CHAPTER - III

REVIEW OF LITERATURE
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3.1 INTRODUCTION

A review of the previous investigations which are pertinent to the present investigation is crucial to put on improved outlook of the catastrophe. A conceptual framework for the study, based on the facts and concepts gathered from the past review work of dynamic literature would make possible setting up the study in an inclusive manner. It also helps to know the previous research work carried out in the particular area and acts as a torch for the new researchers to identify the research gaps and progress to modifications or innovations as the case may be. The review of related studies is necessary to show whether the evidence already available solves the problem adequately with investigation, to avoid the risk of duplication, to provide an idea, explanations or hypotheses, variables in formulating the problem, to suggest methods of research appropriate to the problem and to get an idea about the current trends in the field. The collected literatures, related to the study have been reported in this chapter under appropriate headings and sub-headings.

3.2 LIFE MICRO INSURANCE

UNDP (2007)\(^1\), reported that the outreach of micro insurance was around 5 million people covering only 2 per cent of the poor in the country. The report showed that there was a huge potential for micro insurance market in the country. The study estimation showed that the size of micro insurance market for both life and non-life, in India ranged between Rs.62,304.70 and Rs.84,267.55 million. In case of life insurance, the market potential was estimated to be between Rs.15,393 and Rs.20,141 million and in case of non-life insurance; it was between Rs.46,911.70 and 64,126.55 million. The population uses for this estimation was 40-50 per cent of those who were earning less than US $1 a day and 50-70 per cent of those who were earning between US $1-2 a day.
Prabhakaran (2007)\textsuperscript{2} stated in his study that the issue of consumer awareness had a deeper significance in emerging markets as the economic growth outweighed the social growth due to the absence of awareness levels on the financial tools like life micro insurance. The author also opined that creating awareness on intangible financial services like life micro insurance was a challenging task. He pointed out the two facets to life insurers with reference to the need for creating life micro insurance awareness. One was the business interests and the other was part of their overall corporate social responsibility. The author further revealed that awareness was an ingredient that enhanced the acceptance levels of the life micro insurance products.

Maez. M. S. and Wong. S (2006)\textsuperscript{3} revealed that life insurance penetration in India after all these years was still rather at a low level of 4.1 per cent of the GDP and non-life insurance penetration at a mere 0.60 per cent. In comparison, U.K., South Africa and Taiwan had a ratio between 11 and 13 per cent. The global average was 6 to 9 per cent. Only 24 per cent of the Indian households owned life insurance. Among the rural households, only 18 per cent had life insurance protection. Only 14 per cent of the policy owners were women. Among the 216 million uncovered workers, about two-thirds were “highly unlikely” to think about buying an insurance plan either because they felt they cannot afford it (63.5\%) or because they were disinclined for various other reasons like not interested, no one has explained benefits to me, poor investment, etc. which accounted for (36.5\%).

3.3 AWARENESS ON LIFE MICRO INSURANCE

Chatterjee and et.al (2011)\textsuperscript{4} revealed that the clients’ awareness level on life micro insurance as a financial product was low but varied widely across the regions. But it was found that the level of awareness depends on access to financial services, geographical proximity and exposure to insurance companies but not as much on the economic status of low income respondents. The authors further pointed out that though the respondents were able to understand the risks faced by them and the need for risk cover, life micro insurance is regarded as a ‘sunken’ expense which is unlikely to yield returns. However, the respondents who had purchased life micro insurance products and benefited were able to appreciate the utility of the service much better than the non-clients. The findings summarised that the awareness level of insurance products available among the insurers is low.
Gaurav and et al. (2008) found that understanding the concept behind life micro insurance among the potential as well as the actual clients were somewhat mixed. Where a majority of all the households in the survey reported that they generally understood the idea behind insurance, most of them only referred to the case of health micro insurance, which is well-known in the area. Accordingly, it was found that most of the potential clients were interested in buying health micro insurance. Further, life or other types of insurances provided by the private sector were not very well-known. There was also quite a share of share of clients who were unaware or confused about the range of benefits included in their policy.

The Centre for Microfinance, Jaipur (2010) found that awareness about the various social security schemes varied in the rural and urban population. It showed that 46.72 per cent of rural households were aware of any one of the social security schemes and amongst them, 21.44 per cent were availing any one scheme. In contrast to this, only 4 per cent of the urban households were aware of any one social security scheme out of which only 2 per cent were availing any scheme. UNDP (2007) pointed out that there was lack of effort by the insurers and the microfinance institution staff to explain the life micro insurance products in a way that is understandable for the target groups.

Ajit Kanitkar (2005) suggested that effective life micro insurance services required greater awareness levels among the prospective SHG members and clients. He emphasized the need to sensitishe the field staff in banks, microfinance institutions, NGOs and insurance companies to recognize the special needs of the rural communities. The author insisted that a comprehensive communication strategy for marketing the concept of rural micro insurance was very much needed. The service provider should also maintain a suitable database of insured/uninsured SHG members based on one’s own life micro insurance needs.

Leftley and Mapfumo (undated) claimed that a majority of the life micro insurance products were sold as part of a loan package and this means there was little motivation on the part of the loan officer to sell the insurance to the client. The insurance was presented as part of the loan and often the client did not even know that they possessed an insurance. They certainly did not understand all the terms and conditions. They stated that lack of understanding leaded not only to low claim ratio,
but also to a low level of client satisfaction concerning insurance and the microfinance institutions in general as the client believed that they were being ripped-off.

Arora (2009), concluded from his study that awareness of life micro insurance products available among the low-income groups was low. Also they had the assumption that insurance was a status symbol and it can only be afforded by the rich people. They did not prefer giving a good chunk of their income to the insurance people to hedge themselves against the indefinite and doubtful future risk. The study suggested that institutions will have to take the initiative not only to remove these misconceptions but also in providing more attractive, useful and more affordable options. The author further pointed out that this could be done by overcoming the obstacles and increasing the awareness about life micro insurance which was a boon for the low-income people.

