SITUATING MICROINSURANCE IN SOCIAL PROTECTION

Lessons from six countries

By Gaby Ramm and Mayur Ankolekar
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Gaby Ramm and Mayur Ankolekar
List of acronyms

AABY  Aam Aadmi Bima Yojana
AIC   Agriculture Insurance Company of India
BDT  Bangladesh Taka (currency)
CBHI Community-Based Health Insurance
EPF  Employees’ Provident Fund
ESIS Employees’ State Insurance Scheme
EUR European Union (currency)
GDP  Gross Domestic Product
GIZ   Deutsche Gesellschaft für Internationale Zusammenarbeit
HEF  Health Equity Fund
IAIS International Association of Insurance Supervisors
IGNOAPS Indira Gandhi National Old Age Pension Scheme
ILO International Labour Organisation
INR  Indian rupee (currency)
IRDA Insurance Regulatory and Development Authority
JBY  Janashree Bima Yojana
LIC   Life Insurance Corporation of India
MGNREGA Mahatma Gandhi National Rural Employment Guarantee Act
MFI  Microfinance Institution
MOH  Ministry of Health
MOLISA (Vietnamese) Ministry of Labour, Invalids, and Social Affairs
NAIS National Agricultural Insurance Scheme
NGO  Non-governmental Organisation
NPS National Pension System
NSPS National Social Protection Strategy
PKSF Palli-Karma Sahayak Foundation
PSF  Programa Saúde da Família
PPP Public Private Partnership
RSBY Rashtriya Swasthya Bima Yojana
SHG  Self-help Groups
SPF Social Protection Floor
SSK Shasthyo Shuroksha Karmasuchi
SSNP Social Safety Net Programme
USD  United States Dollar (currency)
VND  Vietnamese Dong
VWU  Vietnam Women’s Union
WBCIS Weather-Based Crop Insurance Scheme
EXECUTIVE SUMMARY

Although Article 22 of the United Nations Declaration of Human Rights (1948) states that, “every member of the society has the right to social security,” approximately 75% of the world population is inadequately protected, and approximately 40% lack even basic protection. Confronted with these figures, the recommendation of the International Labour Organisation (ILO) Social Protection Floor Initiative (SPF-I) calls for a pragmatic step-wise approach to social protection, defining some minimum social security benefits that should be extended to the underserved as soon as conditions allow.

Within the context of social protection, microinsurance is one possible instrument to mitigate risks and reduce vulnerability of poor and low-income households, particularly in the informal economy. Microinsurance is not conceptualised as a mechanism that competes with or replaces public social protection. It is most effective when embedded into a comprehensive social protection framework that goes beyond public social protection measures and includes informal, private, and other public risk management strategies of preventive measures, mitigation, and suitable coping strategies. Evidence of how microinsurance is successfully integrated into social protection frameworks is still scarce. In order to enhance knowledge of the synergy and complementarity between microinsurance and other social protection mechanisms, this paper synthesises the key messages of the country studies (Bangladesh, Brazil, Cambodia, India, Rwanda, and Vietnam), formulates lessons learned, and provides recommendations for better integration of microinsurance with social protection under consideration of the social protection principles of universality, solidarity, and equity. This paper focuses on insurable risks suitable for microinsurance, such as sickness, old age, death, accident and disabilities, and extreme weather events.

All six governments recognised the need for social protection, especially for vulnerable people in the informal sector, and all six countries established:

- Some universal programmes for all citizens, such as basic education, skills training, and basic health care
- Statutory social protection for the formal economy, civil servants, and the military
- Social assistance and other targeted poverty alleviation programmes for the poor, vulnerable, around the poverty line, special groups (such as people with disabilities), and ethnic groups, and other relief programmes for affected people

Some countries have employed the following strategies to integrate microinsurance into their social protection policies:

- Using microinsurance as a transitory instrument toward universal health insurance
- Creating separate social protection legislation (including microinsurance) for the informal economy
- Defining the role of microinsurance in the context of social protection

The strategies employed by the six countries are, as expected, diverse. Also important to note is that whilst explicit government policies on microinsurance are absent in certain countries, other methods of extending social protection coverage to the informal economy exist. An example of this is Vietnam’s policy of extending formal economy benefits to informal workers.

Vietnam’s policy of extending formal economy benefits to informal workers has huge potential. Keep in mind that this approach does not consider a role for microinsurance and assumes
that the delivery of voluntary social insurance will become more effective. Rwanda made important progress using a Community-Based Health Insurance (CBHI) delivery model to extend government supported mandatory basic health insurance to 97% of its population. A similar approach is promoted by Cambodia, but its voluntary CBHI has experienced severe difficulties in scaling up and sustaining the system. India formulated a social protection law through the Unorganised Sector Workers’ Social Security, adding microinsurance to the benefits. India has also implemented the subsidised basic health-care scheme (RSBY) but needs to overcome the fragmentation caused by the many other social protection interventions. Brazil follows a two-pronged approach. Firstly, the government promotes the universal health coverage through the national Programa Saúde da Família. Secondly, the Ministry of Health (MOH) of Brazil enforces very strict rules on additional health plans (including microinsurance), whilst specific standards are not set for non-health microinsurance products. Bangladesh is in the process of developing a comprehensive social protection strategy and took initial steps in supporting microinsurance, though to date it has only integrated microinsurance into one social protection policy; the Health Care Financing Strategy 2012-2032, which explores microinsurance as an interim mechanism until universal health coverage is achieved. The many microinsurance products operated by MFIs and NGOs are not connected to the Bangladeshi government policy and prevent lessons on client value from being learned across products.

Based on the studies of the social protection strategies of these six governments, their social protection benefits for the formal and informal sector, their microinsurance strategies and products, and the associated lessons, some technical suggestions and recommendations are given for the use of microinsurance in the context of social protection:

- Extend coverage to the underserved population
- Improve benefits of social protection programmes
- Increase access to social protection and microinsurance

Microinsurance is important for providing protection to underserved people of the informal economy and also for complementing and supplementing other forms of social protection for the low-income formal sector. But if basic public social protection systems are not available, contributory voluntary microinsurance jeopardises the principle of solidarity. As stand-alone protection, microinsurance neither contributes to universal coverage nor to equitable access. Thus, it cannot be a substitute for universal coverage for all citizens.

