Does microinsurance improve social inclusion? Overview over empirical evidence

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Many parts of the developing world have seen a resurgence of government engagement in the field of social policy in the Post-Washington Consensus era. The renewed interest in social policy has gone hand in hand with the development of new instruments and new forms of governance. International institutions, such as the ILO and the World Bank, have strongly supported the implementation of innovative social policy approaches.

The concept of microinsurance is currently seeing a particular boom, as a transnational network of UN institutions, international NGOs, bilateral donors, national and local governments and international and national (re)insurance companies advocates this approach. Microinsurances are insurance products that are adapted to the needs of low-income people. Not only are the premiums of the schemes lower than among usual insurance schemes, but the technicalities of product delivery and the claims process are also supposed to be adapted to the client group. Life insurance, life endowment insurance, health insurance, asset insurance and agricultural/weather index insurance are among the common micro-insurance products. While health microinsurance is most prominent in South Asian and African countries, in Latin America life microinsurance is most common.

Among the purposes attributed to microinsurance are the smoothing of consumption, an increase in investments, and in the case of micro health insurance an increased use of health care services. Microinsurance is supposed to contribute not only to poverty reduction, but also to an improvement of social inclusion, and it is suggested that it can partly substitute for deficient public social security schemes.

This article provides an overview over the empirical evidence with regard to the impact of microinsurance. For the purpose of this conference, the paper pays particular attention to the question, if microinsurance can contribute to social inclusion. Social inclusion is understood here as an increase of the chances of subjects with a marginal social status to participate fully in economic and social life.

The evidence shows that microinsurance schemes can contribute to the improvement of social inclusion, but that this is highly dependent on the particular design of a scheme. This implies

that microinsurance can only under very particular circumstances be considered as a substitute for comprehensive social policies that aim to increase social inclusion.

This paper refers to the expectations with regard to microinsurance as they are spelled out by the most prominent institutions in the transnational network of UN institutions, NGOs, bilateral donors, international and national (re)insurance companies, and national institutions that promote micro-insurance. Among them is the Microinsurance Innovation Facility, which is anchored at the ILO and sponsored by the Bill and Melinda Gates Foundation. It can currently be observed that the concepts which are developed by international organizations and discussed in international fora strongly influence the development of national regulations and of particular insurance offers.

This article turns first to the conceptual foundations of the microinsurance instrument. On this basis, it exposes in the second section the wide range of expectations with regard to microinsurance. An overview chapter then sums up several key empirical studies that address these expectations. Turning to the topic of social inclusion, this article finally considers the empirical evidence with regard to the consumers of microinsurance and the distribution of insurance benefits.

1. Risk Management and Social Protection: Conceptual Foundations of Microinsurance

The expectations with regard to the impact of microinsurance are based on specific notions of risk management and social protection that where developed by the ILO and the World Bank at the end of the 1990s and the beginning of the new millennium. This chapter lines out how some of the basic notions of the microinsurance discussion are anchored in these concept.

The standard reference for microinsurance practicioners and researchers, the “Microinsurance Compendium“, was published in 2006 by the International Labour Office (ILO), the Munich Re-Foundation, which is financed by one of the world’s largest reinsurance companies, and the Consultative Group to Assist the Poor (CGAP), a microfinance policy and research centre anchored at the World Bank. This book sums up 25 micro insurance case studies that were realized by the CGAP.

The editor of this often cited volume, Craig Churchill, embraces the view that vulnerability, understood as the exposure to risks, and poverty reinforce each other: “Not only does exposure to […] risks result in substantial financial losses, but vulnerable households also suffer from the ongoing uncertainty about whether and when a loss might occur. Because of this

perpetual apprehension, the poor are less likely to take advantage of income-generating opportunities that might reduce poverty." (Churchill 2006: 12).

In face of this perceived problem, Churchill defines microinsurance as an instrument that helps to reduce poverty by improving risk management: "Microinsurance is the protection of low-income people against specific perils in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved." (ibid.)