3.4 THE DEMAND FOR MICRO INSURANCE

Basaza and et. al (2008) conducted a comparative case study evaluation of two community health micro insurance schemes. They pointed to a series of not mutually exclusive explanations for low take up of these insurances both with respect to demand and supply issues. They found that the potential explanations for low demand may be the insurance scheme’s design and operation, insurance principles, community involvement and lack of trust in the management of the scheme.

Chankova and et. al (2008) identified some important issues relating to life micro insurance in policy perspectives from his study. The major findings of the study revealed that the usage of life micro insurance was low and less effective. In many cases it was involuntary among the low-income micro-credit clients of microfinance institutions. The actors which influenced the demand for insurance were found to be diverse at group and regional level and not adequately considered while designing the insurance product. The low demand for insurance was reflected largely due to low customization of the products, contrasting perspectives of insurance clients, microfinance institutions and insurers. Some trends in the demand for insurance as emerged from the analysis were high performance for comprehensive health insurance and money back or endowment type of insurance products. The
study concluded that this will meet some expectation of the target groups who were looking for good value for money spent on insurance products.

Dror and Radermacher (2005)\textsuperscript{13} mentioned the factors that could be explored within the existing structure of open market competition with multiple players, to make health micro insurance more accessible to rural poor in India. The authors highlighted that there was an untapped market due to low penetration of health micro insurance products. The paper recommended that the government could invest in the environment and infrastructure building efforts to support this sector.

Schneider (2005)\textsuperscript{14} conducted a series of 24 focus group discussions among micro health insurance (MHI) members, non-members, MHI managers and healthcare providers as participants. The author found that trust in the management of the insurance scheme, trust in the professional competence of healthcare providers and trust in legal and control mechanisms had influenced the enrolment of the members.

De Allegri and et.al (2006)\textsuperscript{15} found through in-depth interviews and focus group discussions that, scepticism about the insurance, lack of adequate knowledge and understanding of the insurance product and previous bad experiences with similar collective arrangements were explanatory factors for demand of life micro insurance.

Bardhan and Udry (1999)\textsuperscript{16} argued that in a nation where hardly 10 per cent of the population had formal insurance coverage, it was not surprising that around 2 per cent i.e. around 5.2 million of the poor had access to insurance which showed volumes of the potential in the huge underserved segments of the population. The study mentioned that India had 638,596 villages (as per Census 2001) and a total rural population of around 780 million. The authors said that life micro insurance was viewed as a new market opportunity for insurers to develop business models to serve the larger underserved market or as a social security tool to address the larger development needs of the vulnerable sections by reducing their risk exposure. The key aim in attaining equilibrium in the sector lied in striking a balance among the basic competing objectives of providing coverage to meet the needs of the target populace and optimizing costs for the insurer and optimizing the price for the clients to attain the twin objectives of affordability and accessibility.
Cohen and Sebstad (2006) highlighted the need to carefully study clients’ insurance needs before introducing a new product where market research could include studying (i) the clients’ needs, (ii) specific products, or (iii) the size of the potential market. However, the authors warned that despite these patterns, households’ priorities regarding demand for insuring certain risks were nevertheless context specific and solid research was essential before entering a market.

Das (2006) suggested that the potential health micro insurance market was 600 billion rupees in 2007. Since the share of the elderly in the total population would increase to 6.9 per cent and the total number of senior citizens would increase by 107 per cent to 113 million by 2016, immense scope should be provided for the sector’s unprecedented growth.

Prasad (2007) argued that with over 90 per cent exclusion rate and several million of those excluded falling within ‘insurable’ range, the potential for life micro insurance was huge in India. However, the author identified that the attitudes and affordability of the vast majority of the people were based on pricing and product design, lack of cohesive and reliable data on insurable population and assets, inadequate technical knowledge and inappropriate skills, high distribution and service costs and poor consumer awareness and knowledge.

Schneider and Diop (2004) found that location dummies, education, gender, household size, and distance to the health facility were significant factors explaining community health micro insurance uptake. They estimated a model based on a household survey which included age, financial status, cattle, having small children and recent pregnancy. Bhat and Jain (2006) analyzed factors determining the demand for private health micro insurance in a micro insurance scheme setting by using a two-stage model. The model seeks to determine the factors which would affect the insurance purchase decisions at first and secondly, studying the factors which would affect the amount of insurance purchase.

Ito and Kono (2010) carried out experiments which found that age, household size, gender, value of land assets, credit constraints, sickness, hyperbolic risk preference, risk loving and location dummies were factors significantly explaining health micro insurance uptake. In their model education, financial status,
non-land asset value, piped water, sewage, toilet, having small children, periodic instalment for the insurance and risk aversion were included but not found to be significant.

Cohen and et. al (2005)\textsuperscript{23} conducted case studies in Kenya, Tanzania and Uganda. After demonstrating that self-insurance is the dominant and highly efficient method of insurance for the poor in their sample, they concluded that there is clearly a demand for life micro insurance. They included products for death, health, life and property insurance for analysis in their study.

Giesbert and et. al (2011)\textsuperscript{24} identified that risk-aversion, vaccination, risk perception, age, non-land assets, remittances, education, and the location dummies were significant factors explaining the uptake of voluntary life micro insurance. Their model, based on a household survey included gender, sickness, land asset value, dependents, marital status, employer/employee, risk-loving and risk experience but these were found not to be significant.

Chankova and et. al (2008)\textsuperscript{25} conducted surveys on micro insurance in Ghana, Mali and Senegal. They developed a model trying to predict enrolment in a mutual health organization which found that handicapped, sickness, risk perception, age, gender, education, occupation, financial status and the location dummies were significant explanatory factors. The factors which were found to be significant were household size and the distance to the health facility.