**Summary of recommendations**

**Extend coverage to underserved population**

- Mixing targeted social assistance and contributory microinsurance for the “upper poor” and “special groups” categories of beneficiaries could generate value, particularly for the “upper or near-poor” and the “special group” category, such as ethnic minorities, single parent households, and people living in disaster-prone areas. Even people below the poverty line are willing to pay for insurance products of value. For example, straightforward initiatives that bundle a credit life insurance product with government loans would not only enhance the existing social protection benefit but also, when executed with government support, could lay down the foundation of an insurance culture.

- Reaching out to individual customers is essential. Whilst group insurance policies still dominate the microinsurance market, large sections of the population—not restricted to migrant workers and urban residents—are not organised into groups or linked to NGOs or MFIs. For microinsurance to significantly increase in scale, these individuals need to be covered. Standard operating procedures to help the insurance industry and intermediaries enter the low-income markets need to be provided. Technology by itself is insufficient for selling microinsurance and must be complemented by institutional structures that raise awareness and help individuals select
and access appropriate microinsurance and social protection mechanisms.

- Special attention needs to be given to low-income people. Low-income people who are not covered by statutory social protection or entitled to social assistance fall beyond the social safety net. They comprise the main customers for microinsurance and bear the full burden of its protection costs, which jeopardises the solidarity and equity principle of social protection. Usually governments cope with this issue by partially subsidising insurance premiums, which causes the challenge of targeting. The Indian example of welfare funds for defined occupations is one model for providing targeted social protection to workers in the informal economy, regardless of worker income. If the significant diversity of occupation-based funds could be overcome, a consolidated system would provide low-income workers with greater protection.

- Government-supported, community-based delivery structures (or other microinsurance models as envisaged in the Bangladesh Health Care Financing Strategy 2012-2032 and the Indian RSBY health product) can be professionalised to create larger risk pools. In Cambodia and Rwanda, community-based health microinsurance is promoted as a transitory step towards universal, nationwide, social health insurance. However, only as a legal requirement can mandatory insurance lead to significant coverage (as in the case of Rwanda, which has over 90% coverage). Cambodia’s experience with a voluntary system demonstrates the substantial challenges that arise when coverage is optional.

**Improve benefits**

- Convergence and standardisation of social protection programmes and insurance products are needed. Highly diverse and inconsistent public programmes make it difficult for customers to understand value and for the state administration to gain suitable overview. The situation, particularly seen in federated government structures (where there are different governments at the centre and at the province/region), could be improved through convergence of schemes, which could result in higher benefits and secure advantages of economies of scale. Customer-oriented insurance products are required, but it is doubtful that the huge diversity of products always creates additional value to customers. Standardisation of some products would be useful and need not compromise client value. Standardisation would also be attractive to the insurance industry, since the design of multiple, highly-specified products for a limited number of clients would be prohibitively expensive. A standardised approach could add to economies of scale.

- Microinsurance could serve as a bridge until public benefits come into effect. The time taken from the event triggering social assistance to the first payment from the public social protection system may be substantial. Microinsurance (e.g., disability insurance) could address the gap in coverage. For example, the victim may be able to avoid taking loans to pay for medical costs and livelihood during the interim period.

- More complex products and packages are in demand, including products for special occupational groups, insurance against agricultural losses, Takaful Islamic products, and old-age pension systems. The use of technology to deliver inexpensive but valuable solutions is an appealing proposition.

- Gender-sensitive benefits and services are necessary. Women are more exposed to risks from working in unregulated, hazardous environments and more susceptible to illnesses due to sexually transmitted diseases, low nutrition, and complications related to pregnancy and childbirth. Product design, if drawn from gender-specific demand studies, can help to reduce infant mortality and maternal death if outpatient and preventive medical and gynaecological checks and pregnancy-related issues are integrated within the health-care benefits. Suitable premium collection, including new technology (e.g., mobile phones and smart cards) and simple claims documentation, can improve consumer experience and access.
Increase access to social protection and microinsurance

- Bridging the gap between the government and low-income people could be achieved through increased collaboration with civil society organisations. When compared with government administration, civil society organisations have often succeeded in achieving greater reach, lower transaction costs, and better services, not only in microinsurance but also in social protection activities such as sanitation or health, provided they were appropriately trained and equipped with basic resources. If both actors are willing to build upon each other’s strength, the government needs to institutionalise the supportive function of civil society organisations, clarify the roles and responsibilities of all stakeholders at all levels, authorise the civil society’s mandate, and arrange financial compensation for delegated tasks.

- Train microinsurance agents and brokers. When cooperating with the private insurance industry, microinsurance delivery is dominated by agents, which limits the relationship to one insurance provider. This is not in the interest of the clients and runs counter to market principles. Only a few brokers have entered the low-income market—an opportunity which should be further explored.

- Use a combination of national and local structures to leverage capacity development and delivery effectiveness. Government support would enhance the lessons learned from experiences, especially in very diverse insurance environments. This can be seen in Rwanda and Cambodia, where they created national community-based structures, and in the initial step the Bangladeshi government took of giving the national Palli-Karma Sahayak Foundation (PKSF) a more prominent role in microinsurance. At the international level, a product database of good practices and critical issues would create useful knowledge that could be instrumental in product development.

General recommendations

- Collaborate with and transfer risks to the insurance industry through public-private partnerships (PPPs) and encourage the industry to enter the low-income market. Whilst social health insurance or tax-financed benefits are often organised by national funds or paragovernmental organisations, the risk can also be shifted to the private insurance industry for leveraging resources of the public sector. Such a shift could provide potential effectiveness and efficiencies of the private sector, but would need robust monitoring (as is important for any other government delivery). Prominent examples are India’s RSBY, Weather-based Crop Insurance Scheme (WCIS), and National Pension System (NPS), which are delivered in collaboration with the private sector. Another encouragement for the industry is a carefully designed incentive system, not only for the insurance providers, but also for intermediaries (e.g., brokers). On the other hand, investigations of tainted commercial insurers have revealed “cream-skimming” and other problematic industry practices, which need to be monitored and strictly supervised.

