there is a place for microinsurance to add value on the top of informal risk-sharing practices and existing social security schemes to protect low-income populations against life and health risks. The reviewed markets provide differing client value results - success for life insurance in the Philippines, growing value of health insurance in India, and limited value from composite life and health products in Kenya. Findings presented in this paper confirm the limitations of informal risk-management arrangements and further explore how microinsurance should complement social security systems.

The three-country analysis points to the correlation between client value and maturity of markets. In the Philippines, where for more than a decade microinsurers have been continuously improving life products, there seems to be no question about the value of all the reviewed products. In Kenya, where innovations in composite products, such as health and life, have just started, the client value of most offerings is under question as they are not much better than informal mechanisms nor do they complement the social security scheme. Indian health microinsurance products seem to be half way in their journey to delivering client value with interesting dynamics between valuable offerings by community-based or NGO-run schemes and the growing importance of government sponsored initiatives.

In the ongoing value creation process, the competitive environment, market orientation and/or social commitment can lead to significant improvements. Often enhancements were small adjustments that made a significant difference for low-income consumers. However, it is rare that one product excels in Product, Access, Cost and Experience. Hence, there remains room for improvement because clients are looking for value across the four dimensions. There are many trade-offs in this process, but if improvements lead to greater efficiency, that might make a balance proposition possible.

The examples showcased in this paper are inspiring, but client value is contextual and not all ideas can travel across borders to markets with different client's preferences, social security set up, competitive landscape, and availability of technology or distribution channels. And yet, while context matters, some client value drivers seem sufficiently universal to be put on the global microinsurance agenda to further improve client value. This includes exploring:

- improvements in claims processing, customer care, consumer education and enrolment processes
- translation of efficiency gains (through process improvements and use of technology) into better client value
- value of mandatory versus voluntary product designs
- balance between simplicity and coverage (simple covers versus more comprehensive appropriate covers) in the context of marketing, demand and acquisition costs
- ways of structuring public-private partnerships for health and agriculture microinsurance
- opportunities to build on informal mechanisms and ensure better coexistence with microinsurance
- market segmentation and better product positioning for various segments

Lastly, in microinsurance, like in any other retail business, client value should drive business viability. Better products mean reaching economies of scale, a prerequisite in microinsurance, in a more timely fashion. Some life products reviewed in this paper show that striking the right balance between client value and business viability is possible. There is no simple answer on which business strategy is the most effective, but it is very difficult to come up with a good strategy without understanding clients' needs and without a tool that will link the market intelligence into the strategic planning process. To understand clients' needs, microinsurers need more client data.

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ANNEX A: DATA COLLECTION AND SOURCES FOR CLIENT VALUE ANALYSIS

The PACE analysis can be done relatively quickly as it relies just on available secondary data and a limited number of staff interviews. Key data sources (listed below) are: product specifications, performance data, manuals and process flowcharts, reports and staff feedback. The data collection approach is similar to one of an audit, for which answers to specific questions are validated based on data from different sources. Depending on complexity, the data collection for one scheme should take no more than two to three days for an experienced consultant in microinsurance.

The more data on clients that is available the better. Client's socio-economic profile and income levels can often be extracted from the management information system, while data on needs, preferences and behaviours should be provided by available market and client studies. If the client data is not available, then the accuracy of the PACE analysis is undermined. It is also a sign for the provider that more effort is required to understand the served market. Having access to enough client data was also a challenge during the PACE tool testing. Most of the information gaps, are due to limited client data availability. Collecting primary data directly from clients increases significantly the cost of the PACE analysis, but is definitely an option for those organisations who are serious about serving the low-income market.