Churchill's notion of microinsurance as a risk reduction instrument coincides with the World Bank's conceptualization of social protection. When the World Bank started to lobby more strongly for the improvement of social protection in developing countries at the end of the 1990s, it coined a new conceptual framework, called Social Risk Management (SRM): This is "an approach which presents social protection as a safety-net as well as a springboard for the poor…" (Holzmann 2001: 3f.) The SRM framework aims to surpass the notion of social protection as focused on public measures and includes private and informal social protection mechanisms. Public policies are considered as only one possible option among others to provide income security. The SRM framework differentiates and includes risk reduction, risk mitigation (measures to reduce the impact of adverse events) and risk coping strategies.

It should be noted that around the same time the ILO, which has since its creation lobbied social protection and embraces a rights based development approach, also developed a broadened concept of social protection that included informal and market mechanisms and a new social protection strategy (Reynaud 2002). The World Bank's proposition that social protection is to be understood within a framework of social risk management has however been gaining more ground among development practitioners and researchers, and now even representatives of the ILO resort to this conceptualization and to "risk management" terminology.

Both the World Bank as well as the ILO developed their new social protection concepts with reference to the insight that many if not most states in developing countries had failed to extend public social security schemes to large numbers of their population. The Microinsurance Compendium takes up this notion: „Microinsurance as a social protection mechanism strives to fill the gap to provide some coverage for the excluded." (Churchill 2006: 21).

Churchill defines "two varieties" (ibid.: 15) of microinsurance: one that aims at the extension of social protection to those, who are not covered by governmental social security schemes; and another one which offers essential financial services to the poor that also are profitable for the provider.

Yet, according to Churchill these two aspects are so intricately linked that microinsurance is to be considered as "janus" (ibid: 16) faced: "Regardless of whether one is looking at micro-insurance from a social-protection or a market-based approach, the body of the insurance scheme, its basic operations, will be largely the same." (ibid: 15f.) Churchill suggests that in any case microinsurances should be as inclusive as possible, that they should be affordable, that rules should be clear and easy to understand and that the resolution of claims should be simple.

2. Diminishing risks, providing social protection, creating business opportunities: Expectations with regard to micro-insurance

The expectations with regard to the potentials of microinsurance range from the creation of income stability for the poor to the creation of new market niches for insurance firms. This chapter provides a brief synopsis over the diverse expectations, which shows that the promotion of social inclusion is among the central aims of microinsurance activities. It will become clear that the majority of the expectations with regard to microinsurance schemes can be traced back to the SRM framework of social protection and to the suggestion that microinsurance can at least partially substitute for public social security schemes. These approaches also strongly influence the language in which discussions about micorinsurance are usually framed.

One of the main expectations is that microinsurance changes ex-post risk coping strategies in the case of adverse events, for example in the case of an illness. The general expectation is that the occurrence of that risk does not force people any longer to sell their assets and that thus their further impoverishment is halted (Mosley 19). It is supposed that this will help to stabilize consumption and savings, and will enable investments of those concerned (Vargas Hill & Torero 2009).

Another major expectation refers to the ex-ante risk management strategies of those ensured. It is suggested that insurance will allow low-income people to incur major risks, which means that they can make use of a major range of income-generating opportunities and change their investment behaviour (ibid).

In the case of micro health insurance it is suggested that people with insurance will more readily make use of health care services. This would allow for an improvement of their health status (Churchill 2006: 14). Many schemes do also involve education campaigns, which are supposed to reduce the incidence of diseases (ibid: 15). Finally, it is expected that microinsur-

ance can improve the governance of health care providers, because people feel entitled to the services and monitor service delivery more strongly (Radermacher et al. 2006).

Beyond this, it is also expected that microinsurance can contribute to the "empowerment" of women, for example if their special needs are taken into account at benefit and procedure design (Ahmed & Ramm 2006).

Churchill suggests that in these different ways microinsurance can contribute to the achievement of several of the UN's Millenium Development Goals (MDGs) in the areas of income creation, gender equality, health and education (Churchill 2006: 15).