Clarke and Kalani (2011)\textsuperscript{26} in their research article considered livestock ownership, credit constraints, financial status, cattle and membership of a community network as significant in explaining index insurance take up. Their model was based on experimental evidence collected from a framed micro insurance lab experiment. Age, education, gender, household size, occupation, understanding, financial literacy and membership of the community insurance were not found to be significant.

Thornton and et. al (2010)\textsuperscript{27} found that the marketing strategy, membership of microfinance institution, number of young children, and chronic diseases are significant with micro insurance up take. They performed an experimental evaluation in which education, gender, marital status, number of visits to healthcare provider,
smoking, costs of healthcare; financial status and having savings were included but not found significant with micro insurance uptake.

3.5 LIFE MICRO INSURANCE PRODUCTS AND DESIGN

Brown and Churchill (2000) discussed a number of criteria in the design of a micro insurance product that should be evaluated regarding the insurability of the risks the product is intended to cover which included, (i) a large number of similar units exposed to risk, (ii) limited policyholder control over the insured event, (iii) the existence of insurable interest, (iv) losses that could be identified and measured, (v) losses should not be catastrophic, (vi) chance of loss is calculable and (vii) premiums to be economically affordable.

ILO (2004) conducted a study about the products of Indian insurance companies which documented that out of 80 listed insurance products, 45 (55%) cover only a single risk. A broad majority of the insurance products covered life (40 products or 52%) or accident-related risks. Most of the life insurance products (23 out of 42) were addressed to individuals. Out of the 12 health insurance products, 7 had been designed and were restricted to groups. Out of the 12 health products, 7 products proposed the reimbursement of hospitalization expenses while the other 5 had chosen to narrow down the coverage to some specific critical illnesses. Most of these products also mentioned about their exclusion clauses; HIV/AIDS.

Leftley and Mapfumo (2006) highlighted the importance of a focus on the demand side for developing a successful product coupled with an iterating process of examining the operational and regulatory environment as well as risk carrier options. The authors further underlined that insurers always had to strike a balance between inclusion, premiums, policy coverage and financial sustainability.

Morduch (2006) focused on the design of insurance products for poor customers. Several promising innovations were described: credit life insurance, health insurance partnerships and weather insurance. Each was created to serve populations that were previously un-served, and workable institutional solutions were emerging. He suggested that the next step should be to shift from the question of what creates workable institutions to the question of how to refine designs to best
serve low-income populations. In doing so, he pointed out that, current approaches should be reassessed in order to most improve clients’ lives and to avoid doing unintended harm.

NABARD report (2008) documented that in case health micro insurance, penetration level was even much lower than life micro insurance. The two categories viz. critical illness and hospitalization were the main product segments which the report pointed out. Further, the report pointed out that some state governments have developed health micro insurance schemes which were still in the very early stages. The report had observed that the health micro insurance models had the advantages of its members performing a number of roles such as awareness creation, marketing, enrolment, premium collection, claims processing, monitoring, etc. The report suggested that the high co-variant risks such as epidemics will have to be taken care of by a mutual entity taking re-insurance for such risks.

Sahu (undated) in his research paper mentioned the following specific reasons for low demand of life micro insurance in spite of the intense need. The reasons were: (i) The rural financial markets characterized by limited inappropriate services, inadequate information and capacity gaps hindered the growth of rural insurance market, (ii) Product design, which resulted in a mismatch between client’s needs and standard products on offer, (iii) Absence of adequate and suitable insurance data was a major concern. In the absence of a suitable insurance database calculation of premium, costs, benefits, willingness to pay, based on macro aggregates may not give actual insights, (iv) The high cost of penetrating rural markets, combined with under utilization of available distribution channels, hindered the growth of rural insurance services, (v) Cumbersome and inappropriate procedures inhibit the development of the sector and (vi) Contrasting perspectives of the insured and the insurers will lead to low customization of products and low demand for what is available.

Ito and Kono (2010) found that take-up rates of life micro insurance had been low despite its perceived need and the enthusiasm of life micro insurance practitioners. They found some evidence that people believed in a risk-loving way when facing the risk of losses. Brown and Churchill (2000) described some criteria on life micro insurance relating to the following aspects: (i) a large number of similar
units exposed to risk, (ii) limited policyholder control over the insured event, (iii) the existence of insurable interest, (iv) losses could be identified and measured, (v) losses should not be catastrophic, (vi) chance of loss is calculable and (vii) premiums are economically affordable.

Siegal and et al (2001)\textsuperscript{36} argued that the design of micro insurance programmes was a critical determinant of their success. The paper pointed out that design affected the ability to overcome information asymmetries and reduce transactions costs. These factors determined, to a large extent, the financial viability of such programmes. To date, the types of risks and services provided by micro insurers had mainly been limited to minimal health insurance coverage and small-scale death payments. The paper further pointed out that identification of risks and coverage of services are only one part of the overall programme design.

Cohen and Sebstad (2005)\textsuperscript{37} pointed out to product design elements worthy of consideration. They included: (i) Separate out the different risk elements of health or life/loan insurance, (ii) provide differentiated products able to meet different needs, (iii) time premium payments to match income flows, (iv) assess the range of formal and informal insurance options until to gain a better understanding of effective demand, (v) de-link micro-credit and micro insurance, (vi) focus on protective mechanisms for property loss rather than ex post insurance. Learn from the advantages and disadvantages of reciprocity and social obligation in informal group-based mechanisms.