Information Sources for the products reviewed in this paper:

Provider, product name and country	Information sources:
NHIF, informal sector cover, Kenya	• Public documents and interactions with CIC and NHIF staff
CIC, Bima ya Jamii, Kenya	• Meetings with CIC and NHIF senior management • Field visit to one SACCO and one MFI • John Wipf mid-term project review report • Client satisfaction survey conducted by SCC • Preliminary results from impact study conducted by Oxford • Progress reports from the Facility innovation grant
Pioneer, Kenya	• Review meeting with Pioneer, Faulu and SIB (Broker) on October 12 2010. • Faulu Afya Product specifications • Mission report of May 2010 • Process manual • Client information brochure ("Faulu Afya Micro Facts") • Progress reports from the Facility innovation grant
Britak, Kenya	• Meetings with Britak senior manager and microinsurance operations person • Product description, policy document • Policy enrolment form; hospital form • Presentations and other materials collected through the Facility capacity building project by Britak
Jamii Bora, Kenya	• Interview meeting with various JBT team on October 14 2010. • Annual report 2009 • Meeting with 3 claimants in community (slum) • Client application and claims form
RSBY, India	• Publicly available documents • Discussion with ICICI Lombard RSBY team
ICICI Lombard, India	• Meetings with ICICI Lombard staff • Public information
Yeshasvini, India	• Public Information

	• Meeting with TPA administering the scheme
PWDS, India	• Meetings with CIRM staff in charge of PWDS project • Progress reports from the Facility innovation grant
SEWA, India	• Meetings with VimoSEWA staff • Public information • Facility Learning Journeys and Reports • CGAP Working Group Case Study • Progress reports from the Facility innovation grant
Uplift, India	• Email exchange with Uplift management • Public Information • Dimovska et al 2009, Ruchismita and Virani 2009
FICCO, Philippines	• Meeting with FICCO in Cagayan de Oro • FICCO Product Kit • Online public information • Various Forms – enrolment, claims, policy
CARD, Philippines	• McCord and Buczkowski (2004) • CARD MBA website
CLIMBS, Philippines	• Meeting with CLIMBS in Cagayan de Oro • CLIMBS Annual Report and Newsletyer • Company documents (policy wording, flyers)
Microensure/TSKI, Philippines	• Meetings with Microensure and TSKI • TSKI Flyer

Completeness of data on the analyzed offerings (H- high, M-medium, L-low)[18]

	Product	Access	Cost	Experience
NHIF, Kenya	H	M	M	M
CIC, Kenya	H	M	H	H
Pioneer, Kenya	H	M	M	L
Britak, Kenya	H	L	M	L
Jamii Bora, Kenya	M	M	M	M
RSBY, India	H	L	M	L
ICICI Lombard, India	M	L	L	L
Yeshasvini, India	H	L	M	L
PWDS, India	H	M	M	M
SEWA, India	H	M	M	M
Uplift, India	H	M	M	M
FICCO, Philippines	H	L	H	L
CARD, Philippines	H	L	M	L
CLIMBS, Philippines	H	L	M	L
Microensure/TSKI, Philippines	H	M	H	L

[18] This table reflects how complete was the data used for the PACE analysis. Low can mean that there were limited secondary sources or that meetings with relevant staff were not possible. For example, analysis of CARD MBA product was done just on publicly available sources, without interaction with CARD MBA staff (hence low on access and experience). The final results of the PACE analysis were validated by CARD MBA.