- Regulation and supervision in microinsurance is required to develop the market, with a focus on important issues such as: (1) the definition of ‘microinsurance’ and how to segregate regulation, (2) the supervision of delivery channels, including in-house or mutual underwriters, (3) the harmonisation of reporting and information systems, and (4) the creation of a consumer protection infrastructure that includes education and grievance redress.

- Build capacity development at all levels and across a range of actors. Affordable, demand-based capacity building is needed and current programmes need accessible training facilities. To date, only a few local training institutions exist that could enhance the capacity of civil society organisations and other relevant stakeholders for operating microinsurance. Given the complexity of microinsurance and the need to integrate it into a comprehensive social protection framework and larger risk management strategies, comprehensive curricula for all actors need to be developed and implemented.
Evidence of how microinsurance is successfully integrated into social protection frameworks is still scarce. In order to enhance understanding of synergy and complementarity between microinsurance and other social protection mechanisms, the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and the Microinsurance Network’s Social Protection Working Group commissioned studies of the role of microinsurance in social protection in three countries—Bangladesh, India, and Vietnam—and a study covering Brazil, Cambodia, and Rwanda where the experience of a social health protection and its interface with microinsurance has been communicated.

This paper synthesises the key messages of the country studies, formulates lessons learned, and provides recommendations for better integration of microinsurance into social protection while considering the social protection principles of universality, solidarity, and equity.

This paper explores the integration of microinsurance into social protection systems and focuses on insurable risks suitable for microinsurance, such as sickness, old age, death, accident and disabilities, and extreme weather events.

Concept of social protection and the role of microinsurance

People worldwide are exposed to many risks, but poor and low-income people are particularly vulnerable to crises and economic shocks such as sickness, old age, unemployment or extreme weather events. Whilst formal economy employees have access to social protection, the majority of informal workers lack adequate social protection measures. This is especially disastrous for the many informal economy workers whose families are poor, and even more so for women who are particularly vulnerable (more details in ‘Improving Benefits’ section).

The occurrence of adverse events can cause loss of income and depletion of savings and force people into debt, compelling families to sell assets and take children out of school, thus pushing them deeper into poverty. Vulnerability tends to make people more risk averse and reluctant to invest in productive assets and education. Consequently, for such people, poverty is likely to be perpetuated if they are not protected by at least basic social protection (offered by the government) in combination with other risk management measures, including insurance.

As the definition of the broad concept of social protection differs across development agencies, within the context of this study, “social protection” is defined as, “...the total set of public action to address vulnerability or chronic poverty. These interventions can be carried out by the state or

1 The ILO, via the 1952 International Convention No. 102, includes sickness, maternity, employment injury, unemployment, invalidity, old age, death, the need for long-term medical care, and child support among social protection provisions. However, in the ILO’s World Social Security Report 2010/11, social protection is defined in slightly broader terms by helping people to cope with life’s major risks and adapt to change. The OECD refined the definition further in its 2009 publication, Promoting Pro-poor Growth: Social protection. Promotional, preventive, and protective measures identified in the World Bank’s recent social protection typology is very broad reflecting the earlier comprehensive Social Risk Management: A new conceptual framework for social protection and beyond, by R. Holzmann and S. Jørgensen.
other actors such as commercial companies, charitable organisations, self-help groups, etc.” (Deblon and Loewe 2012).

Social protection under this definition aims to fulfil the functions of prevention, protection and promotion and aims at “preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation” (UNICEF 2012).

Although Article 22 of the United Nations Declaration of Human Rights (1948) states that, “every member of the society has the right to social security”, approximately 75% of the world population is not adequately protected, and approximately 40% lacks even basic protection (Kimball et al. 2013). Confronted with these figures in 2011, delegates at the International Labour Conference on Social Protection Floor Initiative called for a pragmatic, stepwise approach to social protection, defining some minimum social security benefits that should be extended as soon as conditions allow2.

Within this context, microinsurance is one possible instrument for mitigating risks and reducing the vulnerability of poor and low-income households, particularly in the informal economy. Microinsurance is defined as, “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” (Churchill and Matul 2012).3 There are cases where the state plays a stronger role in fully funded schemes—as with social assistance—but these would only be considered microinsurance if they are run according to insurance principles.4

The microinsurance mechanism need not vie with or displace public social protection. Such an approach would overload the scope of protection microinsurance can offer with its limited benefits and would be politically problematic as it cannot comply with the three social protection principles of universality, equity, and solidarity. But looking at the huge protection gap and following the realistic recommendation of a step-wise approach to social protection, microinsurance can have significant advantages for uncovered or under-covered people.

Certain groups have different needs and have very low contributory capacity. The successful extension of social security requires that these differences be taken into account. The potential of microinsurance should also be rigorously explored: even if it cannot be the basis of a comprehensive social security system, it could be a useful first step, particularly responding to people’s urgent need for improved access to health care. Policies and initiatives on the extension of coverage should be taken within the context of an integrated national social security strategy (ILO 2001).

From a social protection perspective, the benefits of microinsurance are most effective when embedded into a comprehensive social protection framework that goes beyond public social protection measures and includes informal, private, and other public risk management strategies of preventive measures, mitigation, and suitable coping strategies.

Under the current circumstances, with insufficient social protection, microinsurance could provide enhanced protection for the near-poor. These people are just above the eligibility criteria in many social assistance and poverty reduction programmes, thus remaining unprotected despite their vulnerability. Microinsurance would also be useful for those low-income people that earn above the threshold amount for accessing current targeted social protection benefits, yet earn too little to buy insurance products from commercial insurers. It has vast potential for seasonal and internal migrant

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3 According to the IAIS (2012) “…there are cases where the State plays a stronger role in fully funded schemes, but these would only be considered microinsurance if they are run according to insurance principles.”

4 There is an international debate about whether subsidised products should be defined as microinsurance. This paper uses the definition according to the 2012 IAIS Application Paper on Regulation and Supervision Supporting Inclusive Insurance Markets. The current international discussion is increasingly talking about “inclusive insurance” rather than microinsurance. For the social protection discussion in this paper, the term microinsurance is used.
workers and could even be useful for people working in enterprises which officially fall under formal economy laws but are not officially registered and, hence, do not provide statutory benefits to their employees.

