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APPLYING AN OVC LENS TO PUBLIC-PRIVATE PARTNERSHIPS IN MICROINSURANCE

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About the Technical Guidance Brief Series

This Technical Guidance Brief series was commissioned by ASPIRES, through FHI 360, to explore the state of the practice of microinsurance, with an emphasis on orphans and vulnerable children (OVC) households.

The *Evidence Base Report on Microinsurance for Orphans and Vulnerable Children* identified a number of knowledge gaps in the literature that have formed the basis for a series of four technical guidance briefs (TGBs), covering:

- The role of microinsurance in the social protection space;
- The role of public-private partnerships (PPPs) and how government subsidies for orphans and vulnerable children can be leveraged in the microinsurance space;
- The existing state of health microinsurance and how health microinsurance can target orphans and vulnerable children; and
- The potential to link microinsurance benefits to education in order to meet a key need of orphans and vulnerable children.

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As the final brief in the series, this report looks at the current literature surrounding public-private partnerships (PPPs) within the realm of microinsurance and takes the current conversation a step further to explore potential issues specifically regarding OVC-relevant microinsurance and PPPs.

Throughout this series, the authors have touched on the complementary role that microinsurance plays within an existing social protection framework (see TGB 1 and the *Evidence Base Report*). Microinsurance offers an advantage in its ability to leverage a market mechanism to fill gaps left by the government, donors, or other privately-led social initiatives. However, there are often limitations to purely private microinsurance initiatives.

These limitations are particularly salient in providing microinsurance products to orphans and vulnerable children[1] and their caregivers, a population that tends to be poor and marginalized. Commercial viability of an insurance scheme targeting OVC households can be threatened by insurers' limited ability to reach clients, which prevents them from reaching the critical mass necessary for product sustainability. Commercial viability can also be affected by the financial limitations of the target market, which reduces affordability of premiums, or by limited available data on the target market, which complicates elements of product costing and design.

In light of these challenges, there may be an important role for public players to fill in the gaps necessary to provide sustainable and viable

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forms of microinsurance to OVC households. One method through which the state can get involved is through public-private partnerships (PPPs). This report explores what defines a PPP, typical players in a PPP, divisions of roles, and the potential benefits and challenges of such partnerships. The report also explores the unique considerations to be made when extending social protection to orphans and vulnerable children through PPPs.

What is a Public-Private Partnership?

Governments can support microinsurance programs in a variety of ways, such as providing flexibility to regulations regarding new products, tailoring capital or intermediation requirements to facilitate inclusive insurance markets, providing financial incentives for insurers to explore down-market opportunities, or mandating the provision of certain necessary insurance coverage (such as through national insurance schemes). Thus governments can either create an enabling environment for market provision, or can direct or become involved in provision itself. Such policy and regulatory instruments have, among others, been successful in countries such as the Philippines, India and Peru in providing the poor greater access to (regulated) financial services such as microinsurance.[2] These interventions, however facilitative, are not considered PPPs.

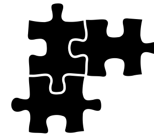
PPPs are a unique form of intentional partnership between public and private players. PPPs are contractual relationships between public sector bodies (usually donors or government) and private sector players (private companies or non-governmental organizations).[3] These formal legal partnerships are typically long-term collaborations[4] with common objectives and a stipulated division of responsibilities. Furthermore, without some sort of agreement, the schemes developed through PPPs typically would not have otherwise been likely to be implemented.[5]

The responsibilities of the different parties involved in PPPs depend on the specific objectives of the partnership and the regulatory environment. In existing microinsurance PPPs, typical roles include the following:

- **International donor agencies** often provide technical expertise to pilot projects. They also use market research to define client needs in order to inform product design[6] and address information asymmetry in the insurance market. Additionally, they often play a role in initiating a PPP and bringing together the various implementing partners. They may also provide funding.[7]
- **National or provincial governments** most frequently get involved in subsidizing microinsurance premiums or providing the necessary infrastructure (including that needed for distribution purposes).[8] The government of Ghana, for example, subsidized premiums for the poor to extend coverage.[9] Government can also play a facilitator role in bringing together various parties and advocating for a project, especially where resources for direct support are limited.[10] For health insurance PPPs, governments can provide funding as well as access to public healthcare.
- **Commercial insurance providers** typically take on the responsibilities of product design and carrying risk, in some instances outsourcing administrative functions to a third party.[11] Such a third party may include a broker, whose main responsibility is the sale and negotiation of the product with customers on behalf of the provider, or a

systems provider, who provides information technology systems required to manage the products. In some instances, the third party plays an important role in initiating and facilitating the partnership.[12]