3.6 DELIVERY MECHANISMS IN MICRO INSURANCE

McCord (2006)\textsuperscript{38} discussed a number of disadvantages for insurers, agents and clients for the partner-agent model to work for the poor. The author stressed that (i) the insurance product and distribution had to be driven by clients’ needs, (ii) the regulatory framework should facilitate simple procedures while at the same time protecting customers’ rights, and (iii) microfinance institutions should involve clients in product development and obtain feed-back to use the information in negotiations with the insurer.
A report of the Committee on Financial Inclusion by NABARD (2007) documented that in India with a vast rural population characterized by challenges and complexities, it made sense to latch on to an existing mechanism operating in these segments to lower the costs and to help the insurer to leverage on the faith already generated by the entity. The study observed that it would be prudent to choose a **partner-agent model** for delivery where the insurer underwrites the risk and the distribution was handled by an existing intermediary. For this they cited the reason that the model kept the cost of insurance attractive enough for the poor to enter and remain in its fold even while addressing the concern of the insurers about the low returns of life micro insurance.

Fisher and Qureshi (2006) examined the **community-based model**. They claimed that in the community-based model the insurance was entirely owned and managed by the community members i.e. the policyholders. It was not-for-profit and characterized by the participatory processes and the important role of social cohesion. Community-based insurance or mutual insurance could be found in a variety of set-ups including: (i) standalone mutual (or cooperative) insurance providers, (ii) insurance companies affiliated to a network of financial cooperatives such as savings and credit cooperatives and (iii) networks of mutual insurance associations.

According to McCord (2001) under the **full service model**, the insurance provider assumed all functions, from product development to marketing, sales, premium collection and claims processing. The author emphasized the need to establish the most effective delivery channels for micro insurance to different risk categories. He underlined that further knowledge was also required regarding effective delivery channels for different risk categories, effective marketing and selling, underlying incentive contracts of agents and also pointed out the importance of customer retention for building trust and for an insurance to function, to provide adequate incentives and agents get higher commission for renewals than new sales.

Churchill (2006) discussed the various design, marketing, premium collection and governance on micro insurance. The author also discussed the various institutional arrangements available for delivery such as the **community-based approach**, insurance companies owned by networks of savings and credit cooperatives and microfinance institutions. The roles of key stakeholders were also
explored and the book offered insightful strategies for achieving the right balance between coverage, costs and price.

Verma (2006) criticised that direct marketing model was not an effective model as outreach to provide micro insurance to poor through his model had been very limited. The paper argued that this was a costly distribution strategy as insurance company does all identification of clients, selling of policies, collection of premium, receipts of claims etc.

McCord, Brown and et. al (2000) concluded that there was no single optimal health insurance model. The authors said that the appropriate model demand on the availability of local healthcare services, the existence of insurance companies willing to service the poor and informal sectors and the existence of institutions such as microfinance institutions or associations to partner served as links between healthcare providers, insurers and clients. They emphasized that despite the desirability of exploiting linkages between parties and agents, it was important to have separate entity provide the insurance.

3.7 LIFE MICRO INSURANCE - WILLINGNESS TO INSURE

Sarath Gaurav and et. al (undated) conducted a study and found that 76.25 per cent of the respondents expressed willingness to cover at least one person and 10.42 per cent expressed their interest to cover at least two people. Willingness to insure three or more members of the household registered were found to be extremely low affirmatives, as low as 1 to 2 per cent of the households surveyed. The study presented the apparent difficulty in understanding the concept of family floaters for communities where the average household size stood at around five members. Around 83 per cent of the respondents found it hard to say why they were not willing to be insured or purchase the product, while 9 per cent complained of having a bad experience with insurance in the past as the prime reason of their unwillingness. Only 0.21 per cent of the respondents said that they do not need insurance, 0.42 per cent said they do not trust the insurers and around 3 per cent feared losing the premium to be the principal deterrents.
Dror and et. al (2007) analyzed data from a bidding game conducted in more than 3,000 households in India. They found a higher level of nominal willingness to pay for life micro insurance compared to previous studies. Further, they showed that household income and nominal willingness to pay were positively correlated, while household income and willingness to pay as a percentage of household income was negatively correlated. Their results suggested that household size was the most important determinant of willingness to pay levels.

Chankova and et. al (2008) found that willingness to pay could also be enhanced by simplifying the premium collection methods and that making premiums payable in higher frequencies could be helpful in promoting enrolment by low-income households. They also stated that paying premiums should be in line with households’ cash flows.

Rao (2007) discussed and proposed few issues concerning the life micro insurance suppliers’ reluctance to enter the rural fray and the unexplained and disinclination of the intended rural beneficiaries to accept the ideas behind the initiatives of the insurers. He insisted that the value and belief systems of the rural people that are targeted for sale of life micro insurance products had to be understood. The insurance products to be sold had to be acceptable and must be useful alternatives to current sources of need, the premiums must be affordable when the cost Vs. benefits analysis is made, selling non-life insurance products where there was no return of paid money, needed more insurance education of buyers and popularizing insurance as a habit by spreading the message of what life micro insurance buying can do.

Giesbert (2008) found that around 95 per cent of the non-insured households interviewed were interested to participate in any life micro insurance scheme. But 78 per cent of the households thought that contracting an insurance product would be too expensive for them, whereas other reasons apparently played a minor role for not buying life micro insurance. The study concluded that a high share of the participating non-insured households is just not informed about adequate insurance product in the study area.
Patt and et. al (2009)\(^{50}\) suggested that trust of people in the life micro insurance product and the organizations involved in selling and managing was important for understanding their decision to participate in insurance. They suggested that these factors may be more important than the socio-economic ones influencing willingness.

McCord (2000)\(^{51}\) made a study on healthcare micro insurance based on four health insurance programmes representing a number of models: partner-agent model, community-based model, full-service model and provider model. The article continued by comparing coverage with premiums and found that the key is to provide road coverage at a premium level that the poor are willing to pay coupled with a mechanism to minimize the negative impact of the premium payment while efficiencies are improved.