ANNEX B: DETAILED CLIENT VALUE PACE ANALYSIS FOR KENYA

	Informal	NHIF	CIC	Pioneer/Faulu	Britak	Jamii Bora Trust
1. PRODUCT	2.3	2.6	3.3	4.4	1.9	3.2
1.1 Coverage, service quality, exclusions and waiting periods	1.5-> mostly life cover; ad-hoc, ex-post coverage for major health risks, group decisions on health risks	2.5-> full hospitalisation in public hospitals; low service quality, limits in other facilities; no life cover, typical exclusions	3.5-> health as for NHIF plus hospital cash; low funeral cover; inappropriate AD&D, typical exclusions	5.0-> very comprehensive health; good health-care quality; appropriate life cover, typical exclusions	2.0-> life cover; very limited health cover, typical exclusions	3.0-> full in-patient cover in good missionary hospitals, only credit life cover, typical exclusions
1.2 Sum insured in relation to cost of risk	1.5-> KES 20-50,000 for life; low health cover	3.0-> 340,000 for hospitalisation, no life cover	4.0-> 340,000 for hospitalisation, 50,000 hospital cash, 100,000 for AD&D, 30,000 for funeral	5.0-> 200,000 for hospitalisation, unlimited out-patient, full maternity, HIV/AIDS, critical illness, 100,000 for life, disability based on tables	2.0-> 100,000 for life, 20% for hospitalisation	3.5-> unlimited hospitalisation, outstanding loan life cover
1.3 Eligibility criteria	4.0-> very inclusive	3.5-> inclusive family cover	3.5-> inclusive family cover	4.0-> very inclusive family cover	2.0-> only adults	3.0-> for borrowers only, inclusive family offer
1.4 Value-added services	4.0-> social network, mutual help	1.0-> none	1.0-> none	2.0-> wedding benefit	1.0-> none	4.0-> access to JBT social services
2. ACCESS	4.3	2.2	2.3	2.7	3.7	3.3
2.1 Choice and enrolment	4.0-> voluntary, very accessible for most, simple enrolment, restricted choice	2.0-> voluntary, many documents required, limited help from NHIF staff	2.0-> voluntary, many documents required, limited added-value from sales staff, no choice in a composite product	3.0-> voluntary, simplified enrolment process supported by Faulu loan officers, no choice in a composite product but possibility to select from three cover levels	3.5-> voluntary, opt-out option	3.0-> mandatory, linked to loan, very easy enrolment leveraging microcredit operations
2.2 Information and understanding in relation to complexity	4.0-> simple, easy-to-follow rules, only oral, subject to manipulation	1.5-> limited information available to the public, confusions about empanelled hospitals	2.0-> marketing sessions with no follow up, limited knowledge of sales staff, confusions about empanelled hospitals, complex product	2.0-> well-designed brochure for clients, marketing efforts with visual support and FAQ sessions, confusions about empanelled hospitals, complex product	3.5-> simple product, high usage, some confusion about empanelled hospitals, no specific education	3.5-> simple product, most of staff had or has same policy so explain well, simplified list of hospitals, no specific education
2.3 Premium payment method	5.0-> frequent payments, flexibility	3.5-> monthly payments possible	2.0-> annual premium payment, possibility of credit facility to pay premium	2.0-> annual premium payment, possibility of credit facility to pay premium	5.0-> deducted from monthly pay check at tea collection centre, 3-month grace period	2.5-> annual premium payment, possibility of credit facility to pay premium, lower amount and lower interest rate
2.4 Proximity	5.0-> close community, no restrictions on use of health care facilities	3.0-> offices only in major and secondary towns, good network of	4.0-> close contact by the sales staff	4.0-> close contact by Faulu staff, effort to develop dense network of health	3.5-> tea collection centres are close but not all of them are	4.0-> close contact with JBT staff, close network of hospitals in urban areas