As already pointed out above, it also expected that microinsurance can substitute partly for absent governmental social security. Hence, the microinsurance compendium suggests that beyond poverty reduction, microinsurance can under some circumstances contribute to the reduction of inequalities and other social security objectives. The authors take up the ILO definition of social security according to which "social security is the protection which society provides for its members through a series of public measures" (Jacquier et al. 2006: 47). Social protection is understood to include also private and non statutory schemes. It is seen as a "comprehensive, collective tool to reduce poverty, inequality and vulnerability. It promotes equity and solidarity through redistribution." (ibid: 45)

However, not all microinsurance schemes are considered to be relevant in the context of social protection: "For a scheme to be of interest in the context of social protection, some of its beneficiaries should be excluded from formal protection schemes, in particular informal-economy and rural workers and their families." (ibid.:52) Moreover, the microinsurance compendium suggests that a scheme should cover one of the essential risks defined by the ILO's Minimum Standards Convention of 1952 in order to be relevant in the context of social protection. The authors conclude that health and life insurances are the most relevant instruments in this context.

According to the Microinsurance Compendium microinsurance has several comparative advantages above conventional social security schemes, for example the inclusion of people who are excluded from statutory schemes (ibid.: 54). Other publications have taken up this notion. Mosley assumes that microinsurance could have the "wider" impact of incorporating the socially excluded (Mosley 2009:20)

Among the perceived limitations is the fact that many schemes are rather small, so that many people remain excluded and that the ability to pay may be rather low among the target population (ibid: 55). In order to overcome these limitations it is suggested that links with govern-

mental mechanisms should be created, including financial support and institutional cooperation.

While it helps to achieve different social policy objectives, it is expected that microinsurance can be a profitable market for insurance companies and a mechanism that supports the development of the financial market as a whole.

This brief overview shows that the improvement of social inclusion is among the aims of those who support the extension of microinsurance. The term is (just as the terms poverty and inequality) not defined by the publications which are cited in this section. Considering its usage, the term can be understood to denote an increase of the chances of subjects with a marginal social status to participate fully in economic and social life. The next section considers the evidence on the broad range of microinsurance objectives spelled out here. The following two sections then turn to the evidence with regard to social inclusion.

Overview: Expectations with regard to the impact of microinsurance

- Changed "ex-ante risk management": microinsurance allows low income people to incur major risks and to use a wider range of income-generating opportunities. Their investment behaviour changes.
- Changed "ex-post risk management": microinsurance prevents the depletion of assets in the event of adverse events. It thus stabilizes consumption, and frees resources for savings and investments.
- Micro health insurance contributes to the increased use of health care services and helps thus to improve the health status of the population.
- Microinsurance can contribute to the empowerment of women.
- Microinsurance raises supplementary resources that enhance social protection as a whole.
- Microinsurance contributes to the incorporation of socially excluded.
- Microinsurance can at the same time be a profitable market for insurance companies and supports the development of the financial market as a whole.
- Microinsurance can improve the governance of social protection providers, particularly in the area of health provision.

→ Contributes to the realization of the Millennium Development Goals (MDG).

→ Substitutes partially for deficient public social security systems and contributes to the realization of the objectives of social protection.

(from Churchill 2006, Jacquier et al. 2006, Ahmed & Ramm 2006, Mosley 2009, Vargas Hill & Torero 2009, Radermacher et al. 2006)

3. Microinsurance in action: case study evidence on impacts

This chapter takes up two articles that provide overviews of microinsurance impact studies (Dercon et al. 2008, Mosley 2009), and complements their insights with other recent publications on the issue. Most of the evidence is provided by comparative statistical case studies, which are usually realized by economists. A major part of the articles on the impact of microinsurance is published by the same institutions that support its proliferation, namely the Microinsurance Network and the World Bank, but there are also some journal articles.

Most studies on the issue of microinsurance are concerned with schemes in Africa and Asia. Mosley (2009) takes up five impact assessments that employ control group methods in order to compare insurance clients and non-clients. Dercon et al. (2008) consider a much larger number of studies that employ a variety of statistical methods, including randomized control trial and comparative household surveys.

The expectations with regard to the impact of microinsurance on ex-ante risk management, which were spelled out above, are confirmed only in part by these studies. Dercon et al. (2008) have also found negative evidence. For example, a study on a weather insurance scheme in Malawi suggests that enrolled farmers do not increase their risk-taking by using modern inputs for agriculture (Gine and Yang 2007).

The data with regard to the impact of microinsurance on the development of savings is ambiguous. Dercon et al. (2008) cite several studies according to which precautionary savings have decreased due to health insurance. This result is contradicted by Mosley (2009) who finds that health insurance schemes in Uganda and India have significantly increased savings among enrolled households.

