Access to Insurance for the Poor -

The Case of Indira Kranti Patham in Andhra Pradesh, India

By Vijay Kalavakonda


In 2000, the World Bank joined hands with the State Government of Andhra Pradesh in India to support the government's rural poverty reduction agenda through the Indira Kranti Patham (IKP) program. The objective of the rural poverty reduction programs is to enable the rural poor, particularly the poorest of the poor and poor women and children, in the State to improve their livelihoods and quality of life by way of (a) empowering the rural poor through developing and strengthening civil societies/community based organizations (CBOs); (b) providing access to technical and financial resources in order to expand their asset base and livelihood opportunities; and (c) mitigating risks faced by the rural poor. CBOs are the Self Help Groups (SHGs) and the federation of SHGs namely the Village Organization (VO) and Mandal Organization (or Mandal Mahila Samakhayas –MMS), and District Organization (or Zilla Samakhayas –ZS). SHGs, similar to rotating savings and credit associations (ROSCAs), consist of 10 to 15 individuals who form a group.

Insurance is part of the broader livelihoods framework adopted by the IKP program. The four pillars of the framework are to a) increase incomes (strengthening and deepening both existing and new livelihoods), b) decrease expenditure, c) increase employment days (skill building and retooling) and d) reduce risks (risk mitigation and risk transfer instruments). Insurance for the poor as part of a broader social risk management agenda, to mitigate risks and in the process to address rural poverty was launched in 2003. Prior to 2003, formal insurance instruments, from either the public or private insurers, were rarely accessed by the poor. The risk mitigation and coping strategies adopted by the poor differed on the risk i.e., in the case of low severity risks the poor resorted to borrowing from friends and family as the primary risk management instrument and in the case of high severity risks dependence was on high value loans from either the banks or other institutions (e.g., microfinance institutions (MFIs). Factors for low insurance penetration were similar to those found elsewhere such as lack of awareness and/or knowledge of product functions; lack of sensitivity and customer service in serving the insurance needs of the poor and poor and cumbersome claims settlement processes.

The insurance model adopted by IKP is based on the concept of mutuality but also simultaneously seeks to leverage the opportunities offered by the highly competitive private insurance markets. The model leverages on the CBOs and the social capital within these CBOs (figure – 1) to carryout various insurance functions i.e., identify and enroll members, create awareness and undertaking marketing of the product, premium collection and issuance of individual certificate of insurance to the insured, claims processing and settlement, and maintaining an MIS/IT system. The district-level organization of women’s SHG (or the Zilla Samakhaya – ZS) purchases a (re)insurance cover in the form of a group insurance policy by way of open-competitive bidding resulting in best price and policy terms to the benefit of its members. A small surplus generated (i.e., net of reinsurance and administration expenses) is used for building a reserve at the ZS for future contingencies i.e., rising (re)insurance premium.
Figure – 1: Institutional structure and social capital at various levels of the institution

- Conducts market interface.
- Maintains MIS/IT system.

- Support to VO(s)
- Secure linkage with Govt. Depts.
- Auditing of the groups
- Micro Finance functions

- Strengthening of SHGs
- Arrange line of credit to the SHGs
- Social action
- Village development
- Support activists

- Thrift and credit activities
- Participatory monitoring of the groups
- Group level poverty reduction plans
- Household investment plans

The introduction of an insurance initiative as part of the rural poverty reduction program in 2003 resulted in a rapid expansion of the rural insurance market (Figure – 2). The first product to be launched was a life insurance product (i.e., death and disability insurance). This has to be viewed from the perspective of providing “social protection” to the dependent(s) of an earning member or breadwinner of a poor family. In the immediate aftermath of the death of the breadwinner:

- the family may be deprived of earnings required for nutrition.
- the child may have to stop going to school and switch over to child labor.
- the family may already be in debt, death of an earning adult will result in financial catastrophe to the family.
- poor mostly live in nuclear families, hence they cannot enjoy the social security that is available in a joint family.

In addition, having life insurance cover enables better access to credit, both formal (commercial banks and MFIs) and informal (SHGs). Life insurance also provides the initial cushion to the dependents of the deceased and over a period of time the family adopts survival strategies to overcome the loss.
Currently, more than 1.2 million poorest of the poor and poor SHG women members are enrolled in the insurance program on a voluntary basis across the State. This number is expected to cross 2 million poor by March 2007, becoming one among the largest “micro insurance” programs in the world.