		hospitals		care providers	staffed with insurance reps	
3. COST	2.2	4.2	3.4	2.4	3.2	3.8
3.1 Premium in relation to benefit	2.5-> ratio to risk coverage= 40; ratio to all benefits= 27 [average monthly premium per beneficiary= KES 60]	4.5-> ratio to risk coverage= 13; ratio to all benefits= 12 [average monthly premium per beneficiary= KES 32]	4.0-> ratio to risk coverage= 17; ratio to all benefits= 18 [average monthly premium per beneficiary = KES 61]	3.0-> ratio to risk coverage= 29; ratio to all benefits= 33 [average monthly premium per beneficiary= KES 145]	2.0-> ratio to risk coverage= 39; ratio to all benefits= 42 [average monthly premium per beneficiary= KES 77]	4.5-> ratio to risk coverage= 11; ratio to all benefits= 10 [average monthly premium per beneficiary= KES 33]
3.2 Premium in relation to client income	2.5-> 2.3% of monthly income in rural and 1.5% in urban areas [average monthly premium per family = KES 300][19]	4.0-> 1.2% in rural and 0.8% in urban [average monthly premium per family = KES 160]	3.0-> 2.3% in rural and 1.5% in urban [average monthly premium per family = KES 304]	2.0-> 2.9% in urban [average monthly premium per family = KES 583]	4.0-> 1.2% in rural [average monthly premium per family = KES 155]	3.0->1.4% in urban [average monthly premium per family = KES 200]
3.3 Other costs	1.5-> high transaction costs of patching multiple strategies	4.0-> limited other or transaction costs	3.0-> same as NHIF but additional premium financing costs	2.5-> copayment for out-patient and premium financing costs	3.5-> copayments for hospital admission; limited other costs	3.5-> premium financing costs (lower base), limited other costs in urban areas
3.4 Cost structure and controls	1.5-> health cover is ex-post, ineffective if many members affected, no stop-loss arrangement	4.0-> less of an issue for government scheme (from client's perspective)	3.5-> lean structure with limited number of intermediaries, life component, slightly overpriced, some good adverse selection controls and health risk covered by NHIF	1.5-> broker involvement increases costs without clear benefits, lack of adequate adverse selection measures, unlimited outpatient cover	3.5-> reasonable cost structure and pricing for this segment, no fraud controls for hospitalisation cover	4.0-> skilled claims team and good fraud controls, good management of health care providers, likely cross-subsidy option in case of excessive claims, some adverse selection from pregnant women
4. EXPERIENCE	3.3	3.0	2.7	3.1	2.9	4.0
4.1 Claim processing procedures	4.0-> Simple but gets complicated with ad-hoc health claims. Much efficient in urban areas where groups are more organized.	3.0-> NHIF cards are recognized in government hospitals, however, those have customer care standards. More confusion expected in private hospitals.	2.0-> Bima ya Jamii card not recognized in all facilities. Additional document needed, which complicates emergency situations. Typical documents for life claims.	3.0-> Good sms system to validate eligibility at hospital. Too early to judge client satisfaction.	3.0-> Simple for health but cumbersome for life claims.	4.0-> Additional letter needed. But JBT members are recognized in hospitals.
4.2 Claim processing time and/or quality of service provided	2.0-> In most cases, this works for life claims in urban areas. Health claims are ex-post, same for life claims in rural areas. This results in 1-2 month delays on claims	3.0-> Cashless but low quality of core provider network.	3.0-> Same as NHIF for health. Quick funeral pay outs.	3.0-> Cashless for health. Some rejections. In theory, should be a better quality of care.	3.0-> Cashless for health. No actual TAT data for life claims.	4.0-> Cashless for health. Good quality of care.

[19] Assuming KES 200 per month for life and average KES 100 per month for health.

	settlement.					
4.3 Policy administration and tangibility	4.0-> Tangible because of frequent meetings. No written proof.	4.0-> NHIF card is widely recognized. Limited information to judge any problems in this area.	3.0-> One month to get a Bima ya Jamii card, which is not widely recognized. Inefficient way to process uncompleted registrations.	3.0-> 3 weeks to get the insurance card.	2.5-> Policy document is the only proof (can be reissued at the factory level). 2 month to get policies to clients.	4.0-> Efficient process as integrated with microcredit processes and smart card system.
4.4 Customer care	4.0-> small groups managed by members. Potential risk of being dominated by some members.	2.0-> As in other countries, this is a level of service one can get from a government agency.	3.0-> Weak customer care at the field level, much better at the head office level. Call centre.	3.5-> Good loan officers that need be further trained. Planned call centre at Faulu head office to support the field.	2.5-> Reduced field network.	4.0-> Expected high customer care inbuilt in organisational culture. But not many institutionalized elements for insurance.