- **Service providers.** Particularly in health insurance PPPs, there is an important role for service providers, such as doctor, hospital, or pharmaceutical networks. These players can be public and/or private. Private management may play an important role in reducing fraud and catalyzing innovation.[13]
- **Local community and delivery partners** are important to ensure buy-in, loyalty, and trust.[14] It is also vital to the project at large to be able to leverage existing infrastructure at the community level for the distribution of microinsurance products. There are a range of private actors that play a role in product delivery or distribution,[15] ranging from the traditional focus on local microfinance institutions (MFIs) to a recent emphasis on "alternative" channels such as retail outlets, post offices, or electronic mechanisms.[16] For example, in the case of Bima ya Jamii health microinsurance in Kenya, the partners were the National Health Insurance Fund (NHIF), a cooperative insurer (CIC), and various savings and credit cooperatives (SACCOs) operating at the local level. In two PPP examples from the Philippines, Cebuana Lhuillier Insurance Solutions (CLIS), with support from GIZ, partnered with 1,400 pawnshops as microinsurance distribution channels and the Bankers Assurance Group distributes microinsurance through a network of drugstores.[17]
- Lastly, especially in PPPs relating to disaster risk, a **reinsurer** may be involved to carry some of the risk.[18]



What role can Public-Private Partnerships play?

A relatively robust amount of research has been published on PPPs and microinsurance. It highlights a number of ways that PPPs can help facilitate the development and delivery of microinsurance products, including the following:

Bringing together diverse expertise. Public and private players often come to the table with different types and levels of expertise. While private sector players, like insurers, might be more suited to carry risk and develop products, public players might be able to better provide infrastructure, education, and financing.

Extending activities beyond a core insurance product. Often, microinsurance schemes can offer secondary benefits to society beyond direct insurance coverage, such as educating the target market on risks. In this case, the public sector may play a role to make sure that the public benefits of a private product are preserved and fostered.[19]

Leveraging complementary objectives. While the nature of public and private entities can vary greatly, PPPs can help both partners in achieving their respective objectives. Microinsurance has the potential to offer financial returns and market share to private companies while providing valuable cover to individuals and helping governments and donors meet social protection objectives.[20]

Achieving scale. Where microinsurance schemes might be limited in their ability to reach a sufficient number of clients to be viable (for example in health microinsurance), partnerships with public bodies can extend their reach through mandates or taking advantage of existing infrastructure.[23]

Creating viability for challenging products. Some of the most effective PPPs have been formed around microinsurance products that are typically commercially difficult to run, most notably weather insurance for agriculture[24] and health insurance for low-income people.[25]

Establishing cost-effectiveness. PPPs for microinsurance offer governments the potential to cost-effectively reduce vulnerability for OVC households. Premium subsidies are often more certain and affordable than the unpredictable costs associated with providing support after a risk event has occurred.[26]

Fostering buy-in and trust. Whereas low-income individuals may be unfamiliar or uncomfortable with insurance companies, partnerships through governments and their existing social protection channels can help establish client relationships more easily.[27]

THE OVC CONTEXT: ROLES OF PUBLIC-PRIVATE PARTNERSHIPS

Although the microinsurance market is dominated by products such as life and accident and credit life insurance, OVC households' most immediate need is to access health care, as discussed in the *Evidence Base Report* and the second brief in this series. Given the typical sustainability challenges associated with health microinsurance, this type of product is a priority for PPPs.

Other microinsurance products that may be beneficial to the OVC population are agriculture and property insurance, especially for OVC

Table 1: Potential Roles for Public-Private Partnerships in the OVC Microinsurance Context

Roles	OVC Relevance
Bringing together diverse expertise	OVC-related social protection is a unique field. Few microinsurance companies are familiar with it, and there are very few examples of microinsurance for OVC-specific coverage. PPPs can play a role in connecting insurers to public programs that understand the needs of orphans and vulnerable children. At the same time, private insurers can offer product and risk assessment experience that can deepen existing social protection initiatives.
Extending activities beyond a core insurance product	Many health microinsurance providers offer consumers financial education to familiarize them with the concepts of risk and insurance and stimulate the demand for their products, as is done by CARE India.[21] Other Indian programs such as UPLIFT and Yeshavini offer free or discounted medical consultations and check-ups.[22] These services may be particularly relevant for OVC.
Leveraging complementary objectives	PPPs can support governmental objectives to support and protect orphans and vulnerable children while helping private partners reach their commercial objectives by increasing their market share among poor and vulnerable populations and building their client base.
Achieving scale	A PPP enables health microinsurance companies to achieve the necessary scale for viability via government infrastructure. The resultant private insurance options for government-mandated care can assist OVC households in need of such care.
Creating viability for challenging products/improving cost-effectiveness	Without government involvement, health microinsurance schemes may experience difficulties in providing the most appropriate care for HIV/AIDS patients, as day-to-day and chronic coverage are costly. Government provision of free or reduced-cost ARVs and CD4 testing for HIV-positive patients could make private health microinsurance more viable and more relevant for OVC.