The Insurance Model

The provision of insurance is via the CBOs which were developed and nurtured since 1999-2000. The CBOs are co-opted in running the insurance scheme. The objective is to use the grass-root institutions to undertake as many functions as they could, given their internal capacity. The Village and Mandal level organizations work closely with their members in a) education on insurance; b) sales & marketing of insurance products; c) facilitating member enrollment; and d) collection of premium and transferring the same to the Zilla Samakhaya (Figure – 3).

The Zilla Samakhaya is responsible for claims settlement process including loss assessment. Once the claim is verified and processed by the Zilla Samakhaya the claims amount (or cheque) is handed to the beneficiary through the Village Organization. The loss assessment by the higher level institution (i.e., the Zilla Samakhaya) is to ensure that the process is independent and not influenced by local and/or community leaders. In addition to the claims settlement the Zilla Samakhaya: a) issues a certificate of insurance to all the insured, as proof of being insured; b) maintains the MIS of all the insurance operation – member profile, premium & claims information, c) manages the insurance risk by purchasing appropriate (re)insurance coverage from insurance companies; and d) facilitates in capacity building of insurance personnel in partnership with insurance companies.
The insurance contract between the insurance company and Zilla Samakhaya works on the “principles of reinsurance”.

Premium flows through one additional layer (i.e., Mandal Samakhayas), as against claims flow, primarily because of the volume of transactions involved and also to keep tab of the money flowing through the system. At an average 3,500 – 4,500 lives are insured per Mandal as against an average of 10 – 15 claims per Mandal are processed in a year.

The role of the insurance company is to a) provide the risk cover, primarily as a group insurance cover with the Zilla Samakhaya as the policyholder; and b) provide technical assistance to CBOs in its capacity building activity on insurance skills (claims adjustment, insurance accounting).

The relationship between the Zilla Samakhaya and the insurance company is beyond the typical partner – agent model as it’s more along the lines of the insurer – reinsurer arrangement. The Zilla Samakhaya manages the underlying risk by a) buying group (re)insurance cover from licensed insurance companies; and/or b) retaining residual risk on its book. In this process the Zilla Samakhaya is able to build “policyholder surplus” unlike in the case of a partner-agent model wherein the total premium from the insured is transferred to the insurance company in exchange for a commission (Figure – 4).
The key challenges are as follows:

a. **Awareness of the need for insurance**: People were generally aware of insurance but did not necessarily buy insurance. Most of the insurance purchased by the rural poor was “mandatory” insurance cover sold at the point of credit. The insurance intervention in the project for the first time encouraged people to buy insurance on a **voluntary basis** and also asked them to **pay for their own insurance coverage**.

b. **Providing a menu of product options**: The rural poor would like to examine the product that best meets their needs. The community should be convinced about first the need for insurance and if convinced they look for a) affordability, b) accessibility and c) availability of the insurance product. Based on the experience in Andhra Pradesh it should be noted that if provided with complete information on product choices the poor make an informed decision and are willing enroll in the insurance program.

c. **Controlling for moral hazard and adverse selection**: The community, particularly at the village level, may be pressured or be sympathetic towards its fellow members and may try enrolling the person even after death. Such moral hazard behavior could be disastrous for any insurance program. Hence, it’s very important to adhere to certain basic rules such as a) enforcement of enrollment cut-off date; b) ensuring proper documentation while enrolling members, particularly the length of time the member has been part of the SHG; and c) ensuring claims are processed and certified by the ZS insurance committee (typically consisting of 8-10 members).

d. **Leveraging the Government’s subsidy**: The insurance intervention under the IKP program ensured that the ZS charged the actuarial premium from individual members, purchased government sponsored insurance as reinsurance in the form of a group cover, and in the process generated a surplus which is retained at the ZS level. This surplus a) will act as a cushion should the government withdraw the subsidy or close the scheme altogether; and b) could be used to provide additional benefits to the members in the future.

e. **Working with the insurance company**: Concerns expressed by the insurance company fall into three broad areas a) insuring the underlying risk i.e., insuring the poor; b) capacity of the poor and/or institutions of the poor (i.e., CBOs) to administer insurance schemes; and c) pricing the risk (or challenges in the absence of data).

i) **Coverage for the Poor**
- Inadequate nutrition and hence more prone to early death (prior to reaching 58 years of age).
- Poor working and living conditions
- No proof of age; potential for older people (58 years old) being enrolled in the program.
- Suicides rates are relatively high

ii) **Community management of the administration:**
- Requires professional input / support i.e., training
- Community cannot be the beneficiary and simultaneously the judge to decide the genuineness of a claim
- Claim settlement / management requires professional staff

iii) **Pricing of the insurance risk:**
• Age-wise cohort data required for pricing
• Mortality and morbidity data for the poor
• Occupational hazards to which poor are exposed to