In contrast with the evidence on ex-ante risk management, the direct impact of health micro insurance on the service utilization and health status of the insured seems to be positive. Comparing several studies about the impact of health insurance schemes, Dercon et al (2008) show that in all cases under scrutiny, the existence of health insurance has increased the use of health facilities. There are few studies about the impact of health microinsurance on the health status of the insured, but the existing evidence hints at an improvement of such indicators as the ADI index (Mosley 2009) and the anthropometric status of the insured.

However, Dercon et al (2008:5) point out that micro health insurance helps to reduce the out-of-pocket expenditure for health only in some cases. The co-payments and exclusions that are common characteristics of most micro health insurance schemes probably help to explain this

result. This finding seems to put into question the expected positive impact of microinsurance on the level of consumption, at least in the case of micro-health insurance.

Still, the statistical evidence on the impact of microinsurance on income stability, investments and spending behaviour seems to be reconcilable with the expectations of donors. Comparing four health and one weather insurance scheme from Asia and Africa, Mosley (2009:19) demonstrates that in most cases the introduction of insurance was paralleled by a significant increase in investments and educational expenditure.

This increase seems to be based on greater income stability: Mosley (2009:20) shows that in three of the five cases that he analyzes microinsurance stabilizes the income level. In two cases the difference between the program and control areas is significant. A recent study by Dekker and Wilms (2010) confirms this finding. Using regression analysis they show that those insured by the Ugandan health insurance scheme Microcare have to sell assets less frequently and that the value of assets sold is on average lower than among those not insured.

The greater degree of income stability is apparently mirrored by the self-perception of the insured: In Mosley's sample a significant proportion of scheme members perceive themselves as less vulnerable in all the cases, where this data is collected (Mosley 2009: 19).

Mosley also confirms the expectation that people take more interest in the quality of healthcare, if they are insured (2009:22). However, he also shows that this does not automatically result in an improvement of service quality.

Under the catchword social capital some studies also look at the question, if microinsurance influences personal relationships and the trust among community members. The concern with social capital has a long tradition in the literature about microfinance (primarily microcredit) (Sanyal 2009), and the World Bank has popularized the concept in the last decade, suggesting that social capital is an important factor for overcoming poverty. There is however no very clear evidence on the issue in the field of microinsurance research (Mosley 2009: 21).

Mladovski & Mossialos (2007) consider the reverse relationship and ask how social capital influences the success of Community Based Health Insurance (CBHI). For this purpose they develop a framework that takes into account four forms of social capital. They suggest that all four forms (bonding and briding social capital at the micro and at the macro levels) are essential for the success of CBHI.

A major concern in the discussion about microinsurance is a possible substitution effect. If formal insurance exists, people are less dependent on informal social protection mechanisms,

and there is a chance that their social networks erode as a consequence. Depending on its degree, the substitution effect could diminish or eliminate the positive effect of insurance on poverty reduction. Possible substitution effects are a general concern in the area of social protection policies.

The empirical evidence on this issue in the microinsurance field is not conclusive. Dercon et al. (2008) find no confirmation of substitution effects in microinsurance, but they hint to substitution effects in other social protection contexts. Also, they cite a study by Jowett (2003) that shows that the existence of strong informal insurance mechanisms and strong social cohesion hinder the uptake of new insurance products.

Dekker and Wilms (2010) reject the idea that microinsurance could destroy existing networks of social protection. In their statistical sample, those insured still rely on their social networks, as they use borrowed money in order to pay for insurance. Moreover, the micro health insurance scheme that Dekker and Wilms study does not cover all health expenses. As mentioned above, co-payments and exclusions apply in most micro health insurance schemes.

Anthropological studies about social protection mechanisms do also only partly confirm a substitution effect. Heemskerk et al. (2004) show for example that the introduction of public welfare programs in French Guayana and Surinam even stabilizes informal networks as there is more to share within the network and people have a lower risk of falling out of a reciprocal structure. According to the authors, pre-existing forms of sharing are only partly substituted for. Another anthropological study, which deals with the introduction of public pensions in South Africa, demonstrates that the new income did not lead to a separation of older people from their families, but to a reinforcement of their integration into the household as they shared the money with other family members (Sagner 2000).