ANNEX C: DETAILED CLIENT VALUE PACE ANALYSIS FOR INDIA

	RSBY	ICICI	Yeshasvini	PWDS	SEWA	Uplift
1. PRODUCT	3.2	3.8	3.0	2.9	2.4	3.6
1.1 Coverage, service quality, exclusions and waiting periods	3.5-> full hospitalisation in public hospitals; full maternity, 1 day pre and post hospitalisation costs, transport allowance, discounts for diagnostic tests and OPD consultations, many exclusions, some pre-existing conditions allowed, 3-month waiting period	4.5-> comprehensive cover, OPD to cover for specific procedures for textile workers, maternity, dental, optical, variable quality of care by geography, limited exclusions, no waiting period, pre-existing conditions covered	3.0-> full comprehensive cover in theory, in reality mostly surgeries are covered, regular hospitalisation and OPD not covered, low tariffs negotiated, limited exclusions, pre-existing covered, no waiting period	2.0-> hospitalisation with full maternity cover, good care quality, many exclusions, pre-existing conditions excluded, 30-day waiting period, minimum 24 hours hospitalisation	1.5-> hospitalisation benefit, good quality care, some exclusions (maternity), pre-existing covered after 6 months in rural and 1 year in urban, 30-day waiting period, minimum 24 hours hospitalisation; some adjustments for rural areas and limits on 'quick', common hospitalisations	3.5-> hospitalisation cover, only complex maternity (C sections not covered), 100% in public hospitals and 80% in empanelled hospitals, some exclusions, 10 days pre and post hospitalisation (drugs included), good quality care, discounts for OPD, 3 year waiting period, minimum 24 hours hospitalisation
1.2 Benefit in relation to cost of risk	4.5-> INR 30,000 no sub-limits	4.0-> INR 15,000 but no sub-limits for specific hospitalisation procedures	3.5-> INR 200,000 INR 100,000 limit for surgeries (per person), high cover but anyway limited to one incidence per person per year, sub-limits	4.0-> INR 30,000 limit for a family of 4, no sub-limits	2.0-> INR 2,000-6,000 for composite products (Sukhi Parivar), INR 10,000 for lower option on stand-alone health product (Swastha Parivar)	3.0-> INR 15,000 subject to sub-limits of INR 2,500-10,000
1.3 Eligibility criteria	1.5-> BPL card holders only, family of five, no age limits	3.5-> only for weavers and other textile workers, principal and 3 dependants (parents or children), 80 age limit	4.0-> members of cooperatives in Karnataka, age limit 0-75, for entire family with no limits	3.0-> only for PWDS members, 3 months - 60 years, inclusive family cover, premium based on who enrolled	3.0-> only for SEWA members, 2 adults and 4 children, enrolling up to 55 but cover up to 70 years old	3.5-> membership with delivery channel partner, family of 4, no age limits

1.4 Value-added services	1.0-> none	2.0-> health camps	1.0-> none	2.0-> health camps and health awareness campaigns	5.0-> health camps and health awareness campaigns, referral system, trained Aagewans, discounts at 6 empanelled pharmacies	5.0-> health camps and health awareness campaigns, 24/7 call centre for health counselling, referral system, one free health check up per year
2. ACCESS	2.6	3.0	2.7	3.4	4.4	4.3
2.1 Choice and enrolment	2.0-> voluntary, enrolment by district within a specific window of time, all of the family members must be present (results low number of persons enrolled per card), need to wait in long lines; issues with ration card (BPL status that was not updated for years, confusion, corruption)	3.5-> voluntary, certificate from Ministry of Textile official, simple process	3.0-> voluntary, need to approach a cooperative, though some enrol all the members, not much support from the cooperative, simple process, must be some confusion about eligibility as not all families are enrolled	3.5-> voluntary subject to minimum enrolment of 75% of each SHG, choice of copayment option, limited paper work and good support from PWDS insurance coordinators	4.5-> voluntary, enrolment every month in rural areas and after harvest in rural areas, simplified process supported by competent staff, SEWA card and other ID are enough	4.0-> voluntary at a group level, often linked to loans (less to savings), simple process supported by competent staff, good system for renewals
2.2 Information and understanding in relation to complexity	1.5-> limited information available to the public, and not sufficient information to clients (results in low usage rates), variable by state and insurer	2.0-> relatively complex product with limited education, exclusions listed on the card	2.0-> relatively complex product with limited education, limited information available to cooperative members	3.0-> simple product but with many exclusions, information session by insurance coordinators, leaflets with the most important information	4.5->simple product, information sessions during enrolment periods by Aagewans, lots of visual materials, movies, SEWA does financial education with some sessions on insurance, Aagewans follow refresher training every year	4.5-> information sessions and training to new groups, constant support by Uplift staff, self-education through fund management by members equipped with good guidelines and clear documents
2.3 Premium payment method	5.0-> Fully subsidized, only small enrolment fee paid	4.0-> upfront payment but small amount due to subsidy (minimum 80%)	2.5->upfront payment with limited subsidy and no flexibility or financing options	3.0-> upfront payment but some flexibility within SHG to use group savings or finance by loan	4.0-> annual premium payment, option to pay through interests of a fixed deposit account	4.0-> yearly, monthly, or weekly payments with options to pay through savings or loans
2.4 Proximity	4.0-> insurer's offices in each district, all public hospitals	3.0-> network of cluster coordinators in weavers' societies, comply with density of health care providers but limited network for OPD	3.5-> one coordinator in each district but anyway cooperatives act as intermediaries, network of 450 hospitals (100 of them public)	4.5-> PWDS federations are close to members, insurance coordinators, small but close health care network	4.5-> close contact by Aagewan, public hospital network, better in Ahmadabad than in rural areas	5.0-> service agents visits at doorstep, health care providers are chosen by minimum service requirements, cost and location (to ensure proximity)
3. COST	4.9	4.3	2.6	2.3	2.7	2.9
3.1 Premium in relation to benefit	5.0-> ratio to risk coverage= 0.1; ratio to all benefits= 0.1 [average monthly premium per beneficiary= INR 0.5]	4.5-> ratio to risk coverage= 0.7; ratio to all benefits= 0.8 [average monthly premium per beneficiary= INR 3.1]	2.0-> ratio to risk coverage= 4.2; ratio to all benefits= 4.1 [average monthly premium per beneficiary= INR 12.5]	2.0-> ratio to risk coverage= 5.5; ratio to all benefits= 3.9 [average monthly premium per	2.0-> ratio to risk coverage= 5.6; ratio to all benefits= 3.4 [average monthly premium per beneficiary= INR 8.3]	3.0-> ratio to risk coverage= 2.4; ratio to all benefits= 2.3 [average monthly premium per beneficiary= INR 8.3]