Guiding questions, methodology, and structure of the paper

This paper explores the coverage of the population, the benefits provided, and the access to microinsurance and other social protection measures. The guiding questions are analysed in the context of three social protection principles:

1. Universality (striving toward coverage for all citizens): How can microinsurance contribute to attempts at universal coverage of social protection?

2. Equity (enhancing benefits and fairness): How can microinsurance reduce its inherent challenge of equitable coverage?

3. Solidarity (risk pooling across a society and not only among high risk poor persons): How can microinsurance minimise the problem of redistribution and achieve greater solidarity?

The answers contribute to identifying the potential and gaps in microinsurance and the most relevant roles it can play in the overall framework of social protection programmes:

- Microinsurance could complement social insurance, even where social insurance schemes cover the most serious risks faced by households but refund only a part of the costs incurred, thereby rendering low-income households unable to shoulder the remaining costs. In this case, the presence of microinsurance and social insurance is crucial for the other to have a significant positive impact.

- Microinsurance could supplement social insurance to top up the provisions granted by social insurance schemes and cover different risks or different effects of the same risk (Deblon and Loewe 2012).5

Information was obtained from relevant legal documents of the respective governments, and reports from international and local institutions. Interviews with key contacts during field visits added to the information acquired from desk research. Contacts included government agency employees, representatives with delivery channels of social protection programmes and microinsurance products, microinsurance and commercial insurance providers, multi- and bilateral agency and other international organisation contacts, as well as academics and other local experts6.

The synthesis paper is structured in four parts:

- Introducing the concept of social protection and microinsurance, highlighting its relevance to the informal economy.

- Describing and analysing the social protection systems and microinsurance practices in Bangladesh, India, and Vietnam, and the consolidated experiences in Brazil, Cambodia, and Rwanda.

- Presenting the lessons learned from integrating microinsurance into public social protection systems, with due consideration to the social protection principles of universality, equity, and solidarity.

5 Other roles for microinsurance mentioned in the article but not considered for this paper are microinsurance as (1) a substitute for social insurance where the state is unable or unwilling to build up social insurance schemes or does not want to extend them to informal-sector workers, (2) as an alternative to social insurance, where social insurance schemes do exist but are not (and are unlikely to become) attractive for all informal sector workers, and (3) as a link to social insurance, where social insurance is potentially attractive for the entire population but fails, for instance, to reach out to rural areas.

6 It exceeds the scope of this paper to discuss reaching a broad goal of universal coverage for all. There are varied experiences with tax-financed programmes operated by governments as they have shown tremendous ineffectiveness and inefficiency in some countries but not in others. The same applies to the Social Insurance approach when cooperating with the private sector. Services and products also vary with commercial insurers. Good governance, robust monitoring, and consumer protection are important features in conjunction with services for maximum effectiveness.
- Recommendations for extending coverage to the informal economy and other vulnerable groups, improving benefits, and increasing access to public social protection and micro-insurance—an approach which can be replicated in other countries if adapted to fit the specific environment.
COUNTRY STUDIES

Bangladesh

Whilst the formal sector is growing, over 85% of employment is still concentrated in the informal economy. Though Bangladesh managed to reduce poverty from 40% to 31.5% between 2005 and 2010, approximately 20% of Bangladeshis still remain on the poverty line. The consequences of natural events such as frequent floods, cyclones, and droughts, threaten the gains in poverty reduction and pose tremendous challenges to the Bangladeshi population, the private sector, and the government.

The social protection strategy of the Government of Bangladesh

Social protection is a constitutional obligation that provides the right to public assistance “in cases of undeserved want arising from unemployment, illness or disablement, or suffered by widows or orphans or in old age or in other such cases.” Within this context, Bangladesh’s Sixth Five Year Plan states that, “a coherent and integrated national social protection strategy based on a comprehensive mapping of existing and emerging vulnerabilities will be developed” (Khandker 2011). Broadly, the Bangladesh social protection system can be divided into four categories (see Table 1), although the last category, private insurance products for middle- and high-income earners, plays a marginal role. In 2012, the Bangladeshi government approved the National Health Care Financing Strategy 2012-2032, which is not part of the national social protection strategy (NSPS) but conforms to the three social protection principles. The strategy is aligned with the WHO universal health coverage approach and will be implemented in phases, initially covering the poor and the formal sector and progressively extending the coverage until achieving universal health coverage through a complete inclusion of the informal sector in the Social Health Protection scheme by 2032. Apart from tax-funded, publicly financed health care with user fee retention, different sections of society will have access as follows:

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7 The Bangladesh Bureau of Statistics (BBS) distinguishes the poverty line into “upper” poverty line (2,122 kcal—BDT 27/person/day) and “lower” poverty line (1,805 kcal—BDT 22/person/day). http://www.worldbank.org/en/country/bangladesh
### Table 1: Overview of the social protection system in Bangladesh

<table>
<thead>
<tr>
<th>Target group</th>
<th>Social protection</th>
<th>Benefits (summary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All citizens</td>
<td>Basic social/human development funded by the public exchequer</td>
<td>Universal programmes providing access to public schools, basic health services, etc.</td>
</tr>
<tr>
<td>Formal economy people</td>
<td>Illness and maternity benefits; work injury system entirely paid by employers</td>
<td>Medical and maternity allowances; accidental and disability benefits due to work injuries; termination benefit but no statutory unemployment</td>
</tr>
<tr>
<td>Informal economy people: very poor and special groups under the social safety net programmes (SSNP)</td>
<td>Allowances for population groups with special needs</td>
<td>Financial support for the elderly, widows, and other destitute groups, such as distressed disabled people and acid burnt women</td>
</tr>
<tr>
<td></td>
<td>Food security and disaster assistance</td>
<td>Provision of subsidised food grains and development services, activities for risk management for natural disasters, including access to interest free loans</td>
</tr>
<tr>
<td></td>
<td>Employment creation addressing chronic and structural poverty</td>
<td>Covering costs of basic needs through for instance employment provision for rural poor (especially women), training and developing rural infrastructure</td>
</tr>
<tr>
<td></td>
<td>Human development and social empowerment</td>
<td>Cash for education programmes for primary and secondary school girls; training and microfinance programmes to increase income earning capacity (especially for extreme poor women); improving health status including maternal health</td>
</tr>
<tr>
<td>Middle- and high-income population</td>
<td>Voluntary private health insurance products, life, and old age endowment products</td>
<td>Various health products offered by private insurers</td>
</tr>
</tbody>
</table>

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9 Although officially the public system provides free basic health treatment at state-run health-care facilities, in fact, 86% of health-care expenses for private households were out-of-pocket (Rahman and Choudhury 2012).
- Below the Poverty Line: non-contributory Shasthyo Shuroksha Karmasuchi (SSK) subsidised health protection (as a part of the Social Health Protection scheme);

- Informal economy: Exploring the potential of CBHI and microinsurance to cover this population as an interim measure gradually moving to the national Social Health Protection scheme;

- Formal economy/civil servants: Social Health Protection scheme and complementary private insurance.