To sum up, microinsurance can in some cases be shown to contribute to higher health care utilization rates, income stability and higher investments. Some of the expected effects, for example with regard to ex-ante risk management are not substantiated by existing studies. Negative side effects like a substitution effect are being discussed, but there is no strong empirical evidence in this regard. It should be taken in mind that most of the schemes considered here are micro health insurance and agricultural insurance schemes. Moreover, it is possible that the strong statistical focus of the studies disregards other possible side effects of the schemes that are not easily measurable.

4. Approaching the issue of social inclusion: who demands microinsurance and why?

This section asks who are those that buy microinsurance. In order to contribute to social inclusion, microinsurance products would have to reach also marginalized parts of the population. Demand factors have met some interest in recent microinsurance research. It is commonly assumed that the economic status of a household is a primary determinant of micro insurance demand. As very low incomes are perceived as a main barrier to insurance uptake, some schemes try to deliberately include ultra-poor clients. Mosley (2009:22) points out that BRAC, an organization that offers micro health insurance in Bangladesh, has successfully employed this strategy. Detailed studies on the topic of micro insurance demand show however a more complicated picture. Apart from household income different social factors seem to be important demand determinants.

With regard to the issue of economic demand determinants, most comparative statistical studies find that poor people do take up insurance, but that scheme members are usually better off than non-scheme members (Dercon et al. 2008: 5f.; Mosley 2009:19f.). This finding is for example confirmed by a well known study by Jütting (2003), who analyzes comparative household data about demand and impact factors of a community-based health insurance (CBHI) scheme in Senegal. He finds that income has a strong influence on the uptake of the scheme. Everybody enrolled in the scheme he studied could be considered as poor, as even the income of the richest quintile participating in the study was below the minimum monthly salary (ibid: 17). However, the ultra-poor were mostly excluded from the scheme. According to this study, other important determinants of scheme participation are religion, since the CBHI is linked to the Catholic Church, and ethnicity. Moreover, Jütting finds that participation is more probable, if people have previous experience with membership in local associations (ibid: 19).

Other studies have also identified the education of the household head (Chancova et al. 2008; Giné and Yang 2007) as an important factor for microinsurance uptake in Africa. Chancova et al. (2008) moreover point out that in West Africa women headed households are more likely to buy insurance than household headed by men. Finally, trust in the insurance providers seems to play an important role (Dercon et al. 2008).

The general perception that the socioeconomic status of the household is the most important determinant of microinsurance uptake is contradicted by Schulze (2010). He asks why microinsurance demand is not greater in his study area in Mali, where only around 15% of the possible target population enrols in a scheme. Employing concepts pertaining to social structure analysis as an analytic frame he foregrounds the influence of social differentiation on demand

and tries to develop a coherent analytic framework for different factors. Using statistical material, he demonstrates that the decision to take up insurance depends on intrafamiliar and household structures, such as household size, and mirrors socio economic and cultural characteristics. Insured households often have an important position in the community and major responsibilities. Personal relationships and particularly trust in the microinsurance representatives seem to be just as important as the voice of women within the household, as they usually advocate insurance. Several of these factors have also been highlighted by earlier studies, but Schulze's sociological study has the merit of considering different demand factors within a more comprehensive theoretical framework.

Household income certainly has an important impact on insurance demand. While the degree of its relevance seems to be context specific, it emerges that in most researched cases economically marginalized groups participate in the schemes, but that in some cases the poorest of the poor have a lower participation rate than other groups. In order to change this, it might take a particular effort, as in the case of the Bangladeshi schemes cited above. It seems however clear that a broader view is necessary in order to fully understand demand, as it is connected to different dimensions of inequality in the local context. Among the social factors that may influence insurance demand are gender, age, education and the social status within the community.

5. Unequal gains: the distribution of insurance benefits

Another important question with regard to the relevance of microinsurance for social and economic inclusion is how the benefits of microinsurance schemes are distributed among a population and among those who have an insurance scheme. It is by no means clear that everybody insured profits equally from a scheme: People have to claim their benefits or make use of health services in order to benefit. This is only possible when they are well informed about the conditions of the scheme and if the services are accessible. Several impact studies disaggregate the group of beneficiaries and ask who benefits most.