### 3.8 PERFORMANCE OF LIFE MICRO INSURANCE

ILO (2004)\(^{52}\) prepared an inventory of micro insurance schemes. The inventory listed 51 schemes that were operational in India. The report pointed out that most micro insurance schemes in India were still very young. 43 schemes covered about 5.2 million people, 66 per cent of the schemes were linked with microfinance services, 12 per cent by healthcare providers, 59 per cent of the schemes provided life insurance, 57 per cent provided health insurance and 74% of the schemes operated in four southern states of India: Andhra Pradesh (27%), Tamil Nadu (23%), Karnataka (17%) and Kerala (8%).

IRDA Annual Report (2009-10)\(^{53}\) showed that the IRDA regulations had allowed non-government organizations and self-help groups to act as agents to insurance companies in marketing the micro insurance products and had also allowed both life and non-life insurers to promote combined micro insurance products. The report documented the total premium income under micro insurance portfolio for the year 2009-10 was Rs.402 crore, which it nearly doubled from the previous year’s premium income of Rs.206 crore. For this, LIC contributed 94 per cent of the total premium under micro insurance and the remaining 6 per cent was contributed by the private insurers.
CGAP (2001)\textsuperscript{54} case study on TATA-IG provided a broad overview of how the micro insurance programme at TATA-AIG emerged and how it operated. The study stated that TATA-AIG realized that relying solely on microfinance institutions to sell its products would not be sufficient in the Indian context which led them to explore other distribution channels and rely on microfinance institutions and NGOs for information about the local community to help build trust with the local community. The study further discussed the partnerships, distribution channels, premium calculation, premium collection, claims management, risk management and controls for the products offered by the scheme. The study concluded that the development of micro-agents and their firms was the most significant innovation of TATA-AIG’s micro insurance work.

Radermacher and et. al (2009)\textsuperscript{55} undertook a case study on Yeshasvini Trust’s health micro insurance scheme which reached 1.6 million low-income persons in its first five year of operation. The study found that the scheme covered 2.2 million in the second year and the membership declined in the third year to 1.45 million largely because the premiums were doubled. The study mentioned that the hospitals providing care were primarily private, which had a good reputation for quality care. They agreed to participate in the scheme even though they earn approx 30 per cent less from Yeshasvini members than from other patients. It was found that the product is affordable to the poor because it focussed on high cost/low frequency events.

3.9 CHALLENGES IN LIFE MICRO INSURANCE

Churchill (2006)\textsuperscript{56} discussed certain characteristics of life micro insurance schemes which limited their contribution to the extension of social protection. Although life micro insurance was becoming more common, many persons excluded from legal social protection schemes were still not covered by life micro insurance either. Many life micro insurance schemes had poor viability and sustainability. Members’ ability to pay was most often very low. Most schemes did not take over the functions that were usually fulfilled by statutory social security schemes. In many countries, the legislative framework and regulations were not adapted to those schemes. And finally, as life micro insurance schemes were usually self-governing organizations. They did not pursue objectives that were not in line with government’s strategy of social protection.
Sahu (undated)\textsuperscript{57} found that adequate awareness, information and use of insurance products were grossly lacking among life micro insurance policy holders. Cumbersome and lengthy process of documentation and claim settlements, inconvenient premium payment system, lack of proximity to the financial institution and lack of trust on staff of the providers were some key factors that discouraged the uptake and renewal of life micro insurance among low-income groups. The author suggested that correcting problems may translate insurance needs of many low-income households into potential demand.

Gunaranjan (2007)\textsuperscript{58} indicated that the following challenges had to be overcome to achieve sustainable and scalable life micro insurance models: (i) Creating actual data for micro-insurance rather than searching for actuarial data to get life micro insurance started, (ii) rationalising underwriting procedures for life micro insurance to make them accessible for target clients, (iii) assessment of market value at the time of claim and (iv) reducing adverse selection especially in livestock insurance.

Radermacher and et. al (2006)\textsuperscript{59} underlined the importance of mutual trust between the insurer and the client. First, the insurer was willing to make payments to clients and second that the insurer was able to deliver the payments. The authors further pointed out that, trust was also essential for customer retention. The trust of individuals and communities could be built by education, building on existing structures, or through careful marketing and sales strategies.

Bullens and et. al (2006)\textsuperscript{60} claimed that providers of life micro insurance faced three sets of specific challenges relative to the insurance industry at large. Firstly, it required specialized actuarial capacity in the light of lack of reliable statistical data. Secondly, for poor clients the concept of insurance might be quite new or negatively loaded because of the past experiences. Thirdly, life micro insurance was quite demanding in terms of distribution. The authors added that a large numbers of clients paying small premiums for limited coverage is different than handling few clients paying high premiums for top-end products.

Nannyonjo (2007)\textsuperscript{61} analysed the challenges of managing life micro insurance schemes in Uganda. The research paper showed that life micro insurance in Uganda...
which was mainly delivered via the partner-agent model had gained importance over the last decade to serve the needs of the informal sector which constituted about 95 per cent of the total workers. The study pointed out the management challenges which had impact on their effectiveness: (i) institutional weakness in the areas of management, administration and technical expertise, data system, poor marketing and weak accountability, (ii) lack of client knowledge of insurance policy and understanding and appreciation of the product, (iii) limited coverage and (iv) sustainability partly caused by small premiums that were not able to cover reinsurance. The study concluded that there was a need to improve institutional, managerial, administrative and technical capacities, develop more efficient transactional and informational systems, ensure client education and awareness and increase the market outreach through other approaches and ensure sustainability.

3.10 MICRO INSURANCE AND VULNERABILITY/POVERTY REDUCTION

Davignon (2006)\textsuperscript{62} examined risk as an inherent factor of poverty and investigates whether life micro insurance could offer a potential solution. It evaluated the ways in which life micro insurance can react to the problems of risk and hazard encountered by the poor. The paper concluded that life micro insurance does alleviate poverty by reducing the impact of hazard in rural areas. It protected the client from risk; reduced microfinance institution loan default and earned additional income for microfinance institutions, enhancing outreach and scalability. It also concluded that life micro insurance complements rather than substitutes, savings and credit in protecting the poor against risk.

