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The Microinsurance Market in Bangladesh: An Analytical Overview*

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This paper provides an analytical overview of the current state of the microinsurance market in Bangladesh comprising of products offered by commercial insurance companies, microfinance institutions (MFIs) and those by INAFI's MIME programme. For the commercial life insurers, available products are characterised by a mix of inadequate risk coverage, excessively high premium rates unrelated to any plausible model of mortality of the insured, lengthy process of claim settlement and, above all, high costs of intermediation. Such products therefore appear unattractive to the vulnerable. The MFIs, on the other hand, mainly offer loan insurance thus minimising lenders' risks and having a much quicker claim settlement process. Some MFIs also offer a variety of other products (notably, term life, health and livestock insurance). However, the health plans reviewed in the paper clarify that most of these are not examples of true insurance products since the bulk of the risk eventually remains with the insured. The requirement of cash transactions in each step of the way is a further drawback eroding popularity of the products. Finally, it is seen that, while INAFI has been implementing

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both term and endowment life policies, the premium structure appears rather steep vis-à-vis the cost of risks, presumably reflecting high costs of intermediation. In view of very limited competition in the market for commercial life coverage, regulatory directives may be targeted at improving competition in each segment of the market, thereby fostering innovation and fair play.

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JEL Classification: G21, G22, G28.

I. INTRODUCTION

While many types of idiosyncratic shocks may cause the poor and the ultra-poor to face increasing risk of further poverty (namely, vulnerability to future poverty), health and illness, death, crop, property and livestock, dowry payments and involuntary relocation are among the more significant ones. Recent analyses have clarified that even if these shocks are mainly transitory, these may nevertheless reinforce the income processes leading to further poverty, i.e., contribute to persistence in the shock-induced income pattern. In the absence of adequate risk shifting devices at the disposal of the poor, the resulting income patterns would impact on actual consumption on their part, which may itself be persistent in nature.[1]

There is long-held evidence that the poor are more risk averse than the rest of society (e.g., Young 1979 and Townsend 1994), and thus the tendency among them to seek insurance-type arrangements ought to be rather high. A wealthy farmer may store grains in good years so as to support him in bad, or he may diversify farming among plots in different locations or go for different crops. However, these risk shifting devices across time and space are unavailable to the poor and landless (Ahsan 1985). Rural poor, instead, have, over the years, developed other varieties of "self" or "mutual" insurance devices to shift risks, e.g., share-cropping, joint family system, choice of technology, transactions in kind instead of cash, voluntary gifts and transfers, or by participation in extant community/village level risk mitigation devices such as informal credit (inclusive of village money lending services) and other risk-dissipation institutions. Traditionally, these arrangements are believed to have been characterised by rather high implicit premiums for the benefits that they entail and the associated

[1]In a companion paper Ahsan, Hamid, Khalily and Barua (hereafter, Ahsan *et al.,* 2011) have examined the variety of shocks and their consequences on poverty and deprivation that affect the poor, using a survey of 4,000 households.

risk-shifting falling short of the social optimum (e.g., Ahsan 1985 and Binswanger 1980). Moreover, the implicit nature of the contract leaves room for discord and possible breakdown of the arrangement itself.

Econometric evidence led Deaton (1992) to conclude long ago that current income still mattered for current consumption by the poor, even when village level effects were controlled for. Lim and Townsend (1998), on a re-examination of the ICRISAT data (1975-84) for three villages in Southern India, suggest that the ultra-poor are indeed less connected to credit and insurance devices than others.[2] Morduch (2003), who also analysed the same ICRISAT data in depth, found that idiosyncratic components in consumption are a shade lower than those in income, thus indicating only a limited degree of consumption smoothing. The limited scope of informal community-based insurance in the rural settings, coupled with the observed role of grain inventory management (i.e., in-kind saving) as a primary coping mechanism against idiosyncratic shocks, suggests that the ultra-poor are unable to participate in this variety of self-insurance practiced in village economies of South Asia. Consequently, Morduch (2006) goes on to argue for a substantial scope for public action targeted at those least able to cope with aggregate and idiosyncratic shocks. In spite of advances in microcredit, effective coping mechanisms remain limited for the extreme poor. The lack of a functioning safety net programme in the Bangladesh context implies that the case for formal risk shifting, e.g., via "microinsurance" as a coping device, is even stronger.

Insurance is a sophisticated risk management strategy, which can protect individuals or households from severe financial crisis generated by idiosyncratic shocks. Over and above stabilising income and protecting human and physical capital, insurance may also encourage investment among the poor, avoiding the use of investable resources in times of crisis. Covariate (or common) shocks that affect a community or a large number of individuals at the same time may, however, only be effectively diffused if the insurer has recourse to reinsurance.

The concept of *microinsurance* can be distinguished from the standard insurance services in the sense that the former is especially designed for low-income households. The discussion in the literature points to the following key elements as characterising the idea. 'Microinsurance' products (a) are targeted at

[2]Somewhat surprisingly Townsend had earlier found that various idiosyncratic shocks (e.g., sickness or unemployment) did not matter as much; while full insurance hypothesis did not hold, the overall effect of income on consumption was not large (1994, p.584). For further remarks on the issue, see Ahsan (2013).

low-net worth households, (b) are designed to reflect pooling of risks faced by the insured, (c) are priced in keeping with the willingness to pay criterion as well as being proportional to the likelihood and costs of the risks involved (Churchill 2006), (d) are such that all phases of the product be developed in close collaboration with the communities they are supposed to benefit (MIA 2006), and (e) must be of substantive value to the poor in terms of addressing the issue of vulnerability to poverty (Ahsan 2009).

While most formal insurance arrangements prevalent in the developing world may not each fulfil all the elements cited above, the key requirements are that the "microinsurance" product be developed in collaboration with the targeted poor and that it must be of value to them, without which demand would simply not be there. As we shall see below, underdeveloped markets features, e.g., high premium rates coupled with poor levels of coverage, would result in a correspondingly low rate of product uptake by the poor. The high premium rates essentially may arise from a variety of sources, including inadequate risk pooling (e.g., due to poor uptake), poor quality of underlying actuarial information and high administrative costs. The insurer's inability to sell policies door-to-door in rural areas in a low-cost fashion may often be a source of high administrative costs (e.g., as in the case of mainstream insurers retailing low-valued life products through commissioned agents). Low demand may emanate from the fact that many of these products do not offer the insured families any real chance to overcome the loss and improve the chances of not falling back into poverty on account of being insured. Hence, in order for the insurance products to have value to the poor, these must offer benefits that have the potential to make the insured less vulnerable to poverty.

In essence, therefore, *microinsurance services are those risk-shifting devices offered by insurers that are especially suited to the needs of low-income households and are affordable*. Correspondingly, microinsurance products must possess some distinguishing features when compared with those of general insurance in terms of *coverage, premiums, delivery channels, terms and benefits* (McCord, 2008) each of which has been discussed in some depth in the Churchill volume (*op. cit*). Briefly, the issues of contract terms and benefits, coverage and premium determination relate to the product design regime, and here one has to adequately address the standard issues of moral hazard and asymmetric informational externalities that typically plague insurance markets in general, and microinsurance cannot be immune to these. Innovations as to the mode of delivery, which is central to the development of a cost efficient product, and legal cover for the insurer and reinsurer may be addressed by crafting a set of effective regulatory directives. The latter may serve as an important public intervention

measure promoting contract enforcement, thus contributing to the emergence of a sustainable market in microinsurance.

Currently, in Bangladesh, a group of mainstream insurance companies, a large number of Microfinance Institutions (MFIs) and some professional organisations (e.g., International Network for Alternative Financial Institutions, INAFI) are offering products that are often termed "microinsurance," though most of these do not satisfy the criteria reviewed above except notionally that these products featuring small "sum assured" are targeted at the poor. Even a cursory review reveals that most of these products do not offer a sufficiently large coverage (whether life or health) that have any chance of reducing future poverty in the event of death or long-term disability of the insured.

Most of the commercial insurers are keen to operate in the "life" market, which is likely to generate profit in short order. Unlike health or crop insurance, moral hazard and adverse selection problems are much less of a barrier in this case. Indeed, over the last few years, lacking serious competition, several life insurance companies have been successful in exploiting the low-income market to generate growth for their business. But the economic benefits of such life insurance products to the poor are less obvious. In addition, credit-life insurance, mostly offered by MFIs, which writes off the borrower's debt burden in case of his/her death, does not provide a significant buffer against vulnerability either. Commercial insurers thus far have been reluctant to offer health (including accident and disability) policies.

Thus, there is an emerging need for developing suitable microinsurance products to serve the interest of low-income households including the ultra-poor; however, the relevant design issues have not been fully analysed in the Bangladesh context. ILO (2003) produced a short inventory of microinsurance activities in Bangladesh describing mainly the nature of products, eligibility criteria and premium structure, which is dated by now. International Network of Alternative Financial Institutions (INAFI) conducted a market study and described the basic features of some microinsurance products, again without much of an analysis (Hasan 2007). Khalily *et al.,* (2009) were the first to dwell on the issues of product inventory, institutional perception and management of the insurance fund. But none of these studies made their key focus the analysis of the entire spectrum of products, which experience continuous innovation from within. However, without a proper and detailed independent review, true product innovations cannot occur as insurers themselves are not fully equipped to do the same and learn from each other's mistakes and good fortunes. Thus, the present study attempts to provide a fairly comprehensive analysis of the current inventory of microinsurance products in the Bangladesh market, the conclusions

of which are expected to benefit both researchers and practitioners to innovate and implement more appropriate microinsurance products for the poor.

With the foregoing paragraphs serving as the introduction, the remainder of the paper proceeds as follows. Section II explains the methodology of the analysis. Section III reviews life microinsurance products offered by commercial insurers, while those operated by MFIs are described in sections IV and V; the latter devoted to the products under experimentation on the concept of mutuality developed by INAFI. Non-life non-health coverage offered by MFIs is briefly touched upon in section VI, while an overall assessment and challenges faced by the non-health sector initiatives of NGO-MFIs is provided in section VII. A more elaborate analysis of the micro health insurance is offered in section VIII, while section IX concludes.[3]

II. THE SURVEY FRAMEWORK

The information used in the analysis was mainly collected through a survey of existing microinsurance providers, categorized into three groups, namely commercial insurance companies, MFIs and INAFI.[4] We enumerated all carriers for each of these three categories of providers. However, insofar as the commercial providers are concerned, the survey targeted mainly the 17 life insurance companies since only the latter offer what may be termed "micro life insurance" products.[5] In addition to the survey approach, we made an extensive review of all relevant documents, both published and on the web, on microinsurance in Bangladesh.

We designed a different set of questionnaires for each category of microinsurance provider, which covered detailed information including the extent and depth of risk coverage, selection criteria to enlist the insured, premium structure, claims settlement procedures, indemnity pattern, and marketing strategies about the products each was offering. We sought the intermediation of Bangladesh Insurance Association (BIA), an industry association of all commercial insurers, for administering the questionnaires to the "life" providers in order to expedite the process. Unfortunately, it proved hard to obtain full cooperation from this group. After many attempts including phone calls

[3]Statistical tables relating to the survey cited above can be obtained by communicating with the authors.

[4]This particular survey of providers has been funded by UNDP (Dhaka) under the REOPA project as cited earlier.

[5]Uddin (2009) also cited 16 companies that offer products targeted at low net-worth households.

persuading them to fill in the mailed questionnaires, on-site visits by trained enumerators, and BIA intermediation, completed questionnaires were received from only nine life insurance companies which offered microinsurance products. In addition, the general insurance companies which responded to the questionnaires reported that they had no microinsurance products. Thus, we conducted this component of the analysis based on 9 commercial insurance companies which offered a variety of life products, some of which are targeted at the poor.

For conducting the MFI survey, we recruited a group of enumerators and provided them with necessary training. We listed a group of 54 MFIs which have an office in Dhaka city. In addition, we listed all the large MFIs which do not have an office in Dhaka. For the former, we sent the enumerators to collect the data. For the latter, we first communicated with them via telephone and email, and then sent questionnaires with a forwarding letter via postal services and email. We requested that they fill in the questionnaires and send them back to the Institute of Microfinance (InM). We monitored this survey process by telephone. We received completed responses from 42 MFIs, of which 37 offer microinsurance products. Thus, we conducted the analysis based on these 37 respondents.

In the case of INAFI, we contacted the programme personnel and discussed the overall perspective of the study with them. We then sent a trained enumerator to collect the information and relevant documents. We also downloaded some information from the INAFI website. Subsequently, a fair amount of exchange took place between the programme personnel and the authors by electronic means.

The data was entered into a computer and analysed in Excel version 7 after necessary coding and editing. As per the nature of the study and as reported below, we analysed and/or inferred the statistical associations in the data mainly based on tables and graphs.

III. LIFE PRODUCTS OFFERED BY COMMERCIAL INSURANCE COMPANIES

This section evaluates the design of microinsurance products offered by commercial insurance companies based on the survey questionnaire conducted during October-November 2009. The commercial insurance sector in Bangladesh has shown a strong growth in recent years reflecting the development of new products and innovation, and the change of the government's policy stance to enable the insurance sector to emerge from a traditional structure of state-owned companies to a more liberalised market (Uddin 2009). There are currently 62

registered companies, including 2 public sector corporations (one each in life and non-life) operating in Bangladesh, of which 44 offer non-life insurance in the formal sector. Among 18 life insurance companies in the country, 17 offer what may be termed as products targeted at low net-worth households. We review below the key features of the "microinsurance" products offered by 9 of these life insurance companies, which hold a major proportion of the market served by commercial insurers.