The current National Plan for Disaster Management (2010-2015) [MFDM 2010], prepared by all stakeholders, incorporates social safety net programmes to ensure food security for the most vulnerable people. Although Bangladesh is extremely prone to natural catastrophes, the model does not transfer some of those risks to the 62 existing insurance companies, which exerts significant financial strain on the government’s budget and leads to dependence on international support.

**Benefits**

**The formal economy**

The sickness and maternity benefits based on social insurance apply to insured employees in the manufacturing industry and in establishments with five or more workers (key benefit: 100% of earnings for up to 14 sick days a year for workers in insured employment). The employer-liability work injury system applies for accidental injuries and 33 listed occupational diseases. In the case of unemployment, no statutory benefits are provided in the NSPS. The 2006 labour law, nevertheless, requires employers to provide several one-time benefits. The only existing formal pension scheme is for public sector employees, providing old age pension at the age of 57. However, it excludes members of the defence service, teachers, and some other groups working for the government.11

**The informal economy**

In the 2011 budget speech, an amount of USD 2.8 billion per annum (approx. 2.5% of GDP) was allocated to social safety net programmes (SSNP) targeting the extreme poor, the poor and special groups of vulnerable—but not necessarily poor—people, with the highest allocation (44.3%) for food security and disaster assistance programmes.12 These included:

- Allowances: unlimited old age BDT 300/month

- Food security and disaster assistance programme (Vulnerable Group Development) of 25 kilograms of flour per month for a programme cycle of 24 months and other services including access to interest free loans

- Employment creation (Employment Generation Project) offering BDT 150 cash per 100 days’ work

- Human development and social empowerment, providing conditional cash transfer for primary and secondary school girls; various programmes providing assistance, like cash benefits for asset building, food and subsistence allowance ( ultra poor), livestock, skills training, microfinance programmes, and sanitation, health cards, and nutritional support to pregnant women (SHOUHARDO).

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10 To view a list of insurance companies in Bangladesh, visit: http://www.idra.org.bd/idra-org/Ins-Com.htm


12 Employment programmes account for 23.5%, allowances for (old age) for 16.2%, and human development and social empowerment programmes (e.g., conditional cash transfers or graduation-focused programmes) for 15.3% (UNDP 2012).
The microinsurance market in Bangladesh

The microinsurance strategy of the Government of Bangladesh

Microinsurance has evolved out of the widespread implementation of microfinance as a development strategy for Bangladesh. In contrast to its microfinance policy, the Government of Bangladesh has not yet developed a strategy for microinsurance and does not subsidise it. However, it has supported the insurance initiative of the semi-governmental institution, Palli Karma-Sahayak Foundation (PKSF). PKSF acts as the apex funding organisation for microfinance on-lending to its current 262 microfinance institution NGO members (PKSF 2011). Recently, a microinsurance regulation was drafted for PKSF to be discussed with the regulator. The following initiatives open up opportunities for stimulating microinsurance in Bangladesh:

- The Insurance Act of March 2010 mentions the possibilities of insurance-based social protection systems, social insurance, and microinsurance.

- The rules of the Microcredit Regulatory Authority Act, 2006 permit licensed microcredit organisations to provide insurance to their clients.

In general, the commercial insurance industry has not yet entered the microinsurance market for the poor. Seventeen insurance companies offer life products and reach a limited number of low and lower to middle-income households. One commercial insurer has started selling a health microinsurance product.

Microinsurance products

Microinsurance products are offered by more than 95 NGOs and MFIs. Four of the largest ten NGOs/MFIs cover around 90% of all microinsurance clients. Their portfolios consist of 55% death cover, 43% of loan insurance, but only 2% insured livestock, health, and accident (BRAC 2012). Most of the life insurance products are mandatory for the borrowers, whereas many health policies are voluntary and primarily offered by smaller NGOs. NGOs/MFIs function as in-house risk carriers and deliver the products as full service providers.

Conclusions and recommendations

In the envisaged process of developing its integrated NSPS, the Bangladeshi government intends to evaluate its social safety net programmes. The present public system is fragmented and some programme benefits overlap, whilst other risks are not adequately covered. The same can be seen in microinsurance, which is dominated by various life products and a few health insurance products mostly offered by MFIs and NGOs. Currently, Bangladesh has not transferred any risk to the insurance industry nor has it developed a microinsurance strategy, but will explore public-private partnerships in the area of health care. However, it did take initial steps through the semi-governmental organisation PKSF, for whom a microinsurance regulation was recently drafted to be discussed with the regulator. Microinsurance is available to rural and a few urban members and sometimes to non-members of local NGO/MFI branches, but since microinsurance is not integrated into public social protection, large sections of the population are not reached and the government is not fully aware of the potential of the decentralised and empowering nature of microinsurance. However, the National Health Care Financing Strategy 2012-2032 suggests exploring health microinsurance as an interim mechanism until achieving universal health coverage.
Key recommendations for Bangladesh

Extend social protection coverage to poor and low-income people

- As the government has not yet transferred any risks to the insurance industry, a mix of SSNP and contributory insurance systems could complement and supplement the government programmes, particularly for the upper poor and the special group category of SSNP beneficiaries. For instance, accident and disability microinsurance products could relieve the immediate burden until possible government support comes into effect, if the government explores microinsurance within its National Health Care Financing Strategy. Health products could supplement benefits of the rural social services programme, which includes microcredit and primary health care. The development of the non-contributory SSK health scheme for the BPL population will extend health services in selected districts with the perspective to cover the whole country after initial experience is analysed.