Jakab and Krishnan (2001)\textsuperscript{63} summarized the literature on community involvement in micro healthcare financing. The authors declared that the evidence on the performance of community financing schemes was limited. Further, there was evidence to suggest that community financing was effective in social inclusion by including a large number of low-income population. Finally, members of community-based health financing schemes were reported to have increased their utilization of healthcare services.
Aliber and Ido (2002)\textsuperscript{64} presented the findings of the fieldwork in Burkina Faso on life, health and cattle insurance. The findings suggested that even in a country as poor as Burkina Faso, micro insurance schemes could flourish. The research found that simpler forms of insurance could be operated relatively effectively, with limited actuarial skills, provided that pricing is prudent and that institutional defenses are in place to combat the hazards that typically affect micro insurance schemes. The paper concluded with a series of recommendations for changes in the existing insurance legislation that will both promote and regulate the nascent micro insurance industry in Burkina Faso.

Barnett and et al. (2008)\textsuperscript{65} reviewed relevant threads of the poverty traps literature to motivate a description of the opportunities presented by innovative index-based risk transfer products. These products according to them, could be used to address some micro insurance and credit market failures that contribute to the persistence of poverty among households in low-income countries, in which applications are considered at the ‘micro’, ‘meso’ and ‘macro’ levels.

Banking With the Poor (2006)\textsuperscript{66} network discussed that micro insurance, when available at affordable prices would be recognised as an important financial service providing some protection to the poor in the event of personal and natural disasters. The report pointed out that in Bangladesh, health life and loan insurance were functioning and covering about one third of the poor. But disaster and livestock insurance were virtually unavailable and the only institution providing them covered about 4 per cent of microfinance institution clients.

Mechler and Linnerooth Bayer (2007)\textsuperscript{67}, examined recent innovations in financial risk management that extend traditional public-private partnerships to include NGOs, international financial institutions and other donors. Importantly, it was argued that these partnerships provide secure financial arrangements to low-income communities before disasters strike and thus relieve the uncertainty and anxiety of depending on ad hoc post-disaster aid for recovery and even survival. The study further examined three examples of extended partnerships: the Turkish Catastrophe Insurance Pool, the Andhra Pradesh micro insurance programme and an index-based weather derivative for farmers facing drought in Malawi.
Ahuja and Jutting (2004) provided a brief overview of community-based micro insurance schemes. In particular, the paper looked at how institutional rigidities affected the demand for health insurance among the poor, how insurance could potentially prevent poor households from falling into a poverty trap and the role of public health interventions. Using a simple analytical model, the paper demonstrated that lack of demand for insurance need not necessarily be the result of affordability. The paper also showed that the absence of insurance could increase a poor household’s vulnerability and push them into a poverty trap.

Chatterjee and Vyas (undated) asserted that even though the long-term viability of the efforts by non-governmental organizations, microfinance institutions, micro insurance companies and the government were yet to be established, it was clear that the poor are insurable. The authors showed SEWA’s experience with providing micro insurance services to the women workers over more than a decade, which pointed to the fact that micro insurance must be integrated with both financial services such as savings, credit and pension and social services such as healthcare for effective delivery. Further he considered that this wholeistic and integrated approach will eventually reduce vulnerability and stem the de-capitalization that occurs when risks and crisis confront the poor families.

3.11PRIORITIZATION OF RISK

Sarthak Gaurav (undated) analyzed the prioritization of risk exposure at Kalahandi, which became a critical element in understanding the approaches to social risk management. In the study, ‘weather shock’ emerged as the most prominent risk that the community was exposed to with around 90 per cent having faced the adverse consequences of uncertain weather events, predominantly droughts. ‘Health shock’ turned out to be the second most important risk that the community had been facing as per the aggregate perception of the respondents. Around 64.53 per cent had experienced some adverse health shock or the other in the near past.

M-CRIL (2008) discussed the prioritization of risks mainly on the basis of the frequency of occurrence and perception of the immediate impact it could have on their livelihoods. It was found that health insurance was the top priority for most of the respondents while life was relatively important. The analysis showed that health
was the top priority for 61.6 per cent of the respondents as they associate illness with unplanned expenses as well as loss of income that caused a huge impact on their cash-flows. Live insurance was found to be the second priority (14.2%) but this was very low compared to the priority for health as a large number of respondents felt that the benefit of their death goes to their family and not to them. The third priority included livestock (6.3%), household assets (6.8%), and assets (4.7%).

Bardhan and Udry (1999) gave an account of the implications of existence of smoothly operating set of institutions that achieve a pareto-efficient allocation of risk within a dynamic optimization framework, with a utility function that is additively separate over time. They showed that marginal utility of any household was a monotonically increasing function of average village consumption. The only risk faced by the household was the systemic or aggregate shocks faced by the community.

Gheyssens and Gunther (undated) analysed the need to expand the current knowledge on risk aversion in poor communities by conducting experiments. The experiment was conducted on more than 130 households in several communes of the Collines department in Benin. The study found that despite the widely known results on the domains of risk perception and their implications on decisions under uncertainty, the ways villagers in rural communities perceived uncertain losses remain empirically largely ignored.

Gine. T and Vickery (2008) found that risk aversion, cultivated land, credit constraints, membership and loan from provider, knowing peers with insurance, having a progressive nature and age were factors significantly explaining the uptake of insurance. They conducted a household survey where financial status, education, gender, household size, land asset value, ambiguity, aversion, patience, pessimism about insurance return and having insurance were found not to be significant in their model.

3.12 RISK MANAGEMENT

was that it can reduce loan losses and the need to draw down savings while simultaneously generating low-risk fees. The discussed ten specific reasons as to why the demand micro insurance is difficult to measure. The author concluded by prescribing action research projects in the context of micro insurance, liquid savings and emergency loans as a possible approach to measure the demand for micro insurance.