households that live in an environment where they are likely to be affected by disaster risks (for example, flood-prone South-East Asia or drought-prone Southern Africa). The table below outlines considerations for developing PPPs to design and deliver microinsurance within of the specific case of OVC-relevant (health) microinsurance.

What challenges do Public-Private Partnerships face?

Despite their potential to improve the viability of microinsurance schemes, public-private partnerships are often complicated by a number of challenges:

Challenge #1: Private and public players come from two different backgrounds. Not only do their objectives often differ, but the environments in which public and private players work are distinct and the terminology the organizations use often do not align.[28]

Challenge #2: Partnerships have long and complex life-cycles. One aspect of the definition of a PPP is the long-term nature of the agreement. Rendek discusses the life cycle of PPPs from seeking out and assessing potential partners to implementing, maintaining, evaluating, and eventually terminating. Maintaining the partnership over such a long time horizon may be challenging.[29]

Challenge #3: Politics can affect PPPs. PPPs can suffer from political volatility in the public sector. An agriculture insurance scheme in Bolivia demonstrates how politics can be damaging to a microinsurance scheme's success.[30]

THE OVC CONTEXT: SPECIFIC CHALLENGES

These challenges are particularly pronounced in the OVC context. OVC households face a great number of socioeconomic challenges.[31] They are often poor, more likely to be food insecure, less likely to have their adolescent members be enrolled in school (which will reduce insurance literacy[32]), and are likely to suffer from psychological trauma as a result of neglect and the parental illness. They also face social stigma and the financial burden due to the illness (and possible death) of a family member, related medical expenses, the loss of productive labor, funeral expenses and the care of the extended family.[33] This financial burden is compounded by the fact that they often have irregular, low income flows.

Moreover, the majority of orphans and vulnerable children in Sub-Saharan Africa live in rural areas where access to health care (and general infrastructure) is limited and there are few, if any, existing mechanisms through which to target and reach them. Even when OVC households are within reach, this context presents additional hurdles to facilitating registration, regular premium collection and claims processing.

All of these features make it particularly challenging—and expensive—for a microinsurance scheme to viably serve orphans and vulnerable children. It is therefore not surprising that health microinsurance schemes, such as NHHP/FINCA in Uganda and SEWA Health in India, often exclude those with pre-existing and chronic illnesses[34] and that coverage for HIV/AIDS and pharmaceutical costs is rare in microinsurance.[35]

How can Public-Private Partnerships overcome the challenges?

The literature identifies a number of factors that contribute to the overall success of a PPP in the longer term. In order for PPPs to flourish they need to:

Appropriately assess partnerships upfront. Before entering into PPPs, it is necessary to have a careful and structured approach to evaluating potential partners. A number of resources are available which can assist with this process.[36]

Clarify roles and responsibilities. It is important that during the establishment of a PPP, all parties must have clearly delineated roles to reduce overlap, ensure efficiency, and prevent certain responsibilities from slipping through the cracks.[37]

Include a strong coordinator for multi-party PPPs. Especially in cases in where PPPs include more than two parties, it is important that one strong player can serve as the primary coordinator rather than relying on a number of bilateral agreements.[38]

Ensure shared benefits across partners. Perhaps no lesson is clearer from the literature on PPPs than the need to ensure all parties involved have incentives and benefits to gain from the agreement. This is necessary to maintain ongoing involvement and motivation for each player.[39]

Build transparency and trust. While PPPs can often be built on personal relationships across organizations, it is necessary to ensure that the partnerships are deeply rooted to ensure they sustain over the long term. Transparency and ongoing trust between organizations is key—when partners' communication suffers or one becomes skeptical of other parties' motives, the momentum behind the partnership can quickly evaporate.[40]

Monitor key learnings. Partnerships should evolve as they progress based on an evaluation of how well they are working. It is important that PPPs put mechanisms in place to capture key learnings and establish timelines for evaluating partnership performance.[41]

Conclusion: Keys to success for PPPs in the OVC context

Due to the lack of current microinsurance PPPs with a specific OVC focus, there is no body of evidence explaining which qualities are needed for a PPP to successfully offer microinsurance to orphans and vulnerable children. Regardless, the above findings suggest that at least four factors are likely to contribute to the success of a PPP aimed at improving the access of OVC households to microinsurance.