The key success factors are as follows:

a. **Simple product design** is a prerequisite if community members are to manage the product (including claims settlement). For example in the case of death and disability insurance sold to members the disability part of the benefit is relatively straightforward. Partial disability claim results from loss of one limb, one leg or one eye and total disability results from loss of both the limbs/legs/eyes.

b. **Low administration cost**, including the cost of issuing individual certificates of insurance. The estimated administration cost (including enrollment and claims processing) is less than 5 percent of the gross premium as against a minimum of 20-25% of gross premium incurred by insurance companies7.

c. **Establishing credibility** has been achieved by issuing a certificate of insurance to each and every insured member. The certificate contains details on the member such as (age/address), insurance coverage period, and nominee(s) of the insured. The certificate of insurance, from the perspective of the poor, is equivalent to a “bond” which could be exchanged for cash contingent upon the risk and after having met other conditions as mentioned in the certificate. Also, timely claims settlement and non-rejection of claims on frivolous grounds goes a long way in further bonding with the community.

d. **The product addresses a critical need of the community.** For instance the life insurance product addresses a critical need in that having an insurance cover helps in a) improving access to credit; and b) provides financial protection to the insured’s dependents, particularly children.

e. **The community as a manager of the product** is essential to building trust and a relationship with the insured. The presence of local people lends comfort to the insured compared to dealing directly with someone from an insurance company who happens to visit the village once or twice a year (i.e., for enrollment and premium collection and subsequently for claims settlement). A local person is much more approachable and is not intimidating from the insured’s perspective.

f. **Eliminating cumbersome claims documentation and speed in claims settlement** is a key factor which has contributed to an increase in the number of lives being insured and in establishing credibility amongst the community. In comparing the scenario prior to and after the ZS undertaking insurance activity (Table – 2), the average turn around time (TAT) in terms of claims settlement is 2-3 weeks. In addition, the claims rejection rate has dropped to less than one percent of claims filed or received.

<table>
<thead>
<tr>
<th>Table – 1: Operational effectiveness of insurance claims processing and settlement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inspection companies</td>
</tr>
<tr>
<td>TAT</td>
</tr>
<tr>
<td>Claims rejection rate</td>
</tr>
</tbody>
</table>

Furthermore, the documentation requirements for filing and subsequent processing of claims have been simplified to reflect the conditions in the rural area. At times the transaction cost, measured in terms of lost wages, informal payments to concerned government/public official, and incidentals (e.g., transportation), could dissuade the rural poor from pursuing a claim from the insurer. Peer monitoring and social networks at the village level are a useful alternative to be explored for the purpose of establishing genuineness of a claim.

g. **Building the trust of the insurer in ZS’s capacity to manage and administer the insurance scheme.** The key concerns of the insurer were a) the capacity of the Zilla Samakhaya to administer the scheme, particularly loss adjustments and b) controlling for moral hazard and adverse selection. The ZS’s approach towards loss assessment was based on investigating the claim using **social networks** in the village. Social networks are more effective particularly in the absence of established business practices. Similarly, transparency by way of a robust MIS and timely claims settlement (not more than 30 days from the date of filing a claim) has drawn ZS close to the insurer since it minimizes the need for establishing huge reserves for “unknown losses” or “incurred but not reported (IBNR)” losses.

h. **Economies of scale** – On an average there are about 250,000 women members per district (Zilla Samakhaya). Including their spouses there is a potential market of 350,000 – 400,000 lives per district, hence across the State the IKP program by itself has a potential market of 8.8 million lives. Within a period of 3 years, from conceptualization to implementation, the project has been able to attract more than a million women members
to buy life insurance. Economies of scale at the district level helps in a) lowering the transaction cost by spreading the fixed cost (i.e., overheads, installing and maintaining the IT system); b) minimizing the impact of adverse selection; and c) benefiting from the law of large numbers in insurance pricing.

