THE ROLE OF MICROINSURANCE VIS-À-VIS OTHER SOCIAL PROTECTION MECHANISMS FOR ORPHANS AND VULNERABLE CHILDREN

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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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Without adequate social protection, orphans and vulnerable children (OVC)—defined in this brief as children under the age of 18 who have been affected by HIV/AIDS directly in their homes[1]—can experience serious threats to economic, health, and development outcomes.[2] Can microinsurance play a meaningful role vis-à-vis other social protection mechanisms to reduce their vulnerability? This brief discusses how microinsurance can be used as a social protection tool and highlights the corresponding design considerations.

Social protection for orphans and vulnerable children

Social protection can broadly be defined as initiatives by the state or other players (including commercial companies, self-help groups and charitable organizations) to address risk, vulnerability or chronic poverty.[3] Social protection is particularly relevant for communities affected by HIV/AIDS, given the social and economic impacts on those affected.[4]

There is an emerging consensus of the need for social protection to be *HIV-sensitive* rather than *HIV-exclusive* to minimize the exclusion of vulnerable people from targeted social programs. In the case of orphans and vulnerable children, this would mean targeting poor and vulnerable children in vulnerable, *communities* rather than exclusively those in *households* directly affected by the virus. The instruments used in HIV-sensitive social protection include financial protection, access to

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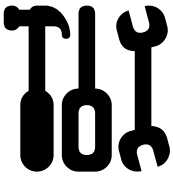
services such as healthcare, education, and policy and legal reforms.[5] Insurance is relevant regarding both financial protection—helping households cope with financial shocks due to vulnerability—and access to services, like health and education.



Including microinsurance in the social protection toolbox

As highlighted in the *Evidence Base Report*, microinsurance—defined as any insurance product targeted to low-income or previously underinsured populations[6]—is increasingly recognized as a potential market solution to extend the reach of the social protection framework.[7] Understanding its role requires an understanding of the full range of social protection instruments.

Table 1 provides an overview of different types of social protection tools available (including microinsurance[8]), the purpose they serve, and the ways in which they work. These tools are classified into four categories: *protection*, *prevention*, *promotion,* and *transformation.* Microinsurance, like social insurance, is a preventative tool. However, as is apparent from the table, it differs from social insurance through the targeting mechanism it uses, the population it reaches, its administration mechanism, and its funding source.

As is clear from Table 1, different social protection tools reach specific, targeted populations through a variety of mechanisms. Yet there are still ways in which traditional social protection tools fall short.[9] Microinsurance can help fill these gaps.

Microinsurance can reach populations that are not covered by social insurance schemes, social assistance programs, or traditional insurance. Whereas many formally employed people receive access to social insurance and the extremely poor typically qualify for social assistance programs, informal workers and moderately poor groups are often excluded[10]—they are not eligible for the *protection* category of instruments, yet are also not within the reach of *prevention* frameworks.[11] Neither are they served by the traditional insurance market, which typically in developing countries reaches only the top end of the population. Microinsurance, with its low-value premium amounts, presents itself as a potentially viable solution for mitigating risks amongst the otherwise excluded.[12]

> "Microinsurance is increasingly recognized as a potential market solution to extend the reach of the social protection framework."

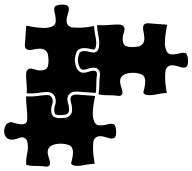
Microinsurance can provide additional benefits beyond what other social protection mechanisms offer. Traditional social protection mechanisms will not be able to cover all risks or completely eliminate vulnerability for those reached.[13] Microinsurance can supplement these mechanisms with additional, valuable benefits. For example, hospital cash plan insurance could pay a lump sum upon hospitalization to cover lost income, transportation, and other secondary costs, even though patients might already access free public healthcare.[14]