"Microinsurance" is not a new concept in Bangladesh's commercial insurance market. As revealed by the questionnaire survey, the first microinsurance product offered by commercial life insurance companies was "micro life insurance" initiated by Delta Life in 1988. In collaboration with Grameen Bank, it started off by offering *Grameen Bima* in the rural areas and *Gono Bima* in the urban slums in the late 1980s and throughout the 1990s; but the collaboration ended shortly thereafter. Later in 1996 *Sandhani* Insurance Company started to offer micro life products in Bangladesh. However, its popularity grew recently in the 2000-2001 period when many other insurers started offering competing products. With the exception of the two companies mentioned above, the remaining seven in our study started this line of business in the latter period. We analyse below the efficacy (i.e., both adequacy and affordability) of this segment of the market in terms of criteria commonly employed to judge the products targeted at the poor.

(a) Sum Assured (SA): The level of insurance coverage is an important indicator to identify whether a product falls into the microinsurance category or not. A high level of coverage may require a long list of formal documents for a claim settlement, thereby raising the compliance costs on the part of the insured and their heirs. Of the 11 products in our database, the two term policies had the lower limit of coverage set below BDT 15,000, while the same figure for endowment type policies was BDT 20,000. Hence, these all appear within the reach of the poor and ultra-poor, and indeed majority of the policies actually sold are believed to be concentrated near the low end of the coverage limits. Having said that, we also observe that the upper limits of these policies are, however, set rather high; only 3 products have the maximum SA below 150,000. For several products, there are no upper limits. These observations lead us to claim that none of these products (except one with a cap of BDT 50,000) appear to have been designed exclusively with the poor in mind (Table I).[6]

[6]Recall that in the Bangladesh regulatory context, there is as yet no set definition of what goes by "microinsurance." While perhaps too restrictive, the Indian regulator (IRDA) has set the upper cap at INR 50,000 (for both life and non-life policies, e.g., health). For further discussion on this point, see Ahsan, Barua and Tax (2010).

TABLE I
SUM ASSURED OF MICROINSURANCE PRODUCTS[7]

Type (Term/ Endowment)	Sum Assured (BDT) (Lower Limit)	Frequency	Sum Assured (BDT) (Upper Limit)	Frequency
Term	SA ≥ 5,000	1	SA ≤ 50,000	0
Endowment		2		1
Term	5,000 ≤SA≤ 10,000	0	50,000 ≤ SA ≤150,000	0
Endowment		6		2
Term	10,000 ≤SA≤15,000	1	150,000 ≤SA≤200,000	1
Endowment		0		4
Term	15,000 ≤SA≤20,000	0	No Upper limit	1
Endowment		1		2

(b) Risk Coverage: The survey data shows that there are only limited types of products available on the commercial segment of the market, namely life insurance (both term and 'endowment' varieties). These 9 companies offered 11 microinsurance products, of which 4 covered only "death" benefit, 3 had elements of "accidental death & disability" (ADD) benefits built into the programme without additional premium, and 6 plans offered ADB or some form of supplemental coverage (e.g., return of premium money for matured 'term' polices) upon additional payment.[8] In spite of including some accident benefits in the plan itself, a few also offered some additional benefit (e.g., disability) for an additional premium. Hence, the risk coverage variety adds up to 13 for a total of 11 plans.

TABLE II
BASIC FEATURES OF MICROINSURANCE PRODUCTS REPORTED IN THE SURVEY

Risk Coverage	Frequency
(a) Death only	4
(b) Death and some Accident /Disability Benefit (ADB) Built-in	3
(c) Death, but ADB available as a Supplementary Policy	6
Type of plan	
(i) Endowment	9
(ii) Term	2

[7]All tables presented in this paper, unless otherwise stated, are based on surveys carried out by the InM team on Microinsurance during the last quarter of 2009.
[8]Actually, these 9 companies claim to offer 12 products, because one sells the same contract under two names ('Bima' and 'Islami Bima') with identical coverage, premium and other terms.

It is also seen in Table II that a majority of the plans were of the endowment type, with just 2 offering term contracts, which is anomalous as it would be hard for the poor and ultra-poor to purchase endowment type plans of sufficiently high "sum assured" (i.e., adequate from the vulnerability perspective) due to cash-flow constraints. By contrast, a check on the products of the major providers in India (e.g., Bajaj-Allianz, LIC and Tata-AIG) shows an entirely different picture with term contracts dominating the microinsurance scene. While the data is incomplete, it appears that the ADD features, mostly available as supplemental coverage upon additional payment, were not uniformly defined for all carriers. In particular, long-term disability/dismemberment was not always available even as a supplemental package. In a competitive setting, these would have been fairly standardised as set percentages of the principal coverage (i.e., the sum assured for life) as is common in more developed insurance markets.

(c) Targeting the Poor: The target group may be effectively reached by tailoring products to suit their preferences and means. In the absence of any study on either of these issues, insurers approach the clientele by ad hoc design of policies such as market products with low "sum assured" (SA) and/or by seeking policy holders of low earnings. The targeting criterion has therefore been largely ignored in the design of policies.

(d) Earnings Criteria: The data on the target income range of potential insured is not of much informational value unless one knows exactly what the reported incomes are for the policy holders, something to which we have had no access. Only one insurer posts a range of monthly income of target clients, between BDT 600 and BDT 7,200, and, if this was enforced, most policy holders here would be deemed poor or near-poor. From the foregoing it would seem these 'omnibus' products offered by commercial insurers accommodate individuals of both low income and those in considerably higher income categories.

TABLE III
AGE AND INCOMES OF TARGETED CLIENTS

Minimum income level of targeted clients	Frequency	Age range of targeted clients	Frequency
≤ 1000 Taka per month	3	18-45	3
> 1000 and ≤ 3000 Taka per month	3	18-50	3
> 3000 and ≤ 5000 Taka per month	3	20-50	1
No specification	2	20-55	2
		No specification	2

(e) Health Status and Eligibility: Commercial insurers typically screen the insured by evaluating their existing health status before agreeing to sell life insurance. The age is usually a first barrier. And on this score, most insurers appear to target those below 50 (except 45 and 55, respectively in two separate instances). Very often insurers also demand a satisfactory medical report before offering an insurance policy. Of the 11 products cited above, in 4 cases, no report was necessary, while the rest required a report, though the precise modalities varied among them to an extent (see Table IV).

TABLE IV
HEALTH STATUS REQUIREMENTS

Information requirement	Frequency
Medical Investigation not required	4
Medical Investigation required by a doctor selected by the company	3
Medical Investigation required by a doctor, hospital or clinic selected by either the policy buyer or the insurance company	2
Medical Investigation required but not specified by whom	2

(f) Premium Structure: A review of the premium information reveals that while the premium rates appear to be very much on the high side, there is not a great deal of variation among age groups, which provides a very clear hint that these can only have a remote bearing with the underlying actuarial calculus, if any. Indeed, 5 of the 9 products have no differentiation whatsoever (Table V).[9] A policy with limits of BDT 12,000-200,000 requires a slightly lower premium rate of BDT 87 per thousand SA for the under 40s but for the 40-60 age range, the rate is BDT 116.

The majority of the policies (8 out of 11) have rates in the range of BDT 87 to 116 per 1,000 SA. Policies with limits of BDT 6,000-200,000 all have rates between BDT 100 and 116 per 1,000 SA. The policy with the highest minimum (BDT 20,000) and no upper limit is not significantly different in price with rates of 98 and 101 respectively. Policies with lower maximum sums are surprisingly the ones with lower rates. A policy with limits of BDT 6,000-50,000, perhaps the only product under examination here that would pass the conventional test of being a bona fide "microinsurance product," has a rate of only BDT 50 per thousand SA, while a policy with limits of BDT 6,000-150,000 displays premium rates in the range of BDT 68 to 105. Evidently, for the endowment of policies,

[9]While the sample under review had 11 products, premium information was usable only for a subset of 9 companies.

the rate decreases as the length of the policy term increases–terms being 10, 12 and 15 years.

TABLE V
PREMIUM STRUCTURES AND RATES

Premium rates (annual)	Lowest (BDT per 1000 SA)	Highest (BDT per 1000 SA)
Range for all companies and policies surveyed	50	116
Range for policies charging one rate for all ages	50	100
Range for policies with rates for the under 40s	87	106
Range for policies with rates for 40-60	101	116
Range for endowment policies (7 policies)	50	116
Range for term policies (1 policy)	116	116
Structure	Term	Endowment
Flat rate for all ages	1	5
Higher rate for over 40s	1	4

Can these rates be deemed too high? The minimum rate for a term policy (with no return of premium) of BDT 116 compares poorly with the rates of 11.6 to 48.8 for various ages between 18 and 60, as that was charged for example by Tata AIG (Navkalyan Yojana) in India for a retail plan as well, and rates there have been continually falling. Even lower rates apply, of course, to group plans with large membership (say one million plus subscribers). It is not plausible that the poor in India have a very different mortality risk than in Bangladesh.

Insofar as the endowment policies are concerned, the rates are somewhat more comparable with those in India. Given that the partner-agent model being practiced in India is only a recent development, the cost of programme placement would be expected to come down significantly over time. The Bangladesh case is still different and as there are no institutional agents (i.e., other than the retail agents engaged by insurers) to approach the poor on behalf of the risk carrier, the administrative costs tend to be even higher.[10] Even then the Indian figures for

[10]Insurance companies reach their clients through (typically freelance) agents who travel from door to door, and this is typically how the products are sold as well as premium money collected. Most companies, however, retain the provision where the insured can also come to the company office to pay the premium due. See the discussion on the costs of intermediation.

term insurance cited here appear to be many times greater than comparable figures in competitive markets, say in North America.[11]

(g) Marketing System and the Commission Regime: Agents receive a proportion of the collected premium of an insurance policy for their financial intermediation services. In the survey it is observed that the proportion in question varies with the maturity term of the policy. In the first year, the agent's proportion is significantly higher than in later periods, as selling a new policy demands the agent's skill, cost of marketing and transportation, etc. In most cases, there is a decline in the agent's commission in the second year. While in the third year for some companies it remains stable, for others it falls significantly. In general, different insurance companies have different incentive structures for micro life insurance products with an average commission of 33.54 per cent in the first year of the policy. The minimum commission share varies within a range of 25 per cent to 66.25 per cent. The average drops to 8 per cent in the third year of the policy, the range being 5 to 10 per cent.

Considering that agents play an important role in reaching the clients, the significant difference in the incentive structure of the agents between companies can have significant implications for the continuation of the policy by the insured. The survey reports that in some cases, as much as 50 per cent of the policies have lapsed in the second year, while for other companies the reported rate of lapses were smaller but still significant. It need not necessarily be the case that there is a link between the temporal pattern of the incentive structure of microinsurance agents and the rate of policy lapses. The insured may on reflection realise that the policies sold by "high pressure" agents were actually too expensive given the benefits, or that the product (especially endowment type) was unsuitable in view of their evolving cash-flow situation and the like. The possible scenarios are too numerous to offer a good rationale behind the causes of policy lapses.

(h) Claim Settlement System: One of the important determinants of the benefits of microinsurance is the ease of the claim settlement process. The fewer documents required, the lower would be the cost of claim placement and the higher the benefit to the insured. In addition, different types of documents involve different levels of complexities. For example, the cost of collecting an FIR report is considerably higher than the cost of acquiring a death certificate

[11] Both the Indian examples and the low-cost term products in the European and North-American markets are essentially group policies. In the Indian market insurers can only sell micro products to members of NGO-MFIs, who serve as agents, and thus market it en masse to their respective member pools.

from a qualified doctor. In the survey it is observed that the number of required documents varies from as low as 4 to as high as 8 per claim. The range of documents required by commercial insurers may include the following: application, vouchers of premium payments or equivalent, other insurance policy documents, proof of age, general diary copy, first information report from police station, death certificate, post-mortem report, local chairman certificate, etc. From this list it is understandable that the cost of a claim settlement on the policy holder's side may be deemed excessive, thereby diminishing the demand for such products greatly. Another important issue is the time required to settle a claim. Policy holders may need some money immediately after the shock to meet the financial obligations. If they receive money after a long time lag, the value of the eventual economic benefit (and that of 'insurance') erodes significantly.

(i) Claim Rejection: In the questionnaire survey five insurance companies reported that one of the important determinants of claim rejection is concealment of facts, such as illness, age, etc., while purchasing the insurance policy. Other important determinants of claim rejection include previous policy lapses, lack of proper documents and fraudulent activities. As medical investigation is not mandatory for selling insurance products, there is a chance that some of the products will be sold to those who are not in good health or are outside the acceptable age bracket by the insurer. However, if policies are sold without prior investigation and claims are eventually rejected on the grounds that the policy holders concealed their real age or health status, such unethical behaviour on the part of the insurer would not bode well for the development of the microinsurance market.