- Lower-income formal sector workers, who are not in “insurable employment” could potentially be attracted by microinsurance (e.g., old age endowment products, if well-designed).

Improve social protection benefits

- Except for some public servants, even the formal sector lacks statutory old age entitlements. The government’s old age social safety net allowances for poor people and destitute widows are small. Given the large number of MFIs officially permitted to receive savings, their present savings schemes could be extended by longer-term endowment products, if well-designed.

- Given the high exposure of Bangladesh’s population to natural catastrophes, there is a severe undersupply of products against harvest failure, livestock, or property. Only one of the two state-owned insurers offers livestock insurance policies and Oxfam has piloted an index-based flood insurance product. Otherwise, neither the government nor the private insurers have transferred weather-related risks to the insurance industry, either at the macro- or at the micro-level.

- Since out-of-pocket payments are high even for clients with NGO/MFI health microinsurance, a flexible hospitalisation cash policy or a combined hospitalisation-savings product would be useful, considering that many clients are members of NGOs and MFIs. As the government explores community-based health insurance and health microinsurance as an interim mechanism toward universal health coverage, the NGO/MFI products should be carefully assessed in order to complement government services and not to duplicate them.

Increase access to social protection and microinsurance

- Due to the strong civil society sector, there is a tendency for such organisations to implement programmes that ought to be the responsibility of the Bangladeshi government. In order to avoid problematic “parallel structures,” a clarification of roles is needed. Several institutional arrangements exist that could be further strengthened, such as multi-stakeholder networks in disaster management or direct...
agreements between government authorities and NGOs [which sometimes exist at the local level].

- If the government would pursue its approach by establishing separate institutions for better cooperation with the civil society, it could, for example, stimulate the registration of a national cooperative insurance under the Insurance Act, 2010. In this context, consideration could be given as to whether PKSF could play a more prominent role in microinsurance. PKSF is already established as an apex funding organisation for microfinance activities as part of the government’s SSNP and has demonstrated capacity in product development. Such national institutions would create clarity about the variety of microinsurance products. This does not mean that the role of NGOs would be diminished, as the success of microinsurance depends significantly on effective and efficient delivery channels.

- So far, government or NGO/MFI strategies do not envisage transferring risks to the insurance industry; only recently have a few products been offered in collaboration with the two insurance companies, and the National Health Care Financing Strategy stipulates the future promotion of PPPs. Bangladesh offers a conducive environment for insurance penetration as 78% of all villages are already covered by NGOs and MFIs. They could sell and manage the microinsurance, assuming the products are developed in a participatory way, involving all actors (including potential customers). Takaful Islamic insurance may be perceived as more “people friendly” because of the important role Islamic banks play in rural areas.
Situating microinsurance in social protection - Lessons from six countries

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India

Whilst India’s economy has been constantly growing, economic development has neither led to significantly lower poverty rates, nor been able to generate an expansion of the formal economy. According to the Unorganised Sector Workers’ Social Security Bill, more than 94% of the working population still works in the informal sector. Poverty, in particular, persists in rural areas, especially amongst certain social and ethnic groups (the scheduled castes and scheduled tribes respectively). Women and children are particularly vulnerable, as they are less educated, are often paid extremely low wages, and work in very hazardous conditions.

The social protection strategy of the Government of India

Article 41 of the constitutional Directive Principles of State Policy specifies that, "The State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want." 13

Broadly, the Indian social protection system can be divided into the following three different target groups (see Table 2).

The Indian system is characterised by a number of social assistance, welfare, and social sector development programmes and schemes. They are cross-sectorial and have been developed for a broad range of different occupations and specific groups, involving various ministries, welfare boards, and departments.

Whilst a social protection framework is in place for the organised sector, a serious gap exists in social protection policy for the informal economy. And although public spending on social safety nets is relatively high by international standards of low and middle income countries, these safety nets need to be adjusted so that they place greater emphasis on ex-ante risk mitigation.

The Government of India developed the Unorganised Sector Workers’ Social Security Bill (2007), which was enacted by the Indian Parliament in 2008. Subsequently, further initiatives were undertaken, such as the national health insurance scheme called RSBY and the National Pension System (NPS) to move towards a more inclusive social protection policy.

## TABLE 2 Overview of the social protection system in India

<table>
<thead>
<tr>
<th>Target group</th>
<th>Social protection</th>
<th>Benefits (summary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All citizens</td>
<td>Basic social/human development funded by the public exchequer</td>
<td>Universal literacy, schooling (including fundamental right to education for children between 6 and 14 years), health care, drinking water, and sanitation, technical training, etc.</td>
</tr>
<tr>
<td>Formal economy people</td>
<td>Employees’ State Insurance</td>
<td>Health cover, maternity, unemployment, invalidity, and survivor benefits</td>
</tr>
<tr>
<td></td>
<td>Employees’ Provident Fund</td>
<td>Old age, gratuity</td>
</tr>
<tr>
<td>Informal economy people</td>
<td>Unorganised Sector Workers’ Social Security Act (intended for every unorganised worker, but currently only for those below the poverty line and some marginally above)</td>
<td>Health and maternity, death and disability, old age, but can be extended at a later stage (not yet fully provided)</td>
</tr>
<tr>
<td>Subsidised and contributory microinsurance</td>
<td>Health (including RSBY), death, disability, weather-related risks/agriculture insurance</td>
<td></td>
</tr>
<tr>
<td>Several welfare funds</td>
<td>Housing, medical care, water supply, education of children, and others</td>
<td></td>
</tr>
<tr>
<td>Indian National Pension System (including NPS lite)</td>
<td>Old age security</td>
<td></td>
</tr>
<tr>
<td>Targeted social and human development schemes (social assistance)</td>
<td>Examples: the Public Distribution System, National Social Assistance Programme, Integrated Child Development Scheme, Employment Guarantee Scheme (MGNREGA)</td>
<td></td>
</tr>
</tbody>
</table>

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14 As social assistance programmes consist of various benefits, they are not listed in the table. Given its relevance, the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) is mentioned again later in this paper.
Benefits

The formal economy

The Employees’ State Insurance Scheme (ESIS) applies to factories employing 10 or more persons. The ESIS provides full medical benefits for the employed and their families, disability benefits, unemployment allowances providing up to 50% of one’s salary for a maximum period of one year, and other benefits, including funeral expenses and skill upgrade. The Employees’ Provident Fund (EPF) is applicable to establishments with more than 20 employees and provides for a deposit-linked insurance scheme and the Employees’ Pension Scheme on reaching the age of 55 years.