Table 1. Different Types of Social Protection Tools

Type	Tools	Description/Examples	Targeting Mechanism	Population Reached	Administered By	Funding Mechanisms
 **Protection** Social assistance provided as safety net to relieve poverty and deprivation for those not reached by promotional or preventative measures	Unconditional Cash Transfers (UCT)	Grants are usually made attractive only to poor households by small transfer amounts or by administrative hurdles that make collecting unattractive.	Community, geographical, and categorical targeting; Means testing	Extremely Poor	Government/ Public Authority	Non-Contributory (Tax/Donor)
	Conditional Cash Transfers (CCT)	Grants provided based on compliance with a condition that usually fulfils human development objective (education, health, nutrition, etc.)				
	In-kind Transfers	Food, assets; can be conditional as well.				
	Social Services	Including case management, fostering, residential care, etc.			Government/ Public Authority or NGO	
 **Prevention** Measures, including social insurance, seeking to avert deprivation by pooling risks	Social security, including social insurance	Typically: Unemployment, Disability, Sickness, Old-age	Categorical targeting	Formally employed	Government/ Public Authority	Tax/ Contributory
	Private (incl. micro) insurance	Weather-indexed insurance, market-based property insurance, life insurance, health insurance, etc.	Self-selection	Traditional insurance largely middle class; microinsurance and community-based schemes reaching further down the income spectrum	Private Entity (sometimes PPP or state)	Premiums
	Community-based risk pooling	Rotating savings & credit groups, burial/funeral societies, village grain banks, community-based health insurance schemes			Community	Contributory
 **Promotion** Measures seeking to enhance incomes and capabilities	E.g. Education	School meals, school fee waivers	Geographical, categorical, means-tested	Vulnerable	Government/ Public Authority	Tax/ Donor
	E.g. Agriculture	Agricultural input subsidies, seed fairs				
	E.g. Enterprises	Public works programs, asset transfers, microfinance			Public or Private	
 **Transformation** Measures seeking to address social equity and exclusion concerns	Legislating rights	Operationalizing the rights to social protection (e.g. Social Protection Floor)	n/a	Entire population	Government/ Public Authority	Tax/ Donor
	Workers' rights	Minimum wage, working conditions, trade unions				
	Social rights	Anti-child labor, anti-discrimination, affirmative action				
	Social Freedoms	Civil society mobilization, NGO advocacy, campaigning media				
	Empowerment	Grievance procedures, social audits				

Microinsurance can leverage private sector investments and expertise toward social protection goals. In many countries, social assistance and social insurance is restricted in scale and scope, often due to budgetary constraints.[15] Private companies, motivated by profits and the ability to reach new customers, can then step in to play an important role in filling the gap.[16,17] Governments can further benefit from the potential of microinsurance to decrease welfare costs by mitigating the risks experienced by those who might otherwise need recourse to social assistance.[18]

Despite these benefits, the discussion below will show that microinsurance also faces significant challenges. It should never be viewed in isolation from other social protection mechanisms. It is not a substitute for social transfers and social insurance, but a complement (for those not reached) or supplement (for risks not covered) to other social protection tools.[19]



How can microinsurance fulfill its social protection role?

Microinsurance is not "one size fits all." Health, life, disability, and funeral insurance are particularly relevant types of microinsurance to address the vulnerabilities of orphans and vulnerable children.[20] Microinsurance can also be administered by different types of providers and distributed through a variety of channels. This brief considers these three dimensions in more detail—the what, who, and how of OVC-targeted microinsurance provision.

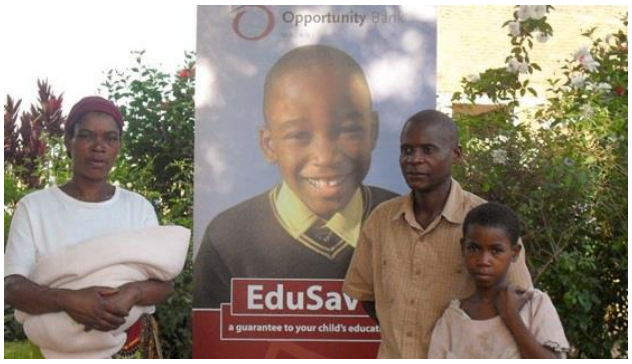
WHAT DOES OVC-RELEVANT MICROINSURANCE LOOK LIKE?