TABLE VI
CAUSES OF CLAIM REJECTION

Causes	Frequency
Concealment of illness, age, etc.	5
Lapsed policies	3
Fraudulence and fake information	2
Lack of proper documents and medical reports	3

In the discussion above, we have attempted to identify some important issues that need to be addressed in order for further development of a poor-friendly microinsurance market.

Sum Assured: If most policies purchased by the poor are in the low range of the SA (say, BDT 5-10K), as is presumably the case, it would seem that the typical figure is too low to cover events leading to significant financial stress

(e.g., death of the primary income earner in a household) even for the ultra-poor. As stated above, none of the products were designed explicitly with the poor in mind. It is a maintained hypothesis of this document that meaningful products ought to be capable of preventing a lapse into poverty by the household suffering a major misfortune, i.e., to prevent vulnerability to poverty.

Risk Coverage: Microinsurance services offered by commercial insurers are mainly limited to life insurance services, and then again mostly of the endowment type. What would be of greater potential demand, as explained above, are meaningful term products designed with the poor and ultra-poor in mind. For these products, as a routine, insurers may offer a supplementary clause whereby the insured may elect to have the premium money retuned on maturity of the contract (less administrative charges). Even within the life categories (term or endowment), although some products incorporate additional services like accident and disability benefits, these ought to be simplified into a standard package (prorated to the SA value) which the insured may decide to include in the policy or not (and the premium varied to reflect the choice). There are no products offering micro health insurance (MHI) or a hospitalisation facility.

Premium Structure: The premium rates appear unrelated to any plausible model of mortality of the insured, thus defying the very definition of life policies. The rate structure in force is excessive, often many times greater than the rates available for comparable products in the nascent microinsurance market in India (i.e., those offered by commercial risk carriers there), with the latter itself being many times greater than what is available for group coverage in competitive markets in Europe and North America.

Claim Settlement System: The claim system of the commercial insurance companies appears demanding, cumbersome and unnecessary. For a poor-friendly product, the claim settlement system should be less paper oriented and executed expeditiously in a matter of days rather than weeks.

IV. CREDIT RISK AND LIFE INSURANCE THROUGH MICROFINANCE INSTITUTIONS

MFIs and NGOs are at a unique vantage point to offer microinsurance to their vast network of clients. Bangladesh has an even higher rural population density than that of its neighbours, which would ideally allow for coverage of a large number of policyholders within a limited geographic area, and thus offer the scope of implementing a good-sized programme at a modest cost. As most MFIs operate at the rural level, they can thus make use of the existing network of contacts for the implementation and enforcement of insurance policies and

thereby reduce administrative costs. It is also easier for MFIs to assess the worthiness of a potential client because they can monitor the client's situation closely without incurring high costs. To an extent, these natural advantages have been seized upon by NGO-MFIs, but so far armed with a rather limited set of products. A survey conducted by the INAFI office in Bangladesh (hereafter Hasan 2007) reported that 92 NGO/MFIs offer insurance services either in the name of "microinsurance" or in the guise of a variety of saving products. Out of approximately 30 million microfinance clients, it is estimated that about 69% (or, 20.69 million, mostly women) were covered by some form of microinsurance products.[12]

BRAC had experimented with an in-kind prepaid health insurance system in 1972, but it was short lived.[13] While Ganoshasthya Kendra (GsK) began to offer some health coverage as early as 1978, MFIs began informally offering microinsurance products (typically credit risk) to their clients about a decade later. However, the available evidence shows that MFIs have introduced credit loss insurance programmes primarily to minimise the institutional risk, and only in part to mitigate the risk faced by borrowers and, because the premium income far exceeds the claim settlement, they gain access to a sizeable revolving loan fund in the process (Khalily *et al.* 2009). A good number of MFIs use this limited type of microinsurance as a mandatory requirement for receiving microcredit from their respective institutions as a safeguard mechanism for their lending activities.

In spite of some efforts and possible on-going overtures, unlike India and elsewhere, a framework of collaborative implementation of microinsurance between an MFI and a dedicated risk carrier, namely the partner-agent model, is yet to take root in the country. While the INAFI had planned to initiate some steps in this direction, it did not materialise.[14]

Though the type of insurance coverage tends to vary depending on the size of the MFI, the main product offered by MFIs is term loan insurance which generally covers the outstanding loan balance and some combination of disability and/or provides a one-time monetary benefit to the client's designated beneficiary. Thus most products marketed by MFIs are meant for their

[12] Among the largest providers are the top lenders, namely ASA (5.7 million), Grameen (5.58 million), BRAC (5.50 million) and Proshika (1.94 million), where the figures in brackets denote the size of their membership, respectively as of 2009.

[13] Under this system the provision was to pay the premium in kind (e.g., five kilograms of paddy per person annually) instead of cash.

[14] See section V for an update.

borrowers, a policy which the Microcredit Regulatory Authority (MRA) guidelines appear to endorse (Ahsan, Barua and Tax 2010). Smaller MFIs tend to offer only term loan insurance due to their limited capacity. Conversely, larger MFIs tend to offer both credit risk and endowment type insurance coverage. BRAC appears to be unique in that it provides credit insurance with the loans as a condition of the loan (along with a modest death benefit) without any explicit premium; in other words, the costs of the insurance elements are already incorporated in the interest rate structure. While there is some variation in the contract terms and conditions by product and by MFI, the contract period for insurance products marketed by MFIs is typically yearly so as to harmonize with the loan term, which is a constraining feature of this type of coverage (Ahsan 2009).

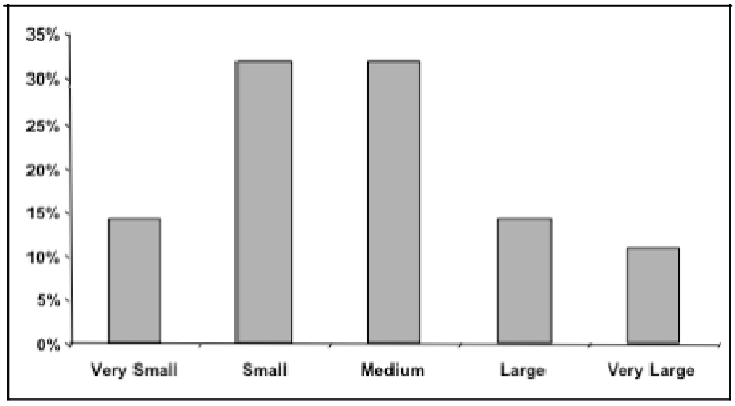
TABLE VII
AVAILABILITY OF MICROINSURANCE

MFI Category	Frequency	Per cent	Cumulative
Very Small	4	14.00	14.29
Small	12	32.00	48.57
Medium	12	32.00	74.29
Large	5	14.00	88.57
Very Large	4	11.00	100.00
Total	37	100.00	

We analyse below primarily the products being marketed by 37 MFIs (out of 42 who responded to the InM 2009 September-October survey cited above). Although most label their products as microinsurance, some are called "Life Fund," "Welfare Fund" "Members' Welfare Fund," etc. Only 5 out of the 42 MFIs surveyed did not have any form of protection against any adversity or shock in the form of microinsurance, although some had a disaster management fund. The present review dwells on the variety of available products, their design aspects and mechanisms utilised to deliver these. Of the 37 MFIs, 46 per cent (i.e., 16) were "very small" or "small" in size, where the size is defined in terms of membership strength of the institution.[15]

[15] An MFI is considered "very small" if it has membership of up to 5,000 members, while "small" MFIs are those with membership between 5,000 and 25,000. Membership between 25,000 and 100,000 is classified as "medium" and "large" MFIs are further classified into large and very large. Membership between 100,000 and 500,000 is defined as "large," and "very large" MFIs carry membership in excess of 500,000.

Figure 1: Microfinance Availability by MFI Size



4.1 The Product Variety

In terms of characteristics, MFIs offer loan (term and endowment), health, accident, property, micro enterprise and livestock insurance. Different combinations of products are offered by different institutions (Table VIII). The INAFI survey cited above found that of the 81 MFI-run products (offered by 61 of 92 organisations), 57 dealt with loan, 13 with life, 5 with health, 4 with livestock and 2 with property insurance (Hasan 2007). The present sample presents a similar pattern (Table VIII). Nearly half offers only credit risk coverage, though the latter was offered by 35 of the 37 MFIs. Life insurance, term or endowment, is offered by 14 MFIs (38 per cent of the sample) on top of the credit loss. Health was in the portfolio of 3 MFIs and livestock of another two.[16] Micro enterprise insurance is offered by just one MFI in the present sample.

Table IX analyses how the product variety is associated with MFI size. Of the 16 smaller MFIs in the present sample, 10 offered just loan insurance and the other 6 offered a term life policy to their members. As anticipated, only medium and larger MFIs offer insurance schemes that incorporate both credit risk and endowment. In view of the diversification in their loan products, larger

[16]Note that while Grameen Kalyan (GrK), a distinct sister ('social business') organisation affiliated with Grameen Bank, has been operating one of the larger health intervention programmes in the country for more than 15 years now, it is not an MFI as it has no credit programme. Hence, Table VIII or IX do not feature GrK.

institutions typically find it convenient to offer a richer portfolio of insurance products.

TABLE VIII
MICROINSURANCE PRODUCTS OFFERED BY MFIS

Insurance Type	Frequency	Per cent	Cum. Per cent
Credit risk only	18	49	48.65
Credit plus life (endowment)	4	11	59.46
Credit with term life	10	27	86.49
Credit plus health plus micro-enterprise (ME)	1	3	89.19
Credit plus livestock plus life (endowment)	1	3	91.89
Credit plus livestock	1	3	94.59
Accident plus term life plus health	2	5	100.00
Total	37	30	

TABLE IX
MICROINSURANCE PRODUCTS OFFERED BY MFI SIZE

Insurance Type	Very Small	Small	Medium	Large	Very Large	Total	Per cent
Credit risk only	3	7	6	1	1	18	48.65
Credit plus life (endowment)	0	0	1	2	1	4	10.81
Credit with term life (death benefit)	1	5	2	2	0	10	27.03
Credit plus health plus ME	0	0	1	0	0	1	2.70
Credit plus livestock	0	0	0	0	1	1	2.70
Credit plus livestock plus life (endowment)	0	0	0	0	1	1	2.70
Accident plus term life plus health	0	0	2	0	0	2	5.41
Total	4	12	12	5	4	37	100.00

4.2 Term Loan Insurance

Term loan insurance is the most common insurance product among the MFIs offering insurance. The principal aim of this product is to protect the loan

disbursed by the lender, which is fully written off against the insurance fund in the event of death of the insured borrower. No other benefit is given to the family. A majority of the medium and smaller MFIs (i.e., 16 out of 28) offer only this kind of insurance. Another 10 MFIs augment the credit risk coverage with additional cash compensation ("death benefit") on the death of the borrower for her family. The sum insured is determined by the original loan size.

4.3 'Endowment Loan' Insurance

This is another loan-based product. However, an endowment type policy is different from term life in the sense that this product offers an additional lump-sum payment even if the insured does not encounter death within the term of the insurance contract. Upon death of a borrower, the family is paid the sum assured, usually equivalent to the principal loan amount, net of any unpaid portion of the loan. If an unforeseen event does not occur during the contract period, the borrower is refunded the premium paid with some additional cash benefits. The basic difference between term and endowment loan insurance is, therefore, the savings element. Only 4 of the 37 MFIs (i.e., 11 per cent), and then again all medium or larger offer such a policy.

V. LIFE INSURANCE PROJECT OF INAFI, BANGLADESH

In the context of the limitations in the product base of both commercial insurers and MFIs, the entry of the INAFI, Bangladesh in the microinsurance arena can be seen as a step forward.[17] INAFI initiated a 4-year pilot project entitled "Microinsurance for Mutual Enabling (MIME)" in May 2007 in collaboration with the Oxfam Novib and Rabo bank.[18] The project operates on a mutuality concept, a notion of apportioning the ownership of the organisation as well as any profit as a bonus among the beneficiaries, i.e., the policy holders. This project has ventured into providing life microinsurance products and services to the poor and the ultra-poor, which are not offered by the existing insurers. MIME had hoped to establish itself as a sustainable and autonomous

[17]INAFI works for the advancement of the local microfinance sector in a group of countries in Asia, Africa and Latin America. INAFI, Bangladesh is involved in the capacity building of MFIs, product development, and campaigning and lobbying with relevant stakeholders to address the strategic issues and concerns for the advancement of the sector. Currently, INAFI has 24 member organisations and two strategic partners in Bangladesh (http://www.inafiasia.net/bangladesh_chapter.htm).

[18] Initially, Stromme Foundation, a Norwegian Development Agency, had provided funding.

entity by the end of 2010; however, the present target for such status has been deferred to 2013. "MIME Limited" is already registered as a joint-stock company and, in pursuant to the new provision in the Bangladesh Insurance Act amendment of 2010, it has applied for a license as a registered insurer under the "mutual" category. The remainder of this section provides a review of MIME products, their salient features, progress to date including analysis and conclusion.