				beneficiary= INR 11.0]		
3.2 Premium in relation to client income	5.0-> 0.1% of monthly income [average monthly premium per family = INR 2.5]	4.5-> 0.5-0.6% of monthly income [average monthly premium per family = INR 12.5]	2.5-> 1.4-1.7% of monthly income [average monthly premium per family = INR 50]	2.5-> 1.7% of monthly income [average monthly premium per family = INR 59]	3.0-> 1.1-1.3% of monthly income [average monthly premium per family = INR 50]	3.0-> 1.1-1.3% of monthly income [average monthly premium per family = INR 33]
3.3 Other costs	5.0-> None, travel allowance provided	4.0-> None, only travel	3.5> 10 Rs registration fee, travel	2.5-> 15-20% copayment	3.5> copayment if outside empanelled hospitals	2.5->20% copayment
3.4 Cost structure and controls	4.0-> less of an issue for government scheme (from client perspective), good fraud controls and cost protocols managed by insurer	3.5-> cost controls managed by insurer, claims costs under control	3.5-> controls by TPA, pre-agreed tariffs, claims costs under control	2.0-> >100% claims ratio, cost/fraud controls not in place	3.0-> quite high admin costs; high frequency and claims costs	3.0-> 60% claims ratio, accurate adverse selection and fraud measures; expenses subsidized by a donor
4. EXPERIENCE	2.7	3.1	3.3	2.7	3.7	3.6
4.1 Claim processing procedures	1.5-> Cashless, widely recognized card	3.0-> Mostly cashless	4.0-> Cashless	2.5-> Planned to be cashless but still mostly reimbursement basis	4.0> Long list of required documents but good support from Aageawan who comes in the hospital the 1st day; 'prospective' reimbursement	3.5-> Reimbursement basis but clear guidance for communities, supported by Uplift staff
4.2 Claim processing time and/or quality of service provided	3.0-> fully cashless with limited restrictions so unlikely rejections	3.0-> 10 days TAT for non cashless claims	2.5-> Authorization target is less than 6 hours. 25% claims rejection rate.	2.5-> longer delays for reimbursement	3.0-> 1-2 days at empanelled hospitals; usual delay in other ones; good quality of care; 15% claims rejection ratio	3.5-> 1 month TAT, 9% rejection rate, good support from staff and good quality of care
4.3 Policy administration and tangibility	4.0-> smart cards issued on the spot	3.5-> insurance card with relevant information issued within 15 days	4.0-> insurance card issued on the spot	3.5-> insurance card issued within 15 days	4.0-> Insurance certificate issued immediately	3.0-> One month to issue a card and distribute discount coupons
4.4 Customer care	3.5-> 24/7 call centre operated by insurer	3.0-> Cluster coordinators only	3.0-> only through representatives at cooperative level	3.0-> Insurance coordinators at SHG federation level	4.5-> Aageawan very close to community, efficient client feedback processes	4.5> 24/7 Uplift call centre, monthly meetings with representatives of the community groups