The informal economy

The Unorganised Sector Workers’ Social Security Act in 2008 (based on Bill No. LXVII, 2007) introduces a minimum social security package for “every unorganised worker” and will be implemented in phases.

Currently, only people below the poverty line or those marginally above are entitled to three schemes:

- The Indira Gandhi National Old Age Pension Scheme (IGNOAPS) provides financial assistance of INR 200 (EUR 3) per month to destitute applicants over the age of 65 years who have no regular means of subsistence.

- The Aam Aadmi Bima Yojana (AABY), of the state insurer Life Insurance Corporation of India (LIC), provides life and disability insurance to the main income earner of all rural, landless households, and is administered by nodal agencies, such as NGOs appointed by the state government. The central and state government equally subsidise the premium of INR 200 (EUR 3). The AABY has now been merged with the Janashree Bima Yojana (JBY), another government-subsidised scheme operated along with NGOs and offered through the LIC to 45 informal sector occupational groups. Both AABY and JBY provide a life cover of INR 30,000 (EUR 425).

- RSBY, the fully subsidised national health insurance scheme, provides hospitalisation benefits. RSBY provides annual hospitalisation coverage up to INR 30,000 (EUR 425) for a family of five and includes all pre-existing diseases, as well as some transportation costs for households below the poverty line and those marginally above poverty. Recently the RSBY has been extended to certain sectors, such as domestic workers, MGNREGA job card holders, and street vendors.

There are a huge number of government programmes aiming to eradicate poverty, irrespective of the beneficiaries’ status as working or non-working poor. The following are the most relevant in terms of strategic relevance, scale and impact:

- The Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA, set up in 2005), entitles poor rural households (self-targeting) to 100 days of employment per year, with reservations for women workers and equal wages for men and women.

- Welfare funds are limited to three occupational categories (cine workers, beedi workers (cigarette rollers), and selected mine workers), regardless of worker income, and are supported by the central government and other occupations by a few state governments (e.g., truck drivers, weavers, cashew workers). They are financed out of taxes collected on the consumption and/or export of related products. The Building and Other Construction Workers Welfare Cess Act, 1996, stipulates a worker’s contribution of INR 145 annually, but the major source of funding is the }
taxes paid by the builder (1–2% of construction costs). Broadly, the package provides benefits for health expenses, maternity, old age pensions, funeral expenses, work accidents, and any subsequent total disability, educational grants, and housing loans.

- The Indian NPS initially introduced in 2004 as a mandatory contribution scheme for new employees of the government, was later also offered to the corporate sector (PFRDA 2010). To extend coverage to the informal sector and economically disadvantaged sections of the population, PFRDA launched the Swavalamban Yojana Scheme in 2009. The voluntary, contribution-based pension scheme provides some government subsidies in the form of initial contribution to promote small savings for old age.

## The microinsurance market in India

### The microinsurance strategy of the Government of India

The government (including the insurance regulator Insurance Regulatory and Development Authority, or IRDA) plays a proactive role in providing insurance to the low-income market, the poor, and below the poverty line households through the following measures:

- Introducing IRDA-enforced obligations for the private insurance industry to meet obligations toward "rural areas" and the "social sector" (implemented in 2002). Private insurers are required to sell a minimum level of insurance portfolio to respond to the development agenda by encouraging the design of products for low-income clients and thereby provide cover to neglected rural areas.

- Defining and regulating microinsurance through the IRDA Microinsurance Regulations, 2005.

- Legalising new microinsurance delivery channels ("microinsurance agents"), such as self-help groups (SHGs), NGOs, and MFIs through the IRDA Microinsurance Regulations, 2005. In order to further increase microinsurance penetration, additional policies permit bank correspondents, point of sale marketing, mobile phone providers involving call centres, and mono-line insurance agents who can sell a single simple insurance product (since 2009).

- Officially incorporating microinsurance into social protection (particularly social assistance) as a risk management mechanism for poor and low-income informal workers. This could be accomplished under the Unorganised Sector Workers’ Social Security Act by subsidising microinsurance schemes, like RSBY and JBY, for below the poverty line households.

- Entering into various PPP agreements between the Indian government and the insurance industry. The most prominent scheme is the subsidised RSBY, but more complex multi-stakeholder PPPs also exist to ensure better health-care service provisions e.g., the Andhra Pradesh State Government’s Rajiv Arogyasri which covers 87% of all families.

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19 Social sector is specified as unorganised workers, economically vulnerable, or backward classes in urban and rural areas.
20 In year one, 5% of total policies (up to 10% in years 6 to 10) in rural areas and 5,000 policies in year one (increasing to 55,000 after year 6) to the social sector.
and the Maharashtra State Government’s Rajiv Gandhi Jeevandayee Arogya Yojana. In addition, the government entered into PPP agreements with private hospitals for improving health-care services, which enhances the acceptance of health microinsurance products. In crop insurance, the subsidised Weather-Based Crop Insurance Scheme (WBCIS) [see Microinsurance Products section below] is offered through a PPP arrangement between the insurance industry and the state government.

**Microinsurance products**

According to the 2011-12 IRDA annual report, there has been a steady growth in the design of products catering to the needs of the poor. Comparing the 30 insurance products mentioned in the 2011-12 IRDA Annual Report with the products available on the market\(^{22}\) shows that most products are not registered as microinsurance.\(^ {23}\) This is particularly true for community-based schemes and/or NGO full-service providers that cannot obtain an insurance licence.

The wide range of products (estimated at more than 500) for poor and low-income people is dominated by life (mostly credit term life) and, to a lesser extent, health insurance. Most health schemes still provide a low level of health protection with benefits ranging from INR 500-10,000 (EUR 7-145). In 2010, more than 70% of the community-based health schemes received financial support, either from international agencies or the government. In addition, there are a number of products offered by official insurance providers targeting the low-income market that are also not registered as microinsurance. Similarly, most of the insurance products mentioned under rural and social sector obligations are not noted under microinsurance, but are available to disadvantaged groups whose economic situation remains unspecified.