5.1 MIME Products

INAFI Bangladesh developed its microinsurance products based on a short survey of 3,000 households; 70 per cent of whom were poor and the remainder ultra-poor. They were asked about their "income," "expenditure," their perceived "need" for various types of insurance coverage, and the preparedness to pay for such services. The survey team concluded that the demand for life insurance products was the highest, followed by health insurance. Thus, in December 2007, MIME started off with life insurance products targeting both the ultra-poor (defined by those with annual income below BDT 12,000 and total asset value of less than BDT 25,000) and the poor (having annual income below BDT 48,000 and total asset value of less than BDT 200,000). It is currently offering two microinsurance products: Simple Term Life Insurance (STLI) and Term Life Insurance with Endowment (TLIE) on a pilot basis. As of 2010, MIME products have been implemented in 16 districts through 13 MFIs, all members of PKSF, each of which has been licensed by the microcredit regulator (Microcredit Regulatory Authority—MRA).[19]

We explore below some key features of the MIME products including organisational aspects, risk coverage, selection criteria, maturity, premium structure, marketing policy, the claim settlement process and the profit sharing policy. Table X captures some of these features at a glance.

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[19] These are BURO Bangladesh, Shakti Foundation for Disadvantaged Women (SFDW), Community Development Centre (CODEC), Voluntary Association for Rural Development (VARD), ASHRAI, Gano Unnayan Kendra (GUK), Pally Bikash Kendra (PBK), Bangladesh Association for Social Advancement (BASA), Anannyo Samaj Kalyan Sangstha (ASKS), Society for Social Service (SSS), United Development Initiatives for Programmed Actions (UDDIPAN), GHASHFUL and POPI, all of which receive funds for on-lending from Palli Karma Sahayak Foundation (PKSF), the wholesaler, and in return have to follow certain accounting and business procedures recommended by the latter. See (http://www.inafiasia.net/ aboutmime.html) for more details.

TABLE X
MAIN FEATURES OF MIME PRODUCTS

Main Features	Type of Scheme	
	Simple Term Life Insurance (STLI)	Term Life Insurance with Endowment (TLIE)
Risks Covered	Life	Life
Eligibility/Selection Criteria	• Solely based on age limit • The age range: 18-47 years • No medical investigation	• Solely based on age limit • The age range: 18-47 years • No medical investigation
Maturity/ Duration/ Termination	• Policies expire at age 60 if no death	• Term: 5, 7, 10 or 12 years. • Maturity: End of each term.
Benefit Package under the Scheme	• Death benefits • 5% bonus on paid-up • premium every five years	• Death benefits or insured amount • Share of profits (to be • determined by the insurer)
Sum Insured (BDT) Minimum Maximum	• 1,800 • 18,000	• 2,780 • 76,300
Amount of Premium (BDT: fixed), See below	• 5, 10, 15 and 20	• 50, 100, 150, 200, 300 and 500
Premium Collection Process	• Insurance officer employed and salaried by MIME collects the premium through using the branch offices of partner organisations	• Insurance officer employed and salaried by MIME collects the premium through using the branch offices of partner organisations
Claim Placement and Settlement Process	• Placement of claims on a prescribed form • Scrutinising the claim by a visit by the insurance officer to the claimant's area • For normal death, the beneficiaries receive a partial payment immediately for funeral expenses • Maximum period for claim settlement: 15 days	• Placement of claims on a prescribed form • Scrutinising the claim by a visit by the insurance officer to the claimant's area • For normal death, the beneficiaries receive a partial payment immediately for funeral expenses • Maximum period for claim settlement: 15 days
Policy Lapse	• Failing to pay premium for three consecutive months • Providing a false statement by the policyholder	• Failing to pay premium for three consecutive months • Providing a false statement by the policyholder
Reasons for Claim Refusal	• Death of a policyholder during policy lapse period • A policyholder receives a surrender benefit if he/she continues the policy for at least one year	• Death of a policyholder during policy lapse period • A policyholder receives a surrender benefit if he/she continues the policy at least for one year

Source: Information collected through a survey questionnaire from INAFI Bangladesh.

(a) Organisational Structure: While INAFI had originally wanted to adopt a partner-agent framework by including a commercial risk carrier in this initiative,

so far this has not been possible, and MIME members (i.e., the 16 partner MFI-NGOs, or partner organisations; POs for short) have been carrying the risk on a mutual basis. However, in the event, MIME is successful in its bid to obtain the status of a licensed mutual insurer, it would at least be in a position to seek a reinsurer.

(b) Duration of coverage: The maturity period for "term life insurance with endowment" (TLIE) is open to choice by the policy holder, which ranges from 5 to 12 years in steps as shown in Table XI. However, the majority (about 60 per cent) appears to choose 5 years, which is also the minimum term, while the rest 40 per cent choosing the ten-year plan. For the "simple term life insurance" (STLI) programme, there is no term limit, subject, however, to the stipulation that coverage terminates on attaining the age of 60.

(c) Risk-pooling: Presently, the risk pooling capacity of the MIME programme is limited by the pace of policy uptake by members attached to the partner MFIs. The programme has, however, witnessed a strong growth; for example the number of policy holders has increased from about 27,000 at the end of 2008 to about 72,000 by end 2010. Looked at from another angle, however, the 72K insured group forms a very small share (about 5 per cent) of the pool of members of the participating POs, estimated at about 1.5 million. Hence, being a voluntary scheme, the adverse selection issue cannot be ignored altogether.

(d) Incentive based enrolment: MIME makes a lump-sum payment of BDT 5K per month, i.e., 60K per annum to each of its POs. It would have been easy to experiment with an incentive structure whereby the POs were compensated on a per-insured basis. For example, rather than the 5K flat, it could be 2.5K flat plus BDT 10 per new STLI and 20 per new TLIE member, or, even no flat payment, but double the per member fee per month. Variations of the structure could have (and can still be) experimented with in different locations or among different POs to explore what works best. A similar incentive based compensation appeared to have performed well in generating faster insurance growth in other contexts (e.g., see Cai *et al*. 2009).

(e) Premium structure: The MIME newsletter indicates that the *monthly* premium range for STLI is BDT 5, 10, 15 and 20, while that for TLIE is BDT 50, 100, 150, 200, 300 and 500, which are all payable on a monthly basis for each type of policy. These are also fixed, presumably over the duration of the contract. Actually, MIME publishes the premium rates in absolute terms as these are easier for its target clientele to comprehend in terms of their ability to shoulder in view

of liquidity constraints. However, in order to render these comparable to the standard premium rate of so much per thousand SA as commonly reported, one needs to translate the data which are presented in Table XII.

The STLI rate structure reported in Table XI indicates that these are higher than the credit risk insurance offered by a majority of MFIs, which are generally one per cent or less. The dual rate for someone of age 30 or so is about BDT 36, which is substantially higher than the MFI rates reviewed above. However, while the MFI rates are flat for all ages, the INAFI rates are determined by reference to a mortality table, and thus as the person gets older the cost rises. For the 45 year olds, the rate almost doubles. Overall, however, these seem lower than those charged by some commercial insurers who sell retail policies through their commissioned agents, a costly way to distribute insurance products to the rural poor.

TABLE XI

STLI: SINGLE VS. DUAL LIFE RATE STRUCTURE

Age Group	Average Age	Rate per 1000 per annum (single coverage)	Age Group	Average Age	Rate per 1000 per annum (dual overage)
18-22	20	12.45	18-22	20	24.28
23-27	25	14.46	23-27	25	28.76
28-32	30	17.54	28-32	30	35.91
33-37	35	20.46	33-37	35	42.86
38-42	40	24.24	38-42	40	51.50
43-47	45	29.75	43-47	45	63.90

TABLE XII

TLIE: 10 YEAR TERM

Age Group	Average age	Premium Rate per 1000 per annum	Insured sum against Tk.5 premium per month	Insured Sum against Tk.150 premium per month	Insured Sum against Tk.500 premium per month
18-22	20	99.5	603	18,090	60,300
23-27	25	100.17	599	17,970	59,900
28-32	30	101.01	594	17,820	59,400
33-37	35	101.87	589	17,670	58,900
38-42	40	103.45	580	17,400	58,000
43-47	45	106.19	565	16,950	56,500

Insofar as the endowment products are concerned, while the products are not very comparable with those reviewed above, it is evident that the premium structure is on the high side. The cost of administration must be rather high to warrant this level of premium which would otherwise not be consistent with the mortality behaviour of rural poor. For example, someone in the age bracket 28-32, choosing a 10-year contract term would end up contributing BDT 18,000 (actually 120 instalments of 150 each) in premium in order to receive only BDT 17,820 on maturity (Table XII), reflecting a negative nominal return on her investment. The implicit annual cost of carrying the risk (inclusive of the cost of intermediation) appears to exceed the nominal interest earned on fixed deposits of comparable maturity, a figure that has been in the 9-11 per cent range per annum in recent Bangladesh history.[20] To date, MIME has actually earned about 10.5 per cent per annum on its investments in the Bangladesh money market. In contrast, the Delta Life's 10-year retail endowment product (scheme 401) effectively returns 5.5 per cent to the policy holder when the bonus payment is accounted for.[21] At another level, it is seen in Table XII that per-thousand of coverage of the endowment product, the annualized premium rate is BDT 101 (i.e., 10.1 per cent) for someone in the 28-32 age group in the MIME plan. If we contrast this with an Indian product, Bajaj Allianz Alp Nivesh Yojana, the comparable figure (for the same age group) is 5.9 per cent, about half of the MIME rate.

(f) Marketing: The partner organisations have been implementing MIME products using their branch offices in order to reduce the operating costs. In each partner organisation, PO branch staffs are involved in underwriting insurance policies, while "the insurance officer" employed and salaried by MIME is responsible for policy approval, premium collection, claim authorization, supervision and monitoring, and educating poor people about insurance.

(g) Benefits: Under the STLI policy, the beneficiaries (usually the nominees) receive death benefits and a 5-per cent bonus (without any interest compounding) on the paid-up premium every five years. The bonus scheme implies only a marginal reduction in the annual average premium rate that the policy holders

[20] The future value of a deposit scheme where one deposits BDT 150 per month for ten years, and such that modest interest at 8 per cent is deposited every 6 months (i.e., half-yearly compounding as is the common banking practice), the fund would have grown into BDT 27,425.61 after 10 years.

[21] However, this rate comparison would have to be recast, though very marginally (see the footnote 22), if the MIME bonus scheme (on paid-up premium) could have been activated. In view of the large administrative and intermediation costs, it has not been possible to pay any bonus as had been originally envisioned.

must shoulder.[22] Under TLIE, policy holders are supposed to receive a share of profits along with the insured amount at the end of various terms. However, the programme is yet to turn a profit and hence no bonus has been paid to the insured, though it is understood that a token bonus of 2 per cent return on all premium paid (again without any interest compounding) has been factored in while setting the sum assured. This would imply that the cost of intermediation far exceeds the return earned on investments.

(h) Policy lapse: Policies are declared to have lapsed if a policy holder fails to pay the premium for three consecutive months. However, by paying the full amount of the outstanding premium a policy holder can reinstate the policy. The policy is also declared lapsed if a policy holder provides a false statement. The claim is not accepted if a policy holder dies when the policy is in a "lapsed" mode. In the case of surrendering a policy, the holder receives a surrender benefit if he/she has continued the policy at least for one year.

(i) Claim settlement procedures: The beneficiaries are required to make the claim using the prescribed claim settlement form with the death certificate. The claim is scrutinized by a visit from the insurance officer in the claimant's area. In the case of normal death, the beneficiaries receive a partial payment immediately for funeral expenses. The remaining amount is paid after investigation, which takes a maximum of 15 days to complete.

(j) Profit-sharing: In principle, the parties have agreed to split any eventual profit in the ratio 51: 49 equally between the participating POs and MIME. However, in view of the evolution of the cost structure, it seems difficult to predict how long it may take for the programme to yield actual surplus on the operating side.

5.2 Going Forward with MIME

Table XIII depicts the progress of the MIME project based on current records. The project had sold 3,883 STLI policies and 67,574 TLIE policies by the end of 2010. These figures reflect an annual growth rate of nearly 15 and 66

[22] If someone aged 40 dies in the 5th year of insurance purchase or earlier, the annual premium for the STLI programme remains unaffected from the posted figure of 2.4 % for single and 5.2% for dual coverage. However, if death occurs in the 6th year, the beneficiary (who had signed up for say BDT 10K coverage at age 34-35) would have received a bonus of BDT 55 approximately on completion of 5 years' coverage for single policy and about BDT 116 for a dual policy. Thus over the 5-year period, the average annual net premium (without compounding) would be reduced to 2.17% (as opposed to gross premium of 2.2% if no bonus) for single coverage. For dual coverage, similarly, the average annual premium rate is reduced from 4.63% to 4.40 % of SA.

per cent respectively since the end of 2008. This rate of expansion is impressive, especially for the TLIE product.

During this period 1.03 per cent of the policy holders placed their claims for STLI and 0.17 per cent for TLIE, all claims being for death benefits. The project has yet to meet any maturity claims as it has only been operating for a little over three years since the minimum term is 5 years. Note that the project had duly settled all claims in a fairly rapid manner, and no claims were rejected.