In order to make microinsurance most relevant for orphans and vulnerable children, it should address several design considerations, including the following:

Premiums should take the irregular cash flows of OVC households into account.[21] As OVC households tend to rely more heavily on informal employment, if employed at all, a premium payment mechanism which provides for flexibility would be most suitable.[22]

Life insurance benefits that revolve around the continued funding of education could be useful. Education outcomes are worse and school attendance is lower for orphans and vulnerable children.[23] An insurance product which ensures that school tuition costs are covered upon the death or inability to work of a caretaker would be a way to ensure that the child's long-term future is improved.[24]

Insurance which provides income protection for the head of household could be useful. As many OVC households are led by a single parent, any interruption of loss of that income could prove devastating to the whole household. Products like hospital cash plans, income replacement plans,[25] and retrenchment insurance (which guarantees income in the event of unexpected employment termination)[26] could serve to prevent total loss of incomes, should a health event, death, or unemployment arise.



Edusave insurance product in Malawi, offered via Opportunity Bank, NICO Life and Microensure. Source: Microensure

Life insurance that provides food baskets as a benefit could be useful. Food security is another key concern of orphans and vulnerable children. By providing vouchers for food instead of lump sum cash pay-outs upon the death of a parent, policymakers might better ensure continued access to nutrition.[27]

A manageable way should be found to remove HIV-related pre-existing condition exclusions in health or life insurance products. With OVC households disproportionately susceptible to HIV, it is vital that any health insurance products offer care for HIV. Furthermore, life insurance plans should not exclude clients who die from AIDS.[28] This raises design considerations, as an insurance product without pre-existing condition exclusions may be more susceptible to adverse selection (where high cost individuals with pre-existing conditions become concentrated within a risk pool and raise prices for everyone). Typically, waiting periods are used to counter adverse selection. Another effective counter-mechanism is to provide insurance on a group basis, with insurance as mandatory for all in the group. Leveraging community groups for microinsurance distribution is discussed further on in this brief.

Insurance companies and regulators must consider the legal implications of payouts to minors. Should one or both parents who held life insurance pass away, a mechanism must be in place to make sure that their children have access to the benefits—whether this involves paying into a trust or creating a specific claims management process for children.[29,30]

WHO IS BEST POSITIONED TO PROVIDE OVC-RELEVANT MICROINSURANCE?

Microinsurance can be provided in different ways and by different types of providers:

Community-based or mutual risk pooling. At the community level, groups often form to pool risks. Community-based schemes relevant to orphans and vulnerable children include health insurance schemes or health mutuals[31,32] and societies or associations that pool risk to provide support to members in the case of death of a family member.[33] These groups may arise spontaneously due to expressed demand unmet by formal mechanisms, or they may be set up by donors. In some instances—as will be discussed below—they are leveraged explicitly into the social protection framework by government or are used as distribution channels by commercial insurers.

Private market. Microinsurance is also often provided by commercial insurers. While they may target the low-income or vulnerable market, their primary incentive is to be commercially sustainable. For this reason, simple products such as personal accident or funeral insurance[34] have gained the most traction in the private microinsurance market.[35] Funeral products continue to diversify and offer a number of benefits which could specifically be of benefit to orphans and vulnerable children—

like the Senehasa children's policy in Sri Lanka which pays out children over time following a parent's death,[36] or products like AIG Uganda and Madison Insurance in Zambia, which amended their policy terms to cover HIV/AIDS.[37]

MICROINSURANCE CONSIDERATIONS FOR IMPLEMENTATION

Market limitations. Where microinsurance is provided purely as a market mechanism, it also faces several limitations. Those taking it up need to have some ability to pay; thus, microinsurance is generally not an effective mechanism to reach the extreme poor. It is also not a vertically redistributive instrument. That is, it redistributes horizontally between different people in the same risk pool, but not between the rich and the poor.[38] The low-income and vulnerable market may also face a number of barriers to accessing microinsurance, including the fact that they are not within easy reach of distribution channels. Furthermore, client value is an increasing concern—how much of the premium is eaten up by distribution costs and various players to be remunerated along the value chain?[39]