Pre-conditions based on the Andhra Pradesh project are as follows

a. **Strong institutions with the capacity to handle financial transactions** is the key to the development of any risk management product. In Andhra Pradesh the IKP project invested huge sums of money to build community-owned and managed institutions. The institutions handled microfinance activities (both credit and savings). The SHGs under the program have accessed credit from commercial banks in excess of Rs 20,000 million (US$440 million) in 2005-06. Similarly, the SHGs are handling Rs 12,000 million (US$264 million) worth of member savings.

b. **The insured should pay the premium** – this is critical from two perspectives a) building awareness on insurance, resulting in knowledge on how and what to claim for; and b) ensuring the sustainability of the insurance program in the long-run. Insurance schemes where the government pays the full or substantial portion of the premium often results in a situation were the scheme is only operational until the next elected government introduces its own version of an insurance scheme.

c. **CBOs are not insurance centric.** CBOs should not be formed with the explicit purpose of providing insurance to their members, e.g., community based health insurance type entities. There are well documented cases which highlight that institutions formed with the sole objective of providing insurance to its members result in lack of sustainability and viability due to adverse selection i.e., only those at higher risk become members of such an entity.

In Andhra Pradesh the CBO’s were formed to support livelihood/economic activities of their members, Currently these institutions are engaged in a broad set of activities such as addressing social issues (gender issues, child care, etc.), dealing with public institutions (local administration, civil supplies, health and education), and working on food security issues for its members. Insurance issues are addressed as part of a comprehensive social risk management framework. As a result risk of anti-selection, fraud and abuse are not the primary concern. Instead the capacity to design appropriate risk management products and ensure affordable and financially viable products are the key issues that the community is grappling with.

d. **The product should be linked to sustaining and/or enhancing livelihood opportunities.** Once this link is established the willingness to pay is largely covered. The two products that have been introduced are death and disability insurance and cattle insurance. Both are popular amongst the members as they facilitate in a) improved access to credit; b) protect the asset’s risk (e.g., death of cattle); and c) act as a means of social security for the dependent(s) of the poor.

**Conclusion**

The Indira Kranti Patham (IKP) program in Andhra Pradesh has provided some useful lessons towards expanding and deepening access to insurance for the rural poor. The key building blocks in expanding insurance services has been a) nurturing and building institutions “owned and managed” by the poor; b) investing in building social capital (i.e., to manage financial products and services); and c) leveraging on the core competencies of respective institutions i.e., the capacity of insurance companies vis-à-vis the capacity of community-based organizations (CBOs).

The IKP program is now working on introducing a host of insurance products, following the success of the life insurance scheme, starting with cattle insurance (started as of January 2006) followed by agriculture insurance (insuring for both revenue/price and yield/production risk). IKP is already working on a health insurance pilot in partnership with private teaching hospitals, duplicating the HMO-staff model, in two different regions of the State. Andhra Pradesh has the potential to develop the largest “micro insurance” programs in the world catering to more than 8.0 million poor women and their family members over the next 4-5 years.

**Acknowledgements**

I would like to acknowledge all the project staff at Society for Elimination of Rural Poverty (SERP), Hyderabad (A.P.), India in particular Mr. Vijay Kumar, CEO, SERP and various the Project Directors. I would also like to thank Mr. Parmesh Shah, Lead Rural Development Specialist, The World Bank (and who is also Task Manager of the A.P. Rural Poverty Reduction Program financing the IKP project) for all his support and guidance.
Recommended Reading

1. Matin, Imran., Hulme, David., and Rutherford, Stuart (1999); “Financial Services for the Poor and Poorest - Deepening Understanding to Improve Provision”; Finance and Development Research Program WPS No 9 (October 1999); IDPM, University of Manchester (UK).

2. Wright, Graham A.N. (1999); “Necessity as the Mother of Invention – How poor people protect themselves against risk”; a MicroSave-Africa publication (Nov, 1999)

---

i In the case of health insurance expenses incurred in treating host of diseases which are not payable during the initial 12 – 24 month period due to clauses such as “exclusion of preexisting diseases” notably cataract and hysterectomy. Also, excluded is treatment arising from or traceable to pregnancy, childbirth, miscarriage, abortion or complications of any of these including c-section pretty common amongst the poor and the poorest of the poor rural women.

ii A Social Risk Management Survey (2003) in the State highlighted that in 25 percent of the cases claim were never settled and 16 percent stated that it took long time to settle the claims i.e., instead of the customary 21 days for claims settlement, it took about 71 days for the actual settlement by the insurance companies i.e., 3 ½ times more than the expected time to settle the claim.

iii Policyholders’ surplus is the difference between assets (or admitted assets) and liabilities of the Zilla Samakhaya’s insurance program.

iv Source: General Insurers Public Sector Association (GIPSA)