The average claim is fairly small, especially for the term life policies, varying between 3,976 for dual coverage and 6,086 for single coverage. The average SA for the endowment type coverage happens to be somewhat higher at about BDT 9,587. It is very clear from these figures that the insured essentially purchase what they can manage in view of their cash flows, regardless of the size of the coverage. The typical monthly premium for term policies actually purchased ranges between BDT 5 and 10 (for both single and dual coverage), while that for endowment policies vary between BDT 50 and 100 per month.

TABLE XIII
SOME STATISTICS ON PROGRESS OF MIME PRODUCTS: 2008-10

Indicators		Type of Scheme	
		Term Life Insurance (STLI)	Term Life Insurance with Endowment (TLIE)
Total no. of policies sold by end 2010 (2008)		3,883 (2,923)	67,574 (24,396)
Total no. of claims received (cumulative)	Maturity claims	0	0
	Death claims	40 (8)[23]	117 (10)
	Ratio of claimants and active policy holders	1.03%	0.17%
No. of claims outstanding		0	0
No. of claims rejected		0	0

Source: Data collected through a survey questionnaire from the INAFI office in Bangladesh.

We raise below some issues of concern for the MIME management, which need to be attended to if the programme is made permanent from the current pilot stage.

First, from a financial planning perspective, one would normally start by asking what size coverage is appropriate for oneself, and then search for a

[23]Out of 40 claims under STLI, there were 5 single and the rest were dual coverage.

suitable contract. Here it appears the insured choose what they can afford as if some coverage is better than no coverage. Though policies of much higher SA are offered, presumably the excessive premium costs prevent the poor from taking advantage of substantive coverage. Interestingly, as most are micro-credit borrowers, the size of life coverage they have been actually purchasing is typically of the same order or even less than the average loan size. The SA of these policies cannot therefore help overcome the vulnerability faced by the families in the event of death, especially if the dead were breadwinners for their respective households.

A second feature of the MIME product design is that it hides the price of the coverage, which is especially worrisome, as insurance is poorly understood anyhow. It is like giving credit without telling the borrower what the interest cost is. It is doubtful if the sales staff can explain well what the cost is; they certainly do not have the incentive to do so. How do you tell clients that they earn nothing (in nominal terms) in return on their investments that they could have earned in a standard deposit scheme? The cost of risk (inclusive of intermediation) eats up the entire money market yield (10 per cent or higher) that MIME typically earns with the premium paid by the hapless insured. While the premium income itself exceeds the claims (inclusive of actuarially determined future liabilities) by design, the operations and distribution costs have been very large, thus calling the sustainability forecasts sharply into question.

The related concern is with the exorbitant premium of MIME products vis-à-vis any relevant comparator in the microinsurance context. The future expansion of the scheme would be unwarranted unless the premium structure can be brought down to a more reasonable level. As we saw earlier, even the retail policies sold by traditional freelance agents working on a commission basis for commercial risk carriers return approximately 5% on the premium paid by the insured on a compounded basis. Even for the pure term policies, the MIME premium rate of 2.24 per cent of SA for 40-year olds (single coverage) is many times greater than that in the microinsurance market in India.[24]

The next concern is with the relatively higher (actually six-fold) mortality rate in the pool of insured of the pure term (i.e., STLI programme) vis-à-vis those purchasing the endowment products. One caution, of course, is that this may well be an isolated event taking place over a limited term (2 years) among a relatively small number of insured, and thus the figures do not lend interpretation when

[24]Indian microinsurance premium rate for *males* 40-year olds (5-yr term) is about INR 2.78 per 1,000 SA as opposed to about double that (4.66) in general insurance. The MIME rates are, however, for women, which ought to be even lower.

generalised. However, if the pattern appears to persist, it needs to be examined carefully.

Organisationally, while MIME has abandoned the idea of developing into a partner-agent mode of operation as it was unable to entice a commercial carrier in shifting risks, MIME's current attempt to evolve into a full-fledged insurer of the mutual type is a notable goal. If successful, this would let in a much needed breath of fresh air into the current microinsurance market as most other programmes are of the provider type with their inherent limitations.

To date, the experimentation on the product side has only been with life products, though there is talk about MIME's interest in launching a variety of health coverage as a rider to existing life policies.[25] However, as noted already, the life premium structure is rather steep, indicating high costs of intermediation, and it would be helpful to understand precisely the source of such costs so that necessary steps may be taken to contain the costs before expanding into a new line of products.

Finally, we note that while an avowed aim of MIME is to reach the ultra-poor with its products, this is going to be difficult to attain unless a solution is found to the source of high premium costs as just stated. Secondly, one also has to ensure that the existing network of NGO-MFIs would allow MIME to reach the target client pool. Indeed, there is a body of literature arguing that MFIs do not always succeed in reaching the poorest of the poor (e.g., Hashemi 1997, Halder *et al*. 1998, Chau *et al.* 1999, Wright *et al*. 1999, Rahman and Razzaque 2000, Navajas *et al*. 2000, and Amin *et al*. 2003).

VI. MFI NON-LIFE NON-HEALTH PRODUCTS

6.1 Livestock Insurance

It is evidently offered only by those MFIs that offer livestock loans; Grameen Bank and Proshika were just two of these MFIs in the present sample. Under the arrangement, the only risk covered by the policy appears to be death of the animal. The borrower does not receive any other benefit. This is essentially a term insurance where in the case of Grameen the sum assured is 50% of the loan amount, while in the Proshika scheme, the full amount (i.e., the purchase price, which is the same as the loan amount) is insured. In the latter plan, upon death or loss of cattle, the policy holder also receives an equivalent cash loan amount to start afresh. The premium rates are 2.5 and 3.0 per cent of the loan value for Grameen and Proshika respectively. In the absence of further details, it is unclear if these rates allow the insurers to break even or not.

[25] No further details of the product orientation are available at this time.

6.2 Micro Enterprise Insurance

Some MFIs offer insurance to protect the relatively higher micro enterprise loans. This is essentially a term policy, which lowers the risk of default. The borrower does not get any other benefit upon death or full repayment of the micro enterprise loan. In the present survey, only one of the sample MFIs, namely IDF, offers this type of coverage. For this purpose, any enterprise loan above BDT 30,000 is considered to be a micro enterprise loan. Under the scheme, only a maximum of 20 per cent of the losses incurred by borrowers is covered by the policy. The premium structure varies between BDT 30 and 250 (for loans from 30 to 200K). Above 200K, it becomes flat rate at 250. Borrowers also undertake to pay 4 per cent of the income derived from loan utilisation to the insurance fund, which serves as a sort of second-tier premium.

VII. CHALLENGES FACING THE MFI NON-HEALTH PROGRAMMES

Not all the products reviewed above have uniform contracts terms, e.g., the nature of eligibility criteria, benefits or the premium structure. These characteristics are seen to vary both by product and by MFI.

(a) Eligibility: The primary eligibility criterion for microinsurance is membership in the organisation. Under term life covering credit risk only, general loan or term loan, livestock or micro enterprise loan, only *borrowers* are eligible (Table XIV). All *members* are covered under endowment life insurance. However, under livestock insurance, borrowers should have the capability to rear cattle. Though Grameen appears to require a high co-payment on the part of the insured (50%), Proshika allows full coverage for a slightly higher premium (50 basis points).

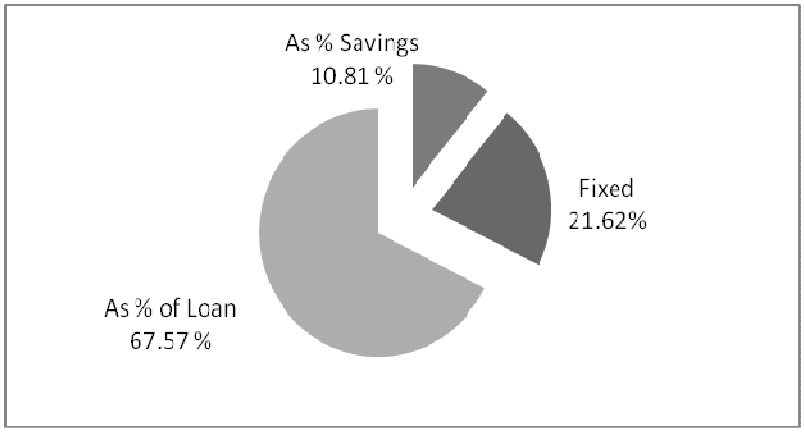
(b) Duration: Most microinsurance contracts generally last for one year coinciding with the typical loan horizon as these provide coverage against loan risk alone. This is evident from Table XV. Only eight of the 37 MFIs offer microinsurance for a term different from the loan term. The latter schemes are for endowment, term with death benefit and livestock. Health, accident coverage and micro enterprise insurance are also offered on an annual basis.

(c) Benefit Package: Basically, policies are broadly offered for term loan insurance and endowment loan insurance. But benefit structures, though similar, vary in details. Table XVII provides this information for the 37 providers offering 47 different microinsurance products.

(d) Adequacy of Premium Revenue: The premium revenue for the MFI sponsored products is accumulated in an "insurance fund." MFIs are expected to settle claims and cover credit risk from this fund. The fact that major providers

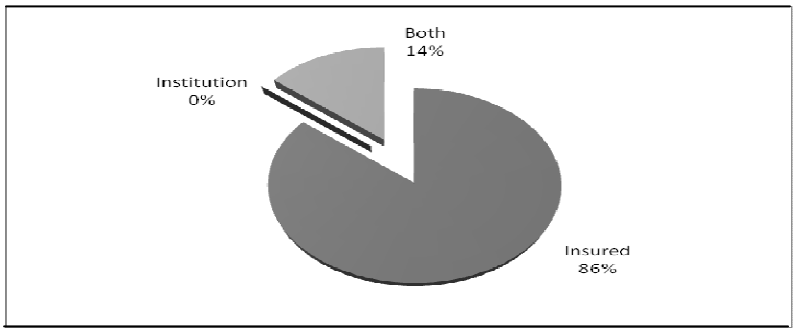
have accumulated a substantial amount of funds, and that annual payment (against typically credit risk) is about a tenth of the annual premium revenue, it is clear premium determination is being done without much of a scientific basis.[26]

Graph 1: Premium Collection Methods



Insurance funds are also used for lending, which increases future risk. In an earlier paper, Khalily *et al.* (2009) have shown that 85 per cent of those surveyed use the insurance fund as a "revolving loan fund," exposing the fund to the same risks that the insurance products attempt to guard against rather than investing it prudently for dedicated use and in building plan sustainability.

Graph 2: Premium Payee



[26]For example, in the Grameen Bank's credit risk policy, between 2004 and 2006 (inclusive), a total of BDT 3.35 billion was raised as premium, while, over the same period, a mere BDT 0.35 billion was paid up in indemnity claims. This calls its 3.00% premium (each for the borrower and husband, if applicable) for such coverage into question.

*(e) Premium Collection Modality***:** A premium is the price that is being paid by an individual member or borrower for the risk to be covered by MFIs. Three basic approaches are found in determining a premium. They are (i) fixed amount, (ii) premium as a per centage of the loan, and (iii) premium as a per centage of member's savings. The most common practice is premium as a "per centage of loan." Twenty two of the 37 MFIs surveyed have actually adopted this method of premium collection (see Graph 1), which varies between 0.5 per cent and eight per cent. Of this group, 22 charge less than or equal to one per cent of the loan typically for credit risk (Table XVI).

TABLE XIV
ELIGIBILITY TO AVAIL MICROINSURANCE COVERAGE (BY PRODUCT TYPE)

Eligibility	Number of MHIs by insurance type							
	Credit Risk Only	Credit plus life	Credit with term life	Credit plus health plus ME	Credit plus livestock plus life	Credit plus livestock	Accident plus term life plus health	Total
All Members	1	1	7	1	1	0	1	12
All borrowers including micro entrepreneurs	11	2	1	0	0	0	1	14
Borrowers excluding micro entrepreneurs	6	0	2	0	0	0	0	8
Anyone (Member/Non-member)	0	1	0	0	0	0	0	1
Capacity to rear cattle	0	0	0	0	1	0	0	1
Livestock borrowers only	0	0	0	0	0	1	0	1
Total	18	4	10	1	1	1	2	37

TABLE XV
CONTRACT TENURE BY INSURANCE TYPE

Insurance Type	Yearly	Term	Loan Duration	Total	Per cent
Credit risk only	3	0	15	18	49
Credit plus life	0	3	1	4	11
Credit with term life (Death Benefit)	3	3	4	10	27
Credit plus health plus ME	1	0	0	1	3
Credit plus livestock plus life	0	1	0	1	3
Credit plus livestock	0	1	0	1	3
Accident plus term life plus health	0	0	2	2	5
Total	7	8	22	37	100

TABLE XVI
PREMIUM RATE AS PER CENT OF LOAN

As per cent on Loan	Frequency	Per cent
0.5	11	44
1	11	44
2.5 (Livestock)	1	4
3 (Livestock)	1	4
8	1	4
Total	25	100

TABLE XVII
BENEFITS COVERED BY INSURANCE PRODUCTS PROVIDED BY MFI*

Insurance Benefit	Insurance Type (by Number of MFIs)							
	Credit Risk Only	Credit plus life	Credit with term life	Credit plus health plus ME	Credit plus livestock plus life	Credit plus livestock	Accident plus term life plus health	Total
Exemption of outstanding loan plus interest, but no additional cash payment	14		7	1				22
Adjustment with savings	3							3
Exemption of outstanding loan & interest amount with additional lump-sum cash payment	4	3	3				1	11
Exemption of amount equal to loan and interest outstanding at the death of borrower with cash payment of the same amount			1					1
Reimbursement of 100% of livestock loan					1			1
Reimbursement of 50% of livestock loan						1		1
Return of saved premium with profit		1	1					2
Payment of Multiple of premium paid by insured	1	1	2					4
Return of premium if death doesn't occur within the contract period		1						1
Total	22	6	14	1	1	1	1	47*

Note: *9 commercial insurers, 37 MFIs and 1 Mutual (MIME).