Particular challenges in health microinsurance provision. One of the challenges for health microinsurance and community-based health schemes is that insurance can only work if there are sufficient healthcare services available in a community (although insurance can also be used to trigger the provision of services). Furthermore, since community-based health insurance is locally administered, often via private means, it can be insufficiently reliable and lack a mechanism to ensure that members receive benefits.[40] The viability of private health microinsurance is also undermined by a lack of health data, the cost of managing provider networks, adverse selection, fragmented risk pools, fraud, and excessive benefits that are out of line with patient needs.[41] As a result, very few successes have been documented in terms of sustainable health microinsurance products without public or donor funding.[42,43]

The role of the state. In areas the market finds it difficult to reach, such as health microinsurance or other types of microinsurance targeted at particularly vulnerable and poor groups, governments or donors often subsidize premiums or operating costs of schemes in order to shift the risk-to-return ratio and make the market mechanism viable for the most destitute groups.[44,45] Churchill & McCord show that a significant part of the growth in microinsurance uptake in recent years can be ascribed to the role of the state (through subsidies, public-private partnerships, or public sector insurers), especially in Asia.[46] It is clear that the state can have a role to play when developing new markets, linking microinsurance into existing public infrastructure, managing large-scale risks,[47] financing health services,[48] and integrating microinsurance into existing social protection approaches.[49,50,51] In some instances, governments also step in directly to provide insurance/pay premiums on behalf of a target group of citizens.[52]

However, there are also limitations to this approach. Public funding is subject to fiscal constraints and public microinsurance schemes may suffer from inefficiencies in administration. Furthermore, there is a risk that people will not be aware that they are covered if provision of insurance is simply universal and is not clearly communicated to beneficiaries. Technical Guidance Brief 2 will unpack the topic of Public-

Private Partnerships (PPPs), direct provision, and subsidies in more detail.

HOW CAN MICROINSURANCE REACH ORPHANS AND VULNERABLE CHILDREN?

Given the need to minimize costs and maximize the number of people reached for low-premium products to be viable, microinsurance has become a leading field in distribution innovation in the insurance market.[53] While not without challenges, several microinsurance distribution strategies can avoid some of the pitfalls and bottlenecks affecting other social protection tools such as adverse selection and inefficient program administration.

Insurance distributed via mobile phones,[54] weather-index insurance for smallholder farmers leveraging satellite data for quick pay-outs,[55,56] and products which leverage retailer networks[57,58] are all examples of how microinsurance products have tapped into existing, non-traditional structures to create a market-based solution for efficiently and cost-effectively providing insurance.

Such mass-market distribution strategies are however less relevant when the objective is to specifically target orphans and vulnerable children. As discussed above, an HIV-sensitive approach would include targeting whole communities that are vulnerable and poor, or all children in certain areas or communities, rather than only those directly affected by HIV/AIDS. This requires a distribution strategy aimed at linking with existing community-based touch points. The advantage of partnering through existing structures is that it brings together the know-how of formal insurers and the geographical outreach provided by community organizations and groups, MFIs, and NGOs.[59]

A few potential distribution possibilities for OVC-relevant microinsurance follow:

Informal savings groups. Structures like savings and credit groups have been shown to play a valuable role in extending access to financial services in rural and poor communities. In addition to facilitating savings and credit for risk events, these groups have provided direct access to microinsurance in many cases. Kenyan insurer CIC, for example, provided health insurance in collaboration with the National Hospital Insurance Fund (NHIF) via savings and credit cooperatives (SACCOs).[60] CARE's Village Savings and Loan Association (VSLA) and Catholic Relief Services' Savings and Internal Lending Communities (SILC) programs have also linked with microinsurance products in Uganda and Benin.[61]

> "While not without challenges, a number of microinsurance distribution strategies can avoid some of the pitfalls and bottlenecks affecting other social protection tools."