Insurance against catastrophic weather-related risks is not strictly part of social protection in India; however, the vast majority of India’s 116 million farmers are particularly vulnerable to the uncertainties of the monsoon. Apart from the government’s subsidised crop insurance—the National Agricultural Insurance Scheme (NAIS), an indemnity-based crop insurance policy offered by the state-owned Agriculture Insurance Company of India (AIC)—and the 2010 modified NAIS (mNAIS) involving private industry, a number of private insurers have started to develop index insurance for the poor and low-income farmers. Since 2007, the Indian government has developed the WBCIS, an agricultural insurance product based on the weather index, which is subsidised and offered by the government owned AIC and other private general insurers. In these contexts, new crop insurance products were approved during the year ending March 2012 (IRDA Annual Report 2011-12).

**Conclusions and recommendations**

Given the large number of government programmes and microinsurance products, there is a need to overcome fragmentation and enhance the consistency of benefit packages. The current diversity results in a confusing number of national and state supported schemes of which people are unaware. Even if they do know their entitlements, the benefits are spread too thin to significantly improve the situations of poor and low-income people. The sometimes arbitrary distinctions made between target groups, such as people below the poverty line, destitute widows, rural landless households, and selected occupational groups, are severe obstacles to
access benefits resulting in coverage gaps of vulnerable people. Despite the positive action taken by the Indian government and the regulator, some microinsurance practices have a questionable or even adverse impact on the microinsurance sector. India’s recent actions strive to overcome some of these shortcomings.

Key recommendations for India

Extend social protection coverage to poor and low-income people

- The Unorganised Sector Workers’ Social Security Act was a legal breakthrough, as it introduces a minimum social security package for “every unorganised worker”. As the Act is being implemented in phases, it currently covers only the unorganised workers who are below the poverty line, or marginally above it, and provides three benefits: life and disability cover, health and maternity benefits, and old age protection.

- Low-income earners, though vulnerable, are not entitled to social assistance. Alongside the universal programmes and a few social security schemes, selected occupational groups have the opportunity to enrol in welfare funds specific to their occupations. In some of these funds, the risks of death and total disability are covered by microinsurance as part of the fund’s benefit package. This is a successful means of integrating microinsurance into social protection that could be extended through other microinsurance products, complementing the current welfare fund benefits since benefits differ from state to state and from occupation to occupation, and are lost when workers change occupations. However, the welfare fund concept remains limited to selected occupational groups, leaving many other low-income people uncovered.

- Striving towards broader coverage, the Indian government supports the National Pension System and RSBY, insuring 120 million people (Vellakkal 2012). In 2011, the central government made the decision to offer RSBY as a partially subsidised health scheme to selected occupational groups. Whilst the pension programme has the potential to overcome the “targeted” approach, the RSBY extends its coverage beyond the poor but is still short of its intention to reach “all unorganised workers” (as mentioned in the Act). At the same time it transfers health and old age risks to the insurance industry, with premium subsidy shared between the central and state governments and links service provider hospitals to a central database. India’s unique identification programme, Aadhar (“base” or “foundation” in English), which seeks to enrol and link bank accounts of all Indian citizens under a biometric identification system, promises to be a game changer in delivering social protection benefits like the RSBY and NPS. Government support to PPP-designed or NGO-assisted microinsurance programmes could benefit from the Aadhar project. For example, subsidies can be appropriately directed to such programmes.
**Improve social protection benefits**

- Only 30 microinsurance products are listed under the IRDA “microinsurance” regulations (IRDA annual report 2011-12). This reveals that there are many insurance products available to this market segment that do not fall within the IRDA “range prescribed for microinsurance”. It seems that the product parameters set for microinsurance may be counterproductive. This has not hindered the design of microinsurance in itself, but it means the regulator is unaware of the product diversity or the possibility of different approaches to insurance, and is therefore unable to supervise them.

- It is doubtful whether the many products available offer optimal benefits to clients. Rather, the large range of products may lead to confusion instead of enabling people to make the best choice. Hence, some standardisation of products would be useful and could be attractive to the insurance industry, for which the design of multiple, highly targeted products covering only a limited number of clients would be too expensive.

- Whilst there are many similar products available, more complicated benefits are still in demand (e.g., outpatient coverage, other weather index insurance products). Such benefits may be difficult to provide and communicate optimum value and should be conceptualised in the context of broader risk management strategies.

**Increase access to social protection and microinsurance**

- In order to implement social protection mechanisms more effectively and efficiently, the government has extended its cooperation with civil society and the IRDA has regulated microinsurance delivery channels by involving the civil society sector. In some of the public social protection programmes, civil society organisations are directly and/or indirectly involved. For example, the State Social Security Boards of the Unorganised Sector Workers’ Social Security Act include representatives from industry and civil society, thereby providing an opportunity to jointly shape social protection policy. However, execution depends on the political will of the respective state governments and their capacity to implement the Act after incorporating views of relevant stakeholders.

- New microinsurance delivery channels (e.g., shopkeepers, mobile phone providers) that cater to individual clients are becoming increasingly important, as the majority of the population is not organised in groups. These channels sell microinsurance to individual customers but have no support structure in place to assist clients in processing claims (Ramm 2012a). Other microinsurance delivery practices are difficult to supervise and are not regulated (e.g., community-based systems and for-profit MFIs interacting with several insurers). The partner-agent model that the IRDA promotes neglects the latter models in which NGOs or community-based groups independently provide insurance services.
Vietnam

Vietnam’s transition from a centrally planned economy to a market economy in fewer than 20 years has been accompanied by high levels of growth. Although these benefits have been unevenly distributed amongst different population groups (ILO 2012), the achievements of the comprehensive social protection approach in reducing poverty and education are remarkable. The poverty rate declined from 58% in 1993 to 12% in 2011, and poverty remains a predominantly rural phenomenon. In 2010, rural people—particularly ethnic minorities—comprised 91% of the total poor.24

The rate of informal employment in Vietnam has been quite high; 71.7% in 2007 and 70.5% in 2009 (excluding agricultural workers, who comprised approximately 48% of the labour force). But even the formal economy is not necessarily decent employment. In 2009, 44.7% of all wage and salaried employees worked only with verbal contract arrangements or no contracts (ILO 2