TABLE XVIII
BASIS OF DETERMINING PREMIUM AMOUNT BY PRODUCT TYPE (N=35)

Insurance Type Basis of determining premium	Credit Risk Only	Credit plus life (Endowment)	Credit with term life	Credit plus health plus ME	Credit plus livestock	Credit plus livestock plus life (endowment)	Accident plus term life plus health	Total	Per cent (Column/N)
General market practice	7	1	3	0	0	0	0	11	31
Programme costing	2	2	3	0	0	0	0	7	20
Arbitrary	7	1	1	0	1	0	0	10	29
PKSF guideline	1	0	1	0	0	0	0	2	6
Financial need of institution	1	1	2	0	0	0	0	4	11
Financial status of member	2	0	1	1	0	0	1	5	14
Amount of total disbursed loan by institution	1	0	0	0	0	1	0	2	6
Examining historical death rate	5	0	0	1	0	0	0	6	17
Impact study	0	0	0	0	1	0	0	1	3
Total	26	5	11	2	2	1	1	48	100

Note: Of the 47 insurers, 46 have single schemes, while MIME has two schemes.

Around 22 per cent of the MFIs surveyed charge a fixed amount as a premium typically for health coverage (Graph 1). Interestingly, there are a couple of MFIs in our sample that charge a premium as a percentage of member savings. More than 97 per cent of the sample MFIs require individual members to pay in cash, however.

In only five cases (14 per cent), we found that both the institution and members share the premium payment, i.e., those dealing with health and micro enterprise insurance. It is notable that the rest of them do not contribute to the premium from their own funds (Graph 2). This indicates that the insured mostly pay for the insurance coverage although the clientele is poor and vulnerable, which underscores the necessity of setting premiums in an actuarially fair manner so that they are not overcharged.

(f) Premium Determination: MFIs do not appear to have a uniform basis of fixing premiums, for example, in terms of using a standard mortality table for poor households. Moreover, there are no regulatory guidelines that govern premium structure determination or reporting. In such an environment, different MFIs follow different approaches. There are some MFIs that follow the rates of

their peer group–these are generally small MFIs. About one-third of the institutions set premiums arbitrarily without any scientific basis (Table XVIII). However, about one-fifth of the institutions have learnt from their own experience with their borrowers. This may be termed as a pragmatic basis but such an approach is open to drawbacks in that risk may either be underestimated or overestimated in view of limited time to observe the historical pattern.

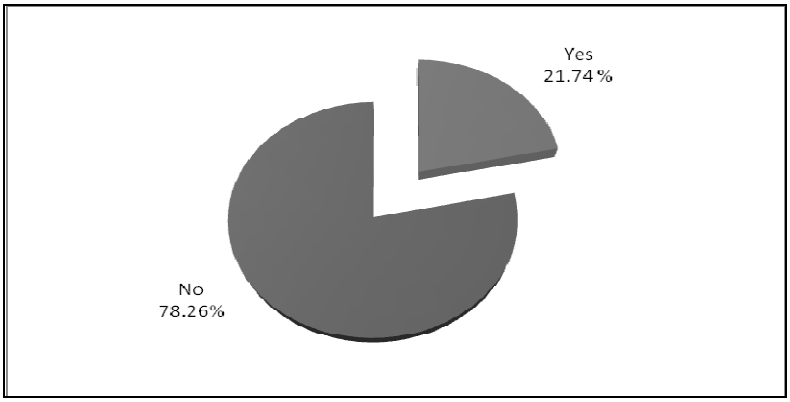
(g) Claim Settlement: Almost all MFIs follow the same procedure for claims settlement with only minor differences. The insured in most cases have to apply for indemnification through the village groups or associations developed by the respective MFIs in their weekly meeting. After a resolution has been passed in that meeting with respect to a given claim, the proposal goes to the MFI branch. At this stage, field officers for the branch investigate with due diligence and submit a report in this regard to the branch manager. In some cases, the branch manager has the authority to duly settle the claim depending on the amount in question. Otherwise, the branch manager sends it to the zonal office or head office for approval. Recognising the financial condition and need of the insured, MFIs generally intend to settle the claims as soon as possible. In a few cases, however, it was found that the insured has to apply using a pre-formatted application form directly to the branch manager, which may be a needless step adding to the delay. In general, claim settlement process takes less than three weeks (Table XIX). Some 53 per cent of the MFIs require 1 to 2 weeks to settle a claim. Only 2 in a sample of 36 MFIs required more than 3 weeks. All MFIs, however, require the insured to provide them with a certificate from the *Union Parishad* member or chairman regarding the insurable incident that has occurred. The MIME practice in this context is simpler, more decentralised and thus poor-friendly.

TABLE XIX

CLAIM SETTLEMENT TIME

Week Required	Frequency	Per cent	Cumulative
Less than 1	11	30.56	30.56
1-2	19	52.78	83.33
2-3	4	11.11	94.44
3-4	1	2.78	97.22
Over 4 weeks	1	2.78	100.00
Total	36	100.00	

Graph 3: Availability of External Finance (% MFIs)



(h) Financing Insurance Products: Only 22 per cent of the sample MFIs received external funding for their insurance products that covers part of or the full cost of the programme. External financing typically comes from different donor agencies, and on occasion from ownership of related for-profit operations. But the great majority of MFIs receive no financing from any external organisations. While pursuance of financial sustainability, and thus reliance on their own resources, is a great virtue, this may at times prevent MFIs from introducing innovative and diversified products on a pilot basis due to lack of technical expertise, additional resource or risk-taking initiative.

(i) Diversification of the Product Base: The introduction of microinsurance by MFIs appears to have emerged out of the need for minimising the risks faced by lenders as is evident from the preponderance of credit risk products in their portfolio (say, with respect to regular annual microloans, livestock loans and ME loans). Therefore, the majority of the products were not even targeted to the members of MFIs in general (i.e., inclusive of saving members), rather, the borrowers. Moreover, the few who offer "credit plus" products do so by building a small saving component around the loan product, but here again the term of the contract is determined by the loan period in question. Yet other MFIs providing credit risk coverage, charge a suitably higher premium than necessary to protect it from pure credit risk, and offer a "death benefit" to the borrowers in the event of a claim. Thus other than health, the variety simply does not exist.

In particular, there is no real "life" product in the market uncoupled from the loan profile, where the insured sum is meant to represent some sort of "value of lost earnings due to death." Such coverage would be easy to design with the help of a suitable life table. The annual premium would, if competitively priced, be a negligible fraction of the sum assured (well below one per cent per year even for

those close to say age 50) at least for the term type (i.e., no built-in saving and hence no maturity value). It would be not so hard to add variations to such products (say, with the highest sum assured around BDT 60K) by adding "premium return," "death benefit" or a substantive endowment product targeted at the young (say, below 30). For small MFIs', entry into such a market would probably require partnering with commercial insurers.

(j) Delivery Modality: All plans reviewed above are provider driven with no third party intermediation. Given the world class standing of our leading MFI-NGOs, they can serve as outstanding agents in a partnership with commercial insurers, or as full-fledged microinsurers themselves (i.e., forming separate entities distinct from their credit twins). However, it ought to be added in haste that the commercial insurers so far have been found to be unimaginative as, as seen above, they have been unable to devise a single dedicated product that would reasonably qualify as "microinsurance." Perhaps a joint venture type scenario is required where international insurers team up with domestic institutions (MFIs or insurers or both) in order to loosen up the commercial market allowing innovations to come forth in the Bangladesh market (witness India).

(k) Regulatory Vacuum: The evidence of high premium rates in most contexts cited above is symptomatic of the absence of real competition in each segment of the market, an evil that can be shown the way by the adoption of a suitable regulatory framework. Regulators ought to define and clarify the overlap between MFIs and commercial insurers, the domain of each in addressing the nascent microinsurance market and bring about modalities for enhanced competition by promoting innovation and fair play.[27]

VIII. MICRO HEALTH INSURANCE

Turning to the health care market, ever since independence, the expansion of public health facilities has failed to keep pace with the growing population and their demand for health care in Bangladesh. Like many developing countries, the depth and reach of public sector health care provision through qualified doctors and nurses is quite low by international standards. WHO (2006) estimates show that the density of medical workers (doctors, nurses and midwives together) is only about a quarter of the recommended figure. It is only 0.58 per 1,000 persons, whereas international evidence suggests the optimal density to be about 2.5.

[27] Further details are available in chapter IX.

A recent report from the World Health Organization shows that of the 3 per cent of GDP spent on health, the government contribution is a mere 1.1 per cent (WHO 2010).[28] The relative lack of emphasis on health as a priority sector would appear to be a bottleneck toward the delivery of quality care in the public sector. During the 2005-2011 period, while tax revenue has increased moderately from 8.7 per cent to 10.45 per cent and, correspondingly, total revenue (tax and non-tax) has been augmented from 10.79 per cent to 12.5 per cent of GDP, there has been an actual decrease in the share of *public health expenditure* in GDP by 0.02 per cent (from 0.99 per cent to 0.97 per cent). Thus with reduced effort it has proved hard for the Ministry of Health and Family Welfare (MoHFW) to augment its services in a dramatic way.

There has, however, been relative growth in the non-governmental sector healthcare expenditure reaching 74.3 per cent from 64 per cent of total health expenditure (THE) over the 10-year period (1997-2007), though a good part of the latter has been in the urban and semi-urban areas. Most striking though has been the burden placed on household's out-of-pocket (OOP) expenses in meeting health care needs. The latter has grown from 57 per cent to 64 per cent of THE, while a modest part is borne by development partners (8 per cent). Appropriate financing of healthcare therefore emerges as a central issue of concern in the public health arena.

On the rural-urban divide in the availability of health care facilities, Bangladesh Health Watch report (2008) shows that only about 16 per cent of qualified doctors practice in rural areas where the majority of population lives, and the situation is made more aggravated by extensive absenteeism. The Bangladesh Health Facility Survey 2009 by World Bank has revealed that in District Hospitals (DHs) 86 per cent of the sanctioned nurse positions have been filled, which falls to 70% for Upazila Health Centres (UHCs) and to a mere 5 per cent in Maternal and Child Welfare Centres (MCWC) located in the district level. The same study finds that the percentages of positions filled by physicians are 73 per cent, 63 per cent and 75 per cent for DH, UHC and MCWC respectively.[29]

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[28] In other words, government and household sectors combined explain about 90 per cent of THE. Then netting out the eight percentage points spent by the donor community leaves a mere 2 percentage points to be accounted for, respectively, by NGOs (one percentage point) and other private sources (e.g., charities) of another percentage point (MoHFW 2010).

[29]These figures are consistent with the fact that the supply of different categories of medical workers is totally unbalanced. For example, according to the international best practice, the nurse-doctor ratio should be 2:1, but in Bangladesh there are twice as many registered doctors as nurses (Chowdhury and Osmani, 2010, p.222).

An earlier study by FMRP (2006) had shown that in 2002-03, 39 per cent of Upazila Health Complexes (UHCs) were without a resident medical officer and nearly 60 per cent of union sub-centres had no doctors, implying that there is a serious lack of physicians and nurses in the public sector facilities, especially below the district level.

Nonetheless, it will be argued below that there is room for feasible measures of financing such that effective healthcare reach all and, at the same time, lessen the current load of OOP payments on households. The innovation in question is the risk-pooling concept, implemented by suitable models of micro health insurance (MHI). Indeed, there have been some developments in this direction over the past several decades, but mostly these have been rather timid in orientation, offering discounted services (typically between 10 and 25 per cent), instead of shifting most of the risk onto the insurance mechanism thus failing to live up to the billing "insurance." As reviewed below, the type of subsidized care being offered by MFI-NGOs barely impacts on the OOP payments shouldered by the poor. Nevertheless, these have been, by and large, steps in the right direction.

Most MFI-NGO activities in the health field are, however, of awareness building and educational in scope, which indeed constitute the first line of attack in the war on improving health and hygiene in society. While it would be of importance to take a comprehensive look at all such activities and embark on an evaluation of the same, this is clearly beyond the scope of the present analysis. Instead, we review below several well-known health financing programmes initiated by NGO-MFIs. Even though many such programmes are labelled "insurance," typically these do not embody a great deal of risk shifting. A key feature of an insurance mechanism is the shifting of the underlying risk from the party in a relatively weak state to weather the risk on her own (e.g., the care seeker) to those who are more capable of doing so (e.g., a risk-pool like a commercial insurer or a mutual association of cooperatives). It is implicit in this arrangement that while bulk of the risk will be shifted in the process, a small share (typically 25 per cent or less) is to be borne by the insured in order to minimise the chances of moral hazard (Arrow 1976). A strict adherence to this quantitative rule of risk shifting, which in the first place is not of the 'cast-in-stone' variety, would imply that none of the programmes that we have reviewed below qualified as "insurance." Instead, we propose a weaker definition in the present context; pre-purchase of a membership card for a fee in exchange for the promise of some services (either free or on a further co-payment basis) may be described as an "insurance" programme.