Dedicated design and structure. The unique circumstances and needs of OVC households require dedicated product design and client communication and education strategies. Furthermore, innovative technologies for premium collection or automatic payment mechanisms via the public or donor partner may be needed. Microinsurance schemes may also require the provision of ancillary services to the core insurance offering (such as regular health check-ups, or preventative medication). Specifically, poor OVC households may require some form of premium subsidy, as well as a premium structure that accommodates irregular income flows.[42] Furthermore, successful targeting and outreach to OVC will require one

or more PPP partners to include entities already working with OVC.

Guaranteeing long-term insurance access. The provision of premium subsidies to orphans and vulnerable children is subject to political change. However, because OVC vulnerability is chronic, any PPP targeting this group needs to have a long-term time horizon. This requires careful set-up of the partnership as well as explicit contractual mechanisms to ensure long-term commitment by all partners. It also requires a sufficient level of flexibility for the PPP to adapt to unexpected changes.

Providing access to services. Whereas the government and donors have a better idea of the specific needs of the OVC population than commercial insurers, they lack the resources to assist all orphans and vulnerable children. Likewise, private players by themselves are unlikely to have the necessary reach into this population. From a public policy perspective, the success of a microinsurance PPP will depend on the breadth of the service provision network that partners can offer and the extent to which the market mechanism can be leveraged to extend public resources.

Accommodating private incentives. Reducing OVC vulnerability is a public policy/social protection objective. In a PPP, however, it should be recognized upfront that some players will not be driven by public interest, but commercial sustainability. For the private partner to reach its objective of financial returns, targeted premium subsidies alone will not suffice due to the high costs of service and service delivery.[43] As a result of the small margins in the microinsurance industry, the partnership may need to allow for a larger pool of individuals with policyholders from outside the OVC population to keep the fixed costs per client low and make the partnership worthwhile for private parties.[44]

Notes

Note: Complete bibliographic information is provided only on first citation to the source. Subsequent citations only include a “Name (year)” reference.

[1] For the purpose of this study, the *Evidence Base Report* identified orphans and vulnerable children as children under the age of 18 who have lost one or both parents to HIV/AIDS, and/or have at least one chronically ill parent, and/or live in a household headed by a chronically ill individual (including child-headed households), and/or are themselves living with HIV/AIDS. This definition is narrower than the one provided by PEPFAR, as it includes children who are directly affected by HIV/AIDS but excludes those who live in areas of high HIV prevalence but do not have HIV/AIDS directly in their home environment. For PEPFAR’s current definition, please see: PEPFAR (2012). Guidance for Orphans and Vulnerable Children Programming. Washington, DC: U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). Available at: http://www.pepfar.gov/documents/organization/195702.pdf

[2] Llanto, G., Geron, M. & Almario, J. (2008). Making insurance markets work for the poor: microinsurance policy, regulation and supervision. CGAP Working Group on Microinsurance. http://cenfri.org/documents/microinsurance/2008/Philippines_Impact%20of%20regulation%20on%20microinsurance%20development_2008.pdf

[3] Ramm, G. (2011). Public Private Partnerships in Microinsurance. Discussion Paper #001. Microinsurance Network. http://www.microinsurancenetwork.org/sites/default/files/MIN_PPP_discussion_paper.pdf. This paper is leveraged as the basis for this technical guidance brief, and serves as a strong starting point for better understanding the current debate around PPPs and microinsurance.

[4] Rendek, K. (2012). Managing Microinsurance Partnerships. Microinsurance Paper No. 15. Microinsurance Innovation Facility. ILO. http://www.impactinsurance.org/sites/default/files/mpaper15.pdf

[5] Ramm, 2011

[6] Ibid.

[7] One important player in this space is the German BMZ and its implementing agency GIZ. See www.developpp.de.

[8] Ramm, 2011

[9] Vargas Hill, R., Gajate-Garrido, G., Phily, C., & Dalal, A. (2014). Using subsidies for inclusive insurance: lessons from agriculture and health. Microinsurance Paper No. 29. Microinsurance Network. http://www.microinsurancefacility.org/publications/mp29

[10] Trommershäuser, S., Lindenthal, R., & Krech, R. (2006). The promotional role of governments. In Protecting the poor: A microinsurance compendium. Churchill, C. (Ed.), 508-528. Geneva: ILO. http://www.munichre-foundation.org/dms/MRS/Documents/ProtectingthepoorAmicroinsurancecompendiumFullBook.pdf

[11] Koven, R., Chandani, T., Garand, D. (2013). The Business Case for Health Microinsurance in India: The Long and Winding Road to Scale and Sustainability. MILK Brief #26. Microinsurance Learning and Knowledge. http://goo.gl/0nI1U8

[12] A prominent example, internationally, is Microensure. It is a broker/administrator that brings together partners from the public and private spheres, and designs and implements systems for microinsurance roll-out at scale. It has a particular focus on health microinsurance for vulnerable/low-income target groups. See: www.microensure.com.