Siegal and et. al (2001) discussed micro insurance as part of a wholestic risk management strategy. The research paper highlighted that micro insurance costs should be compared to alternative risk management options at different levels. Investments in certain public goods such as sanitation, immunization, etc provided alternative forms of risk management. According to the authors, micro insurance provided risk mitigation but investments in risk reduction or formal coping strategies might be preferred. It pointed out that risk reduction might be achieved by investments in sanitation or disease immunization programmes at lower cost than health insurance.

Kapoor and Ojha (2006) showed that 44 per cent of risk-facing households resorted solely to loans, 19 per cent used their past savings, 32 per cent used loans and savings together and the remaining 5 per cent resorted to other means. The proportion of risk-affected households whose past savings were adequate enough to finance emergency expenditure were the highest among large farmers (47 per cent) followed by small farmers (25 per cent), landless farmers (21 per cent) and then marginal farmers (12 per cent). The affected households which used both loans and savings together to meet unforeseen expenditure constituted the highest proportion among the marginal farmers (34 per cent) followed by big farmers (27 per cent), landless (26 per cent) and small farmers (21 per cent). The study found other measures as sale of assets and requested remittances from family members settled outside as risk-coping strategies.

Mosley (2009) reviewed attempts to provide insurance against risks afflicting the poorest. It presented empirical evidence on the impact of different types of micro insurance and recommends the idea of ‘quasi-insurance’ - the provision of insurance functions through a non-insurance route, where institutional or regulatory constraints prevent insurance proper from being offered. The paper argued that micro
insurance so far has been somewhat supply-driven rather than driven by effective
demand especially from the poorest and thus the insurance products which would
benefit the poorest are still at a limited stage of development. The paper concluded
that institutional innovations and new insurance products therefore deserved
promotion.

Dercon and Krishnan (2003)\textsuperscript{79} presented evidence that suggested a crowding
out effect of informal risk-sharing arrangement by food aid. While the evidence base
was limited, micro insurance could also have certain important externalities at the
community level. In case of health insurance, it could produce positive information
externalities through improved preventive behaviour so that also individuals who are
not insured will be benefited from it.

CGAP Bulletin (2005)\textsuperscript{80} provided a strong case for reinsurance in microfinance
stating that risk management capacity of the poor could be enhanced significantly by
promoting the particular concept. The bulletin highlighted some of the advantages of
reinsurance which reduced the risk of bankruptcy and bad years by freeing the life
micro insurer from the unexpected fluctuations of expenses. It removed the need for
the micro-insurer to build up reserves and allowed him/her to use the earned surplus
during good years. Further, the bulletin discussed about the need to extend life micro
insurance to women, considering the gender specific risks they are subjected to and
the high dropout rates of women for reasons of not being able to pay premiums.

Cohen and Young (2005)\textsuperscript{81} examined how micro insurance helped in the
creation and accumulation of assets. The research paper examined the need to protect
the assets of the poor and used evidences drawn largely from East Africa and India. It
looked at common strategies that the poor used to cope with risk and presented micro
insurance as a possible solution. The research paper stated that micro insurance
involves the pooling of risks across individuals who make small, regular payments in
exchange for the promise of future compensation in the event of a financial loss and
targets the low-income market through innovative cost structures, premium payment
systems, terms of coverage, and delivery models. The authors suggested financial
education would help micro insurance clients by focusing on the clients’
understanding and use of different financial products and by impacting asset
protection and accumulation.
3.13 MICRO INSURANCE AND ITS LINK TO MICROFINANCE

Roth and et. al (2005) documented a case study elucidating the role of microfinance institutions in developing market for life micro insurance in India. The document discussed the important lessons learned from leading microfinance institutions in India to develop the life micro insurance market. The document dealt with the financial services offered by microfinance institutions in general, reasons for MFIs to enter into life micro insurance and possible delivery mechanisms to reach the clients. The document also discussed the MFIs that have been chosen for the study with respect to some key factors such as the history; the general profile of the clientele, the risk management products and policies adopted, life micro insurance products offered and various partnership models and partners used.

A report by GTZ (2004) claimed that from a conceptual point of view, microfinance can provide a valuable link to the provision of micro insurance. According to the report, microfinance institutions had important strengths. They had an established institutional framework which were close to the target group and had gained peoples’ trust. They had experience in social mobilization and group methodologies which can reduce the transaction costs of the insurance provision. They had vested interest in delivering micro insurance due to cross-selling considerations and because insurance reduces the financial risk for the borrower and the lender. In addition, the report recommended microfinance institutions could be used for the implementation of demand studies and awareness creation campaigns. Finally, the report observed that some micro insurance products had strong savings character.

Dercon and Kirchberger (2008) argued that a serious constraint to the uptake of insurance had to be trust. The contrast of life micro insurance with micro-credit helped to see the difference between these two microfinance activities. The study highlighted that in micro-credit money is offered first and then lenders had to find ways of ensuring that clients repay the loan – lenders had to find ways to ensure they can trust that repayment by clients will be done. In insurance, clients first part with their money and then had to trust the insurer that they would get money when problems arise. Lenders had to trust borrowers while insurers have to be trusted by the clients.
All India Disaster Mitigation Institute (2006)\textsuperscript{85} agreed that microfinance services were also beginning to include the provision of micro insurance as financial protection for low-income households or businesses against specific losses including death and funeral expenses, health expenses, loss of small-scale assets, damage to property or loss of livestock and crops. The report further pointed out that the emergence of micro insurance was an important development within the field of microfinance and challenged the previously wide-held belief of the “non-insurability” of the poor.