ANNEX D: DETAILED CLIENT VALUE PACE ANALYSIS FOR PHILIPPINES

	Informal	FICCO	CARD	CLIMBS	Microensure
1. PRODUCT	2.3	3.3	3.6	3.7	4.3
1.1 Coverage, service quality, exclusions and waiting periods	1.5-> if ever only funeral benefits covered by ex-ante contributions, other life risks, TPD and major illnesses are covered on an ad-hoc, ex-post way, no exclusions, no waiting period	3.5-> natural death, accidental death, total permanent disability, full cover after one year, suicide and typical exclusions for AD&D	3.5-> natural death, accidental death, total permanent disability, hospital cash for motor vehicle accidents, full cover after, full cover after 3 years (but good one after 2 y), suicide and typical exclusions for AD&D	5-> natural death, accidental death, total permanent disability, burial benefits, fire, no waiting period though pre-existing conditions not covered, typical exclusions for AD&D	4.5-> natural death, accidental death, total permanent disability, burial benefits, no waiting period, full cover after 6 months, limited exclusions
1.2 Benefit in relation to cost of risk	2.0-> PHP 20-50,000 burial benefit	3.0-> Natural death for principal PHP 40,000; PHP 10,000 for others; same for AD and TPD	3.5-> Natural death for principal PHP 50,000; PHP 10,000 for others; same for AD but just for principal, monthly TPD benefits up to PHP 100,000 /18 months, PHP 10,000 hospital cash due to motor vehicle accident	3.5-> Natural death for principal PHP 30,000; 15,000 spouse, 10,000 for others; same for AD and TPD, burial benefit PHP 10,000, 5,000,2,500, fire PHP 40,000	5.0-> Natural death for principal PHP 90,000; 30,000 spouse, 15,000 for others; burial benefit PHP 20,000, 10,000, 5,000, AD and TPD PHP 70,000, 20,000, 10,000
1.3 Eligibility criteria	3.0-> inclusive but limited information on dependants	3.5-> inclusive family cover for FICCO members	3.5-> inclusive family cover for CARD members	3.5-> inclusive family cover for cooperative members	3.5-> inclusive family cover for TSKI borrowers and savers
1.4 Value-added services	4.0-> social network, mutual help	3.0-> access to FICCO funeral homes, other social services	4.0-> wedding benefit, CARD training and social services, relief assistance in case of fire and natural disasters	1.0-> none (though depends on the cooperative)	3.0-> TSKI non-financial services
2. ACCESS	4.3	4.0	3.6	3.8	4.0
2.1 Choice and enrolment	4.0-> voluntary, very accessible for most, one option only, simple enrolment	3.5-> compulsory for all members, one option only, simple enrolment forms and process supported by FICCO staff	3.5-> compulsory for all members, one option only, simple enrolment forms and process supported by CARD staff	3.5-> compulsory for borrowers, one option only, simple enrolment forms and process supported by CLIMBS representative	4.0-> compulsory for borrowers, voluntary for savers, one option only, simple enrolment forms and process supported by TSKI staff, leveraging microcredit process
2.2 Information and understanding in relation to complexity	4.0-> simple, easy-to-follow rules, only oral, subject to manipulation	4.0-> simple and clear policy flyers/document, premium included on loan repayment slip, education session prior to joining, simpler product than others	3.0-> same as FICCO, though more complex product with TPD table, long waiting period and hospital cash rider	3.5-> simplified policy flyers/document, no specific education effort, coop staff supported by CLIMBS representative, relatively simple product (no waiting period)	3.0-> no policy document, two education modules are devoted to insurance, TSKI staff supported by ME, relatively complex product with many covers
2.3 Premium payment method	5.0-> frequent payments, flexibility	5.0-> deducted from savings, 31 days grace period for renewals	5.0-> deducted from savings on a weekly basis, 31 days grace period for renewals	5.0-> included in weekly loan instalments, 31 days grace period for renewals	5.0-> included in weekly loan instalments or deducted from savings, grace period 45 days