Rwandan farmers discuss insurance. Source: Cenfri

Informal community-based health structures. Products like Uplift in India[62] and Naya Jeevan in Pakistan[63] leverage community health systems to provide health microinsurance to vulnerable groups.[64] By linking community-

based health insurance initiatives like these to social protection policies, some argue these schemes can mature and form the backbone for improved healthcare to vulnerable populations like orphans and vulnerable children.[65] Rwanda, in fact, has included their *Mutuelle de Santé* program (community-based health insurance) in their National Policy for Orphans and Other Vulnerable Children.[66,67] At the same time, however, community-based schemes are often challenging to operate and difficult to make viable without government and donor support, as in the case of India.[68]

Informal funeral groups. Funeral parlors in Colombia and burial societies in South Africa[69] are two examples of community-level initiatives to financially support families in the case of death. Insurers like Old Mutual[70] and Hollard[71] in South Africa have leveraged these groups to sell more formalized microinsurance products onward to group members.

Government-led grant or welfare payments. Microinsurance could be distributed on the back of existing social assistance products. In South Africa, for example, automatic deductions can be made from monthly child grant payments towards funeral insurance premiums; however, this can be done only with the written consent of the grant recipient and cannot exceed 10% of the grant amount.[72]

Social welfare systems. Although examples are scarce of microinsurance currently distributed via existing social welfare distribution points, the foster care system, social worker networks, schools, or even childcare centers/orphanages could serve as entry points for insurance provision.

Conclusion

This Technical Guidance Brief has shown that microinsurance can potentially fulfill an important role towards the achievement of social protection objectives. However, it also faces significant challenges and cannot substitute for traditional social protection tools, but must rather be seen as a complementary tool.

What are the most important considerations in designing and rolling out OVC-relevant microinsurance? First, the unique needs of OVC households, from education to food security to health risks and erratic income, must be taken into account when designing relevant microinsurance products. Furthermore, one must consider that although private insurers have a role to play in providing microinsurance, they often must look to partnerships with governments and donors to make products targeted at the most vulnerable sustainable. Beyond this, tapping into existing distribution points like community groups and social assistance systems can help microinsurance reach OVC households as efficiently as possible.

The rest of this Technical Guidance Brief series will explore in greater depth a number of the issues touched upon in this document, including the dynamics and constraints of the health microinsurance market, the role of subsidies, and the typical structure and challenges regarding the successful implementation of PPPs.

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Notes

[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] A broad literature describes the negative externalities experienced by orphans and vulnerable children as a result of HIV/AIDS in the home. See, for example: UNAIDS, (2011); Gilespie et al (2005); Mermin et al (2005); PEPFAR (2012) and Samson (2014).

[3] This is the definition adopted by Deblon & Loewe (2011). Another often-quoted definition is from Devereux & Sabates-Wheeler (2004). Also see, for example, Churchill (2006) and Loewe (2002).

[4] UNAIDS (2011).

[5] HIV-sensitive social protection is generally regarded to include three pillars: *prevention*, *treatment & care* and *support*. See, for example, Roelen et al (2011), UNAIDS (2011), Miller & Samson (2012) and Temin (2010).

[6] See, for example, IAIS (2012). Note that this definition requires microinsurance to operate according to insurance principles (a risk pool, premiums and benefits) and would hence exclude social assistance.

[7] See, for example, Loewe (2002).

[8] A number of authors argue that the traditional view of social protection tools should be broadened to include microinsurance as market mechanism. See, for example, Deblon & Loewe (2011).

[9] For a detailed discussion of the gaps, Deblon & Loewe (2011) and Wiechers (2013).

[10] Deblon & Loewe (2011)

[11] See Deblon & Loewe (2011) for an overview of the literature in this regard and the typical gaps in social protection found in developing countries.

[12] Loewe (2010)

[13] For a fuller discussion on the role of microinsurance in social protection, including country case studies, see Ramm & Ankolekar (2014) and Wiechers (2013), as well as Deblon & Loewe (2011).