[13] Leatherman, S., Jones Christensen, L., & Holtz, J. (2010). Innovation and barriers in health microinsurance. Briefing note 5. Microinsurance Innovation Facility. ILO. http://natlex.ilo.ch/public/english/employment/mifacility/download/brnote5_en.pdf

[14] Matua, C. (2010). Social protection through public–private partnership. Impact Insurance. http://www.impactinsurance.org/videos/social-protection-ppp

[15] Ramm, 2011.

[16] Allianz Group. (2010). *Learning to insure the poor: Microinsurance report.* Allianz Group. https://www.allianz.com/media/responsibility/documents/microinsurance_report.pdf

[17] Malagardis, A. (2011). Process and Success Factors of Developing Public¬Private Partnerships for Microinsurance in the Philippines. [PowerPoint Presentation.] Presented at 7th International Microinsurance Conference, 8-10 November 2011, Rio, Brazil. http://www.munichre-foundation.org/dms/MRS/Documents/Microinsurance/2011_IMC/S6_MIC2011_Presentation_Malagardis_New.pdf

[18] For example, in the Philippines global reinsurer Munich Re together with GIZ and NatCat Insurance developed an insurance product against loan default of around 1800 coops under CLIMBS - a composite insurer - in the case of excess of rain or wind. Triggers are available for 1700 municipalities. See Malagardis, 2011.
[19] Ramm, 2011
[20] Malagardis, 2011.
[21] Burns, C, & Dalal, A. (2010). Explaining Insurance: Implementing Consumer Education in CARE-India's Insure Lives and Livelihoods Program. Financial Access Initiative. Geneva: ILO.
[22] Koven, Chandani, & Garand 2013.
[23] Leatherman, et. al. 2010.
[24]Linnerooth-Bayer, J., & Mechler, R. (2007). Disaster safety nets for developing countries: extending public–private partnerships. *Environmental Hazards*, 7(1), 54-61.
[25] Leatherman, et. al. 2010.
[26] Fonseca, C. & Dalal, A. (2014). Breaking the Ice: The Role of Insurance Associations in Insurance Consumer Protection. Paper No. 31. Impact Insurance. Geneva: ILO.
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[28] Ramm, 2011
[29] Rendek, 2012.
[30] Goldboom, T. (2013). An Instrument for Social Protection and Climate Change Adaptation? The Politics of Implementing Agricultural Microinsurance in Bolivia. Working Paper 2013-1. UNRISD.
[31] See the *Evidence Base Report* for a more detailed discussion.
[32] Matul, M., McCord, M., Phily, C., & Harms, J. (2010). The Landscape of Microinsurance in Africa. Microinsurance Paper No. 15. Microinsurance Innovation Facility. ILO. http://www.ilo.org/public/english/employment/mifacility/download/mpaper4_landscape_en.pdf
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[34] McCord, M.J. (2001). Health Care Microinsurance – case studies from Uganda, Tanzania, India and Cambodia. *Small Enterprise Development*, 12(1): 25-38. http://goo.gl/jukRDF
[35] Ramm, 2011
[36] Hardy, B., Hudson, B., & Waddington, E. (2003). Assessing Strategic Partnership: The Partnership Assessment Tool. Strategic Partnering Taskforce. London: Office of the Deputy Prime Minister. http://webarchive.nationalarchives.gov.uk/20120919132719/http:/www.communities.gov.uk/documents/localgovernment/pdf/135112.pdf
[37] Malagardis, 2011.
[38] Rendek, 2012.
[39] The case of the Aga Khan Agency for Microfinance (AKAM)/First Microinsurance Agency (FMIA) in Pakistan provides an example where a common social mission and organizational network hid the fact that the organizations involved were not always aligned with the objectives of the microinsurance programme. For more detail, see Rendek, 2012.
[40] Ramm, 2011.
[41] Ramm, 2011.
[42] Chandani, T. (2008). Lessons Learned and Recommendations for Donors Supporting Microinsurance. CGAP Working Group on Microinsurance and USAID. http://goo.gl/yQpGO4
[43] Rendek, 2012.
[44] Ramm, 2011.

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