2.4 Proximity	5.0-> close community	4.0-> extensive branch network, close to members, trained MBA clerks	4.0-> extensive branch network, close to members, trained MBA clerks	4.0-> close to members, CLIMBS representatives in all branches	5.0-> weekly meetings, trained TSKI loan officers at doorstep
3. COST	3.4	4.0	4.4	3.9	4.3
3.1 Premium in relation to benefit	4.0-> ratio to risk coverage= 3.3; ratio to all benefits= 1.9 [average monthly premium per beneficiary= PHP 3.3]	4.0-> ratio to risk coverage= 3.2; ratio to all benefits= 3.5 [average monthly premium per beneficiary= PHP 11.3]; accounts for 50% of the equity value returned upon leaving MBA or reaching maximum age	5.0-> ratio to risk coverage= 2.1; ratio to all benefits= 2.1 [average monthly premium per beneficiary= PHP 8.1]; 50% of the equity value returned upon leaving MBA or reaching maximum age	3.5-> ratio to risk coverage= 3.5; ratio to all benefits= 4.8 [average monthly premium per beneficiary= PHP 17.4]	4.0-> ratio to risk coverage= 3.5; ratio to all benefits= 3.6 [average monthly premium per beneficiary= PHP 15.6]
3.2 Premium in relation to client income	4.5-> 0.2% of monthly income [average monthly premium per family = PHP 20][20]	4.0-> 0.8% of monthly income [average monthly premium per family = PHP 90]	4.0-> 0.5% of monthly income [average monthly premium per family = PHP 60]	4.0-> 0.8% of monthly income [average monthly premium per family = PHP 87]	4.5-> 0.7% of monthly income [average monthly premium per family = PHP 78], Dagyaw, subsidized premium for first-time borrowers, makes it more affordable
3.3 Other costs	1.5-> high transaction costs of patching multiple strategies	4.0-> PHP 140 to join MBA	4.5-> no other costs	4.5> no other costs	4.5->no other costs
3.4 Cost structure and controls	1.0-> most of the schemes are ex-post, ineffective if many members affected, no stop-loss arrangement	4.0-> adequate reserves, good adverse selection controls, compulsory scheme, 30% claims ratio	3.5-> adequate reserves, good adverse selection controls, compulsory scheme, 19% claims ratio	4.0-> 40% admin costs, compulsory scheme	4.0-> 50% admin costs, good adverse selection controls, compulsory scheme, 45% claims ratio
4. EXPERIENCE	3.2	3.8	4.3	3.7	3.5
4.1 Claim processing procedures	3.0-> Simple for rare groups with ex-ante contributions. Less evident for ex-post contributions.	3.5-> Standard birth/death certificates. Policy report for accidents.	3.5-> Standard birth/death certificates. Policy report for accidents.	2.5> Long list of required documents. Policy report for accidents.	3.5-> Standard birth-death certificates. Policy report for accidents. Peer or village level attestation.
4.2 Claim processing time and/or quality of service provided	3.0-> In most of the cases, contributions are collected during the burial service	4.0-> 2 weeks TAT	5.0-> 1-3-5 days TAT	3.5-> Quick burial benefit pay-outs. 1-2 months TAT.	3.5-> Quick burial benefit pay-outs. 1-2 month TAT.
4.3 Policy administration and tangibility	3.0-> Often no regular meetings, based on community bonds. No written proof.	4.0-> Clear insurance certificate. Well documented insurance specific transactions.	4.0-> Clear insurance certificate. Well documented insurance specific transactions.	4.0-> Clear insurance certificate. Well documented insurance specific transactions.	2.5-> No insurance certificate, a proposal form as a proof. Insurance transactions documented on loan group passbooks.
4.4 Customer care	4.0-> Self-managed peer groups.	4.0-> Trained MBA clerks	4.5-> Trained MBA clerks. Frequent satisfaction surveys and checks.	4.0-> CLIMBS trained representatives at the coop branches. Coop Assurance Centre in large coops, shared between small coops.	4.5> Trained loan officers, possibility to contact Microensure. Frequent satisfaction surveys and checks.

[20] Assuming PHP 5-10 monthly; or PHP 100 given ex-post; so all together it would be around PHP 20 monthly

MICROINSURANCE INNOVATION FACILITY

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

See more at: www.ilo.org/microinsurance

International Labour Office

microinsurance innovation facility

The social dimension of finance

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