Ahuja and Khasnobis (2005)\textsuperscript{86} mentioned that microfinance institutions are playing a significant role in improving the lives of poor households. The paper provided an overview of the prospects of micro insurance in India and suggested strategies for its further extension. Quite apart from this, linking micro insurance with microfinance made better sense as it helped in bringing down the cost of lending. The paper provided insights on the concept note of Insurance Regulatory and Development Authority (IRDA) on micro insurance. The note detailed IRDA’s plans of introducing supplementary provisions to promote its intermediate model.

A case study by Garand (2005)\textsuperscript{87} focused on the evolution of Vimo SEWA, an insurance programme developed by SEWA, India, providing voluntary integrated insurance product. It emphasized that product development must always consider the ability of the members to pay for the benefits and obtaining a high renewal rate might be difficult because of the widely dispersed membership. The paper concluded that creditor insurance remained the easiest type of micro insurance to implement. However, it pointed out that it was not effective in covering the basic needs of the low-income community for health and life insurance.

Srinivasan and Arunachalam (2002)\textsuperscript{88} focused on micro insurance schemes of microfinance institutions. The paper concluded with lessons learnt about insurance by various insurance companies which were capable of drawing-up flexible procedures if they were convinced about the genuineness of the operating organizations such as strong interpersonal relationships resulting in good customer care from the point of view of the MFI competition in the insurance environment resulting in the very best product at affordable rates and increased negotiating power for the MFI and combination loans mitigate risk.
Brown (2001) argued that microfinance institutions were most likely not equipped to offer micron insurance. He recommended that instead of developing their own micro insurance products, microfinance institutions should partner with established insurance providers. He suggested that with those partnerships, clients could receive micro insurance products and the microfinance institutions do not have to take the insurance risk.

### 3.14 MICRO INSURANCE REACH OUT AND IMPACT

Arora (2009) suggested that to improve the reach of micro insurance, (i) Market research of the risks faced by the poor had to be completed so that the authentic order of the insurance can be assessed. This would not only spread awareness about various insurance schemes available but help the insurers to actually know the kind of risks these people are facing. (ii) If rural people were already using some of the insurance products then the insurers should also try to know the satisfaction level of the existing products they were using. (iii) The insurers should try to make products to the demand of customers (low-income group). If it is not so then the new product will not attract them. (iv) The amount of premium to be paid should be set according to the income these people receive or the mode of premium payment should match their mode of receiving income. (v) Claim cheques should be distributed at publicly held functions to create awareness of insurance and (vi) the schemes and advertisements should be displayed on the village walls that too in local language.

Devadasan (2007) concluded that micron health insurance schemes had not only achieved good enrolment levels against their target populations, indicating the existence of demand, but from a policymaker’s perspective, the study pointed out that these schemes have also improved access to health services for the poor. He observed that also many schemes have grown larger and had continued to be in existence for many years which he argued indicated sustainability of micro health insurance schemes could be ensured through good design and management.

A combined study by ILO, STEP and SEWA (2001) captured the experience of Self-Employed Women’s Association (SEWA) in managing the Integrated Insurance Scheme for its women members. The paper discussed issues relevant to
insurance scheme such as the information related to the SEWA movement, the social environment in which the scheme operates and provides a brief overview of the social protection schemes in India. It defined the unique requirements of SEWA members leading to its development, insurance coverage for hospitalization, introduction of asset loss component in the scheme to take care of asset loss and prevention of misuse of life insurance payments by the husbands.

Kanitkar (2005)\textsuperscript{93} attempted to present the experiences of Pragathi Gramin Bank, Chitradurga Unit, in Karnataka. The note pointed out that the expectations generated in the minds of the self-help group members were high. These expectations were not matched with appropriate awareness about the benefits and limitations of the insurance product. The report concluded by stressing the importance of sharing experiences and creating awareness about micro insurance among self-help group members.

Roth (2005)\textsuperscript{94} focused on the status and key issues facing the Asian micro insurance sector and argued on the need for commercialization of micro insurance. The author stated that the poor needed a variety of products and services such as, savings, credit or insurance, to manage their risks effectively. Taking the example of India, the author explained the emergence of new micro insurance approaches post-liberalization in 1990’s. The author enumerated and compared the various micro insurance products available to the poor, such as those for life, property, endowment, agriculture and health insurance and draws on specific examples to illustrate their advantages and disadvantages for the poor. Finally, the paper listed a number of challenges in commercializing micro insurance such as reducing transactions costs, managing adverse selection, moral hazard, fraud and over-usage, creating an enabling regulatory environment, developing sustainable health, agriculture and property products and overcoming natural resistance and educational barriers.

Chakra borty (undated)\textsuperscript{95} pointed out that as high as 40 per cent of the hospitalized cases in India either borrowed money or sold assets to meet hospitalization costs. The author explained that micro insurance was an effective approach for better health. The paper reviewed the poor not as an object of charity but as an untapped market which was seeking products and services that was being denied due to inefficient public health services, low penetration of private insurance,
market disconnect between demand and supply and affordability. It advocated for a community-based health insurance scheme to be operated under the stewardship of the State, funded by premiums, state budgetary support and international aid. It outlines a five-step process for a broad-based, state-wide insurance scheme; a consortium of interested parties preparing a scheme design appropriate for the state, preparation of business plan, initiation of a pilot scheme to support wider coverage, initiating concerted marketing and community mobilization, strategic purchasing from hospitals and healthcare providers and instituting a sound monitoring and evaluation mechanism to track progress of implementation of pro-poor health insurance.

3.15 CONCLUSION

The detailed review of literature given in this chapter has thrown light on the various studies made by the earlier researchers on life micro insurance, health insurance, awareness on life micro insurance, impact and challenges faced by policy holders in micro insurance which have enabled the researcher to focus on the area of study.

The next chapter makes an attempt to analyse the demographic profile, life micro insurance profile and preferences for taking life micro insurance among rural women policy holders in Vellore Division.
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