While discarding the quantitative restriction cited above, it ought to be emphasized that the degree of risk shifting accomplished in an insurance type

arrangement remains a key criterion of its effectiveness in preventing vulnerability to poverty. As Arrow (1976) had remarked, if the co-insurance exceeds 25 per cent, the insurance principle, namely risk shifting, is lost. The point is that even 25 per cent of a large bill may be so burdensome as to push the household below the poverty line or deeper into poverty.

The health insurance market for the poor in Bangladesh is served exclusively by NGO/MFIs. Many of these entities claim to have been offering a variety of MHI products since the late 1970s, but registered insurers are yet to jump into the fray. Given that many of these programmes were introduced about a decade or longer ago, most were rightfully seen as important innovations in the context. Hence, a time has come to take stock of the situation in the light of current developments and thinking on the issue.

Among the NGO initiatives, health-financing mechanism varies from one organisation to another. Normally, outreach services are provided for free. Some organisations charge nominal amounts. Many NGOs have developed specific, customised interventions to address the needs of the ultra-poor and other disadvantaged groups. The health programmes of different NGOs consist of preventive, curative, rehabilitative and promotional health services, where a greater emphasis is given on improving maternal, neo-natal and child health along with fighting communicable diseases and common health problems. Some organisations focus on other important public health issues such as HIV/AIDS, malaria, tuberculosis, vision care and sanitation.

NGOs mainly use community-based approaches with trained community health workers (CHWs) to implement their programmes. Micro health insurance (MHI) is primarily provided by NGO-MFIs, which also provide health services and microcredit. MHI covers basic and preventive health services including immunization, family planning, consultation and normal deliveries. Discounts are also provided on medicine and pathology tests, where available. MHI of most NGOs specifically target women, micro credit members, and in many cases, the poor and ultra-poor households in the working area. In the case of larger organisations, having their own health service centres or hospitals, over and above basic services noted above, the card holders are able to receive more specialised services such as ultrasound and to avail surgeries (e.g., cataract, C-section and similar) either at their own premises or at referral clinics/hospitals. However, two important features of most programmes are (a) the high co-payment (typically 50 per cent or more) for services such as drugs, pathology, ultrasound tests and surgeries, and, (b) the lack of a formal referral system. Both these issues are discussed further below. Hence, often the very low sticker price of a ‘card’ (say BDT 20) can be very misleading. Some programmes, as we shall

see below, however, do offer extremely low-cost products to the ultra-poor (e.g., Gonoshashthya Kendra).

With these remarks, let us now briefly run through the MHI programmes operated by some of the major national-level NGO-MFIs and those that happen to be major initiatives of smaller/regional NGOs. However, due to lack of publicly available information, we are unable to include all worthy programmes.[30] Those included are BRAC, Dhaka Community Hospital (DCH), Gonoshashthya Kendra (GsK), Grameen Kalyan (GrK) and Sajida Foundation (SAJIDA).

(a) BRAC Bangladesh: While BRAC has a large health programme targeted at the rural poor (through its Essential Health Care programme reportedly covering 16-17 million households), it had only a minor health insurance presence, which has been suspended of late. Though BRAC began its first insurance initiative in Sulla in 1977, it had to be soon closed down due to the difficulty in reaching the target population. A pilot MHI was eventually introduced in 2001 in two rural locations in the Narsingdi and Dinajpur districts, with financial and technical support from ILO. After the termination of ILO funding in 2005, the programme in Dinajpur was discontinued. The programme in Narsingdi continued up until April 2007, after which it was also discontinued. However, in February 2008, the programme in Narsingdi was restarted with BRAC's own fund till the recent suspension in 2010.

The premium for the general package (which lists 695 of 1,210 covered households) was either BDT 150 or 250, differentiated as to the membership status of the member in what BRAC calls "voluntary organisations" (VO, e.g., BRAC/other NGOs) and those not belonging to any VO, presumably a proxy for poor vs. non-poor.[31] As with other programmes cited here, most services are offered on a discount basis; for the general package, the discounts are 10 per cent on drugs 50 per cent on consultations, pathology tests and normal chid delivery at its own facilities. There used to be a provision of a limited cash payment (up to BDT 1,000 per year per family) to be made available to the insured upon referral to external providers, though it was rarely exercised.

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[30]The information cited resulted from both direct discussions with the providers and from what is publicly available in various publications and on the web, and as such they are not uniformly up to date.

[31]Here, the ultra-poor qualify for the "Equity Package," but there is only *one* household in that category. These members do not pay any premium whatsoever, and also receive 80 per cent discount on drugs and pathology.

There was a second programme, "prepaid pregnancy related care package," where the premium was BDT 100 or 150, respectively, again differentiated as above.[32] The latter had a membership of 514 families. The BRAC MHI programme had engaged 2 doctors, 6 nurses, one lab technician and 3 administrative staff members. Between February 2008 and April 2009, the programme as a whole accounted for 2,865 episodes of treatments.

However, the programme appears unexciting to the area residents and they are unenthusiastic about signing up or to renew the packages; the renewal rate as of April 2009 stood at a mere 25 per cent. Perhaps due to the poor scale, the operational cost recovery, at 39 per cent, is well below the break-even level. Table XX briefly summarises the detailed features of BRAC and those of most other programmes reviewed here.

Going forward, it would seem that, perhaps being ambivalent about the programme design, BRAC has been less than serious in scaling up its MHI programme over the past decades. Nor has it done much about developing a business model for its financial solvency. The programme has been "on again/off again," partly depending on the availability of donor grants. Given the important health sector role, it has played over the past decades, it would seem that a viable model could have been developed where it could leverage/upgrade its considerable experience and "already-in-place" dedicated resources (in terms of both trained personnel and existing health infrastructure) to bargain for a prominent role in MHI implementation. It would thus seem logical to conclude that to date BRAC has given greater priority to its role in advancing the cause of UHC outside of the insurance mode.[33]

(b) Dhaka Community Hospital (DCH): Currently, DCH works through 30 primary health care centres outside Dhaka (10 are owned by DCH, and the rest are by other participating NGOs), employing on average 10 persons in each centre.[34] In addition, DCH has its own 250-bed modern hospital in Dhaka, which

[32]The pregnancy package entitled the holder cash benefits which are multiples of the premium cost; for example, these range between 2 and 5 times the premium for pre- and post-delivery complications and newborn illness. For normal delivery, they can receive up to 3 to 4 times the annual premium. But the cash benefit for referrals is half of the figures for the "general" package.

[33]A brand new initiative has been launched in 2011 that avows to implement true insurance type interventions known as BHiP (BRAC Health Innovation Programme), which is in the design phase.

[34] Most of the information about DCH described is taken from its site www.dchtrust.org/health_program.htm.

also acts as the referral centre. DCH has been implementing the health card type insurance scheme for some time. Their schemes are as follows: School Health Programme, Industrial Health Insurance Programme, Family Health Insurance Programme and Rural Health Insurance Programme. Though these schemes are called 'health insurance programmes' they function differently compared to regular health insurance programmes. For instance, there are no fixed premiums. However, each plan involves the acquisition of a "health card" for a fee, as explained below. The core funding comes from the DCH Trust (which runs the medical college), Oxfam and the participating partner organisations.

Under the *Family Health Insurance programme*, for example, each family gets "Family Health Card" against yearly payment of BDT 20 (on average, and this amount is set by the community keeping in mind the 100 per cent cost recovery objective).[35] Family members receive inpatient and outpatient services (managed and financed by the local community), referrals, 10 per cent commission on overall expenditure in the case of additional services, 4 home visits per month by health workers for basic services and health education, and emergency services.

The Rural Health Insurance Programme is similar to the family health coverage and is offered in collaboration with partner rural health organisations, operating in a large number of districts (in excess of 20). Over and above primary health services, both invasive preventive and curative procedures are made available to the cardholders. Typically, in each rural health centre doctors are available 8 hours a day and paramedic service can be accessed 24 hours a day. DCH serves 100,000 people under this programme, presumably via some 20,000 cardholder households. This programme is financed with support from Oxfam and DCH subsidies.

The industrial programme, one of the oldest of the DCH programmes, works in close collaboration with industrial units that are covered by the programme. These units let their staff trained as medical assistants, and factory personnel actually manage the pharmacy set up by DCH on location. DCH doctors provide care services to the cardholders once a week at the factory premises. Cardholders also receive thorough yearly medical check-up and referral service at DCH. Presently, 24 factories are covered and on average 350 workers/employees are being served every week. The current cost recovery for this programme is reported to be 100 per cent.

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[35] Although it is uncertain how the term "cost" is interpreted by DCH, it is unlikely to be consistent with the use of the term by economists.

The school health has been implemented in collaboration with NGO schools, mostly in and around Dhaka city. Each child is provided with a "Health Card" (BDT 20 on average, borne usually by the NGO School or DCH). DCH doctors visit the schools once a week and provide care services to the students. Currently, a total of 13 schools (on average 80 children in each) are covered. The focus here is on general paediatric care, but targeted areas include vision, hearing (ENT), dental, immunisation, etc. Funding of this programme is mainly through DCH subsidies and fixed amounts of token money collected from the NGO school authorities. Estimated 'cost recovery' for this programme is less than 30 per cent.

Unlike the other schemes discussed here, DCH health card schemes are community-based programs. The community decides the health card fee (premium amount) and fees for other services as well with the goal of cost recovery in mind. The primary discount scheme appears to be 10 per cent off the usual rates, beyond the range of free services (e.g., awareness and advisories, check-ups, limited home visits, etc.). The primary attention is claimed to be not cost recovery, but to offer quality health care services at low costs. The low-cost claim must be due to both the equality and variety of free services as well as procedures of payment in instalments, etc. Otherwise, the 10 per cent discount seems to be the lowest of what the other programmes offer. The reason the industrial programme is self-financing is primarily due to the fact that delivery of most services is in effect being imposed (beyond the training phase) on the factory itself (via the training of its staff as "health assistants" and the running of the pharmacy by staff who are already on the factory payroll). And the 10 per cent subsidy for services accessed at DCH is not much of concern from this point of view. In non-industrial packages, these "free" services are given directly by DCH and its partner organisations, which is costly to the provider. Overall, however, the community-based DCH mode is very interesting and may hold the promise of significant expansion especially if means can be found to distribute the large burden of the "free services," a common feature of its core programmes, to a greater number of social actors and not just to charity.

(c) Gonoshasthaya Kendra (GsK): Launched in 1975, GsK's micro health insurance programm has been among the earliest anywhere.[36] The programme's goal is to provide sustainable health care services. Insured persons or families pay for a health insurance subscription according to their socio-economic status

[36]While Gonoshasthya Kendra (GsK) and Grameen Kalyan (GrK) both claim the identical acronym (GK) in their own documentation, to avoid confusion, we have chosen to abbreviate the two names differently.

but everyone gets the essential and comparable health care in GsK facilities. Different risk groups are also differentiated in premium setting (e.g., smokers vs. non-smokers). The GsK premium scheme is progressive so that the destitute, poor and ultra-poor pay little for consultations, medicines and referral services.

Presently, GsK offers its programme through 4 hospitals (Dhaka, Savar, Sreepur and Kashinathpur) and 39 rural health centres (RHCs) covering 648 villages from 47 unions comprising 14 districts. A fifth hospital has recently been established in the Gaibandha-Kurigram area (30-bed as of June 2011). At present GsK employs 58 doctors and 280 paramedics altogether to serve this network of health facilities. One senior paramedic remains in charge of each RHC. Various types of medical care are provided in these centres including minor surgeries. However, only doctors working as consultants on a rotational basis provide regular surgeries.

Presently, the number of families covered by GsK health insurance is about 169,000, which would translate to about a million people, which would by far be the largest programme in the country. The cardholders are mostly categorised as "poor|" (67 per cent, i.e., about 113,230 households), 25 per cent in middle class, 2.64 per cent are ultra-poor and 0.42 per cent belong to the poorest cadre, "destitutes." The remaining 4.5 per cent are declared "rich." It accommodated 232,265 patient visits in 2008.[37] The general premium and co-payment structure appears to be at the low end of what is seen throughout South Asia.

GsK therefore has already played a vital part in allowing the poor to access critical health care needs in remote locations, and is thus playing a significant role in the cause of UHC. However, lack of publicly available financial data makes it hard to evaluate its scalability or its capacity to operate in a self-financed mode. For example, eligible drugs are given free to the "very poor," who also pay a mere BDT 5 as consultation fee for each visit, but it is uncertain to what extent these subsidies are squared off against other surplus generating insurance and non-insurance services. Among non-health premium sources of funds, evidently, the two urban hospitals generate positive cash flows, as does the medical college in Savar. Besides, its own pharmaceutical company is presumably another source of cash, and then there are the donors. However, it would be useful to analyse the issues in clearer terms and explore the relative efficacy of the alternative modes of sustainability open to GsK.

[37]However, the actual breakdown of the number of patient visits into different categories of membership is not available.

(d) Grameen Kalyan (GrK): GrK introduced its version of MHI in 1996 and at its peak covered several hundred thousand individuals. MHI is central among GrK's activities serving the dual purpose of ensuring the participation of the target group as well as acting as a source of revenue for the programme. GrK attempts to cross-subsidize its members by having higher pricing structure for non-Grameen Bank cardholders and non-cardholders.

Earlier, the premium was rather low at BDT 100 for Grameen Bank (GB) members and BDT 150 for non-GB members. Since 2009, the premium has, however, been doubled to BDT 200 and 300 respectively for GB members and non-members per year. Once a cardholder, however, all benefits are identical between both sets of members. The fee entitles the household (up to six persons) to access all eligible services.[38] Insurance coverage (for all members) includes free annual check-up for the family, immunisation against common diseases and home visits for educational, counselling and health awareness campaign. Doctor's consultation fee is BDT 10 per visit and basic annual pathology tests cost BDT 25. Standard discounts apply to drugs (25 per cent for basic, 10 per cent for other) and normal pathology (30-50 per cent). The scheme also allows hospitalisation expenses of 50 per cent of costs at external clinics (but limited to BDT 3,000 per year), and that too just for the cardholder. Some researchers have claimed, however, that the hospitalisation benefits have not being exercised on a routine basis, neither for GrK nor for BRAC MHI programmes (Radermacher and Dror 2006).

Membership has fallen off significantly in recent years due to a variety of reasons. Beyond the premium hike, difficulty in retaining doctors in rural locations is proving to be a major challenge and is prominently among factors causing the decline in subscription. From some 21 doctors in 2009, it now has to do with only 15 for all 53 of its Health Centres spread over 16 districts in Bangladesh. GrK, much like other programs reviewed here, plays both the roles of insurer and of direct service provider (See Table XX for additional details).

While the programme, clearly, is in some turbulence as staff morale is low in the absence of doctors and falling renewal rates. Thus it would need some major paradigm shift in order to break out of the impasse it has been facing of late. The

[38]Additional family members pay only BDT 35 to join in. Recently (2011) GrK has started to allow the cardholder to pay the premium in two instalments than one, as was the practice till then. At the same time, the basic free check-up was extended to all members of the household, not just the head.

decline in the operational cost recovery from 83 per cent in 2008 to about 55 per cent in 2010 is worrying to say the least, though GrK is not alone in that sort of predicament. However, it does have a hefty capital fund (built up from the income earned on an interest-free loan of US$ 42.5 million from Grameen Bank back in 1996, duly returned to the parent organisation in 2002), and the interest income out of this is more than sufficient to meet all operational costs. While the latter is not a viable strategy, GrK can well shoulder the lean period should it be able to reengineer itself. The Grameen brand, despite the recent backlash, is an enviable commodity, and the pool of millions of loyal trusting clients, could provide a win-win backdrop should it choose to experiment with new products and delivery modalities (say, in collaboration with a rural network of external service providers).

(e) Sajida Foundation (SAJIDA): Originally started as a private family-run charity, by 1993 SAJIDA evolved into a formal institution offering micro-credit to poor urban women. It became involved in the health field in 1999 in response to demand from its microfinance members. Currently, it has two micro health insurance programmes: HELP (covering health, education, life/loan, legal and man-made disaster) which is SAJIDA's priority program and mandatory for its microfinance members. This is a comprehensive package inclusive of health, education, life/loan, legal and disaster coverage. The second one, SAJIDA Health Program (HEALTH), which is open to all and used as a marketing strategy to promote SAJIDA's two urban-based hospitals in Keraniganj (100-bed) and Narayanganj (70-bed), the opened in 2010.[39] Both HELP and HEALTH programmes run independently. As of May 2011, a total of 153 people were working in the programme, of whom 60 per cent staff is female with 21 specialist doctors, 28 medical officers, 3 sinologists, 3 pathologists, 43 paramedics and a field team of service promoters and supervisors.

The HEALTH programme is targeted at the non-poor who live in the catchment area of the hospitals, and have to pay BDT 150 *per person* in order to be eligible for coverage. Once a cardholder, they also receive the discounted price as HELP members, but no cash claims unlike HELP (see below). Only those purchasing coverage are eligible, there being no family membership here. The benefits are only available at the two hospitals as there is no referral system.

[39]A third hospital in Chittagong is due for completion in 2012; though the old "satellite clinics" have been closed down to achieve operational efficiency.

The membership happens to be on a growth trajectory from 389 members in 2007-08, it rose to 681 in 2008-09.

In its flagship HELP programme, launched in 2006, the newest of the set analysed here, SAJIDA has about 94,311 eligible families as members as of 2011. Per family annual premium is BDT 250 (for up to 5 members, BDT 50 per additional member), which is to be paid at the time the loan is disbursed. A number of services (e.g., inoculation against major diseases, annual check-up for head of the family, normal child deliveries) are offered on a *gratis* basis to the insured members. They also stand to gain 30 per cent discount on diagnostic (i.e., laboratory tests) services and 10 per cent on medicines and x-ray. The diagnostic discounts are available only if members can access the two hospitals. In addition, panel doctors are available for free consultation at each of the 62-microfinance branches at specific times during the week (about 3 times per week).

This is a two-tier plan; first, the insured residing in the catchment area of the hospitals benefit from discounted rates for all services made available at the two full-fledged hospitals it runs. Various surgeries are offered in packages (inclusive of medication) ranging between BDT 3,000 and 14,000 (as of 2011), which are typically 20 per cent lower than comparable facilities in similar locations. The HELP clients pay on average about 30 per cent less than the posted price cited above.[40] At the second tier, all insured members receive a further cash credit, ranging between BDT 500 and 3,000, against most treatment categories once it is established that they have received hospital treatment. For example, the cash claim for Caesarean surgery is BDT 2,000. The cash "claim" is offered to all insured regardless of where the treatment is accessed from. Note that a majority of the SAJIDA's HELP beneficiaries do not live in the catchment area of the two hospitals cited above, and thus they have to contact outside clinics for these services.[41]

In 2010, it settled 5,043 episodes of health claims incurring an expense of about BDT 9 million. The settlement process is fairly efficient. For example, 67 per cent of the health claims by HELP members in 2009 were all completed within one month, though there exist room for progress in this area.

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[40]For example, in 2009, the hospital rate for a caesarean section (without medication) was BDT 7,500; cardholders had to pay only BDT 5,000. The "'high street" price for this surgery may have a sticker price of BDT 10,000.

[41]The hospitals also market a distinct "insurance" product to the non-poor public (i.e., the HEALTH programme), as well as treating the general public outside of the insurance mode.

One unsatisfactory aspect of the HELP programme is that the benefits received by the insured vary depending on their location, while each paying an identical premium. In particular, those not able to access services of the Sajida hospitals, have to find treatment facilities on their own and pay the market prices in force there, and are only entitled to the cash claim cited above. In other words, they do not benefit from the quality care of SAJIDA's hospitals at a discount as some members do. However, the co-payment rate for surgical care as well as diagnostics remains considerable from the risk shifting perspective, though not out of line vis-à-vis the comparator group here.

On the plus side, the programme seems to be on a sound financial footing, as evident from excellent cost recovery figures for both the HELP (102 per cent) and HEALTH (about 85 per cent) programmes. The two hospitals are self-financing once the set up costs have been incurred. The surplus covers the shortfall in the HEALTH programme. The member fees essentially cover the cost of the various discounts and cash back programmes, while the hospital charges allow an operating margin on the plus side. In terms of capital funds, it may be noted that SAJIDA received a corporate grant of 51 per cent of the Pfizer Bangladesh Ltd (now called Renata Pharmaceuticals) from the parent company in New York, and the annual dividend from these shares amount to about BDT 60 million annually (as of 2010).

Given this backdrop, SAJIDA would appear poised for an even greater role as an important partner in the quest for UHC in Bangladesh. The recent collaboration with "Click Diagnostics" of US is another jump up the ladder, which would allow the mobile technology to be put to greater use so that SAJIDA medical staff located in rural areas may regularly consult the hospital for diagnostics and issuance of prescriptions. The technology being developed by "Click" is expected to be piloted later in 2011. The final obstacle would appear to be what ails all programs we know of, namely the client apathy toward the insurance concept. Given the compulsory nature of the HELP programme, current borrowers have to buy it by default, but it would seem that members, once they are no longer active borrowers, opt out. The number of cardholders is actually less than the number of microfinance members (94K vs. 107K). If made into a voluntary scheme, SAJIDA staff suspect that membership would fall off dramatically. The HEALTH programme, being voluntary in nature, exhibits renewal rates that are rather low, below 50 per cent, echoing the similar proclivities. Once the immediate need seems to disappear, the members feel reluctant to buy further protection.

Is significant reliance on OOP the real concern? One must then address design changes such that once sick, there would be little or no OOP once the package has been bought. Another knowledge gap seems to be "value for money" perception of HELP clients who live close by the hospital and those who do not, since the effective delivery of services are very different. Whether the degree of client indifference is identical in both sets of locations is not known, which can only be discerned by careful experimentation by means of scientific surveys. In the meantime, alternative modalities of delivering MHI must go on till these become synchronised with the tastes, preferences and ability to pay on the part of the poor.

TABLE XX
MHI PREMIUM AND BENEFITS

Organisation	Insurance Product Name	Premium Rate (BDT)		Discounts			
		Member	Non-Member	Consultations	Medicine	Pathology	Hospitalisation (Referral Benefits) (BDT)
BRAC	General Package	150	250	50%	10%	50%	500-1000
	Prepaid Pregnancy	100	150	Included	Free Iron Tablets	n/a	200-500
	Equity Package	0	0	Free	80%	80%	500-1000
Gonoshasthya Kendra (Rural/Urban)	Destitute	5/15		2/Free	Free/77%	n/a	n/a
	Ultra Poor	6/20		3/Free	Free/33%	n/a	n/a
	Poor	10/40		5/Free	75%/25%	n/a	n/a
	Middle Class	50/70-200		10/15-25	MRP/20% -MRP	n/a	n/a
	Rich	80/400		12/30	MRP	n/a	n/a
Grameen Kalyan	Micro Health Insurance	200	300	60%	10%	30-50%	50%, max 3K
Dhaka Community Hospital (DCH)	Family Health Insurance Program	20		BDT 5	10% discount on general services		
	Rural Health Insurance Program	20					
	School Health Program	n/a					
	Industrial Health Insurance Program	n/a					
SAJIDA Foundation	Health Card	Old: 600/family New: 150 per person		Free	10%	30%	No referrals since 2009, but discounted inpatient services
	HELP *	250	n/a	Free	10%	30%	Discounted inpatient services, PLUS cash rebates

Note: * HELP Programme includes: Loan & Life Insurance, Health Insurance, Disaster Insurance, Education Scholarships & Legal Support.

IX. CONCLUSIONS

It is recognised that traditional microfinance programmes are not able to protect against the vulnerability faced by the poor in regular life. The government also has limitations in protecting the poor from relapse into further poverty by means of either a well-designed safety net program or by instituting a functioning public health system. Thus, microinsurance is looked upon as a potential means of minimising the risk of future poverty in the wake of personal disasters related to various idiosyncratic shocks.

Loan risk insurance policies, the primary preoccupation of MFIs, do not by design offer a serious chance of overcoming the risk of further poverty in the case of death of the earning members of the family. Moreover, almost none of these products appear to be drawn up in reference to the mortality experience of the rural poor. Consequently, many collect far in excess of what it takes to underwrite the expected losses, especially when no covariate events are covered by the scheme.

The MIME products of INAFI cover mainly life risks through their "simple term insurance" and "term life with endowment" policies, which are designed in an actuarial context. However, the premium structure seems excessive in view of presumed exorbitant costs of intermediation.

As noted above, in spite of early overtures by BRAC, *Gonoshashthya Kendra* and Delta, to date the microinsurance products available in the Bangladesh market are characterised by serious limitations. Commercial providers typically operate in the *life* area, though there is a dearth of products deliberately designed with the poor in mind.

Moreover, the cost of intermediation is very high in view of the lack of a suitable model for reaching the poor in large numbers in a low-cost fashion. Health products are typically absent from the commercial scene altogether as far as the poor are concerned, and here MFI schemes can best be described as subsidized health care popularised under a different name. The risk carried by the insured in these cases is far in excess of what is reasonable in terms of co-insurance necessary to guard against moral hazard. Besides, in most plans only rudimentary procedures can be availed in the insurer's own facilities. Referral system to third party hospitals either does not exist or is not user-friendly so that such an avenue is rarely used. The requirement of cash transactions in each step of the way is a further drawback preventing popularity of the product.

The primary challenge facing the industry therefore would appear to be the development of meaningful microinsurance products (featuring adequate

coverage) based on sound actuarial calculus, implemented in a compliance friendly way and with the adoption of a low-cost delivery modality. The latter has truly not been experimented with. In particular, the partner-agent model where dedicated risk carriers and MFIs /service providers team up to design and deliver the product is yet to take off.

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