Dror et al (2006) look at the income-related equality of access to healthcare for the case of health microinsruance schemes. They conducted a household survey among insured and uninsured households in five regions of the Philippines. In a first step they analyzed intra-group equality by relating the income of the insured and uninsured groups to their access to healthcare. In a second step they approached the issue of inter-group equality by comparing the access of the insured to that of the uninsured. The results of this statistical operation show that among uninsured households income has a significant effect on the access to hospitalization.

There is no such effect among insured households. This implies that micro health-insurance helps to reduce income-related inequalities of access to healthcare in the Philippines.

This is in stark contrast with the results of Wang et al. (2005) who studied community based health insurance schemes in China. Many of the schemes in their study context involve low premiums so as to make them affordable, but high co-payments. Their household survey shows that income is an important factor influencing microinsurance demand, although the premiums are low. Moreover, it shows that income has together with the health status a strong influence on health service utilization among those insured. This could be caused by the high co-payments The authors conclude that this means that poor and healthy members subsidize rich and sick members of the scheme.

High co-payments are not the only possible reason for unequal distribution effects. Sinha et al. (2007) try to understand who benefits most from the payout of the Indian microinsurance scheme Vimo SEWA. Vimo SEWA offers a bundled product that covers death, hospitalization and asset loss. Sinha et al. analyze the payouts to different groups differentiating between city and countryside and between poor and very poor clients. Using three household surveys conducted by Vimo SEWA they find that the benefits were much higher among urban clients than among rural clients. The overall benefits were distributed equally among different income groups in both rural and urban areas, but the disaggregated data show a second important distribution inequality: In rural areas the very poor were receiving more life and asset loss benefits, but much less hospitalization benefits than the better off clients (ibid:1413). Comparing claims submission, approval/rejection, and claim amount rates for all the groups they study, the authors find that the main reason for the low benefit rates among specific groups were low claim submission rates. They hypothesise that one of the reasons for the low hospitalization benefit rates among the rural poor is the prohibitively high cost of the use of hospitalization benefits, particularly transport costs over long distances (ibid:1418). The authors conclude that the results of their study imply a need for action on part of the insurance provider in order to improve social inclusion.

These three studies suggest that the design of the micro insurance product plays a crucial role with regard to its distributional impact. Co-payments and other additional costs, such as transportation costs for the use of healthcare services, obviously exclude those groups from the benefits, which suffer the greatest social exclusion. However, the Philippine example studied by Dror et al. (2006) shows that micro insurance can under specific circumstances improve social inclusion.

6. Conclusions

Most of the schemes that are taken into consideration by the articles discussed here are micro health and weather insurance schemes in Africa and South Asia. The overview has shown that in these cases microinsurance seems to reach some of its general purposes, such as higher health care utilization rates, income stability and higher investments. Some of the expected effects are however not substantiated by existing studies. For example, people do not in all cases increase their risk taking because they are insured. Existing studies do also not confirm a possible substitution effect of microinsurance for informal social protection mechanisms, which would be considered as a negative side effect.

Turning to the issue of social and economic inclusion, it emerges that household income certainly has an important impact on insurance demand. While economically marginalized groups generally seem to participate in microinsurance schemes, in some cases the poorest of the poor have a lower participation rate than other groups. In order to change this, some schemes have made a particular effort. However, recent research shows that demand is not only influenced by income, but also by many other social factors. Hence low premiums might not be sufficient in order to attract marginalized groups.

Even if marginalized people are insured, it depends on the particular design of the scheme, if these people profit from insurance. Studies on the distributional impact of insurance show that co-payments and other additional costs for the use of insurance benefits can exclude economically marginalized groups from the benefits they are entitled to.

One can conclude that microinsurance schemes can contribute to the improvement of social inclusion, but that this effect depends on the type of insurance involved and on the particular design of the scheme. If no particular attention is paid to the issue of social inclusion, schemes can even have adverse effects in this regard. As a lot of purposes are attributed to microinsurance and as many activities in this field are still of an experimental nature, it is probable that social inclusion will not always be the primary concern of microinsurance providers. Therefore microinsurance constitutes only under particular circumstances a (partial) substitute for comprehensive social policies that aim to increase social inclusion.

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