[14] Childs and Erasmus (2012)

[15] Arun and Steiner (2008)

[16] Dror and Jacquier (1999)

[17] Social protection through public-private partnerships

[18] Dercon et al. (2008)

[19] See, amongst others, Ramm & Ankolekar (2014), Wiechers (2013), and Deblon & Loewe (2011)

[20] Churchill (2006) proposes that not all microinsurance products provide a social protection element, with health, life, old-age pensions and disability covers most likely to play a social protection role.

[21] Ahsan et al (2009)

[22] See the ILO's webpage on premium collection for a number of useful sources

[23] UNICEF (2007).

[24] The topic of education benefits and microinsurance will be explored further in a forthcoming technical guidance brief in this series.

[25] An example is SINAF in Brazil.

[26] An example is Barclays and MicroEnsure in Kenya.

[27] Examples of such "in-kind" benefits include the case of retailer Casas Bahia in Brazil

[28] The case of South Africa, who ranks first in HIV incidence in the world, according to HSRC National HIV Prevalence, Incidence and Behaviour Survey (2012), shows how this can be achieved. In the open enrollment medical schemes environment, regulation does not allow any individual to be denied access on the basis of health status. Likewise, it is standard practice in the microinsurance/mass market industry not to conduct individual risk rating, but to charge premiums on a group risk basis. Insurers have calculated the HIV/AIDS impact on mortality into the standard premium calculations. In both markets, waiting periods are furthermore used as a primary tool to counter adverse selection.

[29] In South Africa, Section 37C of the Pension Funds Act No. 24 of 1956 allows for the creation of a Beneficiary Trust Fund. For an example see Standard Bank.

[30] In the United States, insurance payouts to minors are often guided by the Uniform Transfers to Minors Act

[31] An example is health mutuals in Senegal
[32] An example is community-based health insurance in Tanzania
[33] For an overview of funeral insurance groups around the world, see Hougaard & Chamberlain (2011). Also see Chamberlain, Bester and Hougaard (2009)
[34] Chamberlain and Hougaard (2011).
[35] Mukherjee et al (2013) , McCord et al (2012) , and McCord et al (2013).
[36] Enarsson and Wiren (2006)
[37] Chandani (2008)
[38] Deblon & Loewe (2011)
[39] See the ILO's webpage on client value.
[40] Deblon & Loewe (2011)
[41] For more, on health microinsurance challenges see Greyling (2014).
[42] Greyling (2014).
[43]A recent article comparing private health microinsurance in India and Kenya, found in both countries that without subsidies, products were unable to find a suitable balance between keeping premium costs low and covering the costs of providing care. See Koven and McCord (2013).
[44] Vargas Hill et al (2014).
[45] Bel (2012)
[46] Churchill & McCord (2011) in *Protecting the Poor: A microinsurance compendium, Volume II.*
[47] Rohregger and Rompel (2010)
[48] Holtz, Hoffarth, and Phily (2014)
[49] Ramm (2011)
[50] Malagardis (2011)
[51] Ruchismita and Churchill (2012) in *Protecting the Poor: A microinsurance compendium, Volume II.*
[52] See examples from China and India in Gray et al (2014)
[53] Smith, Smit and Chamberlain (2011)
[54] Prashad, Saunders and Dalal (2013)
[55] Sandmark, Debar and Tatin-Jalerin (2013)
[56] IFAD (2011)
[57] FinMark Trust (2014)
[58] FinMark Trust (2014)
[59] Loewe (2002)
[60] The product has evolved now and is no longer offered via NHIF. More details on the original product can be found at: Bima ya Jamii - Insurance for the family
[61] Chidiac, Dadjo and Kimathi (2011)
[62] Uplift Mutuals
[63] Naya Jeevan
[64] Mutuelles de Sante Rwanda
[65] Jacobs et al (2008)
[66] Government of Rwanda (2003)
[67] Mutuelles de Sante Rwanda
[68] Koven, Chandani and Garand (2013)
[69] Chamberlain, Bester and Hougaard (2009)
[70] Burial Society Support Plan Product Overview
[71] Hollard
[72] Social Assistance Act 13 of 2004 Regulations (26A Regulation 2 Notice R591 of 2009, Department of Social Development, Republic of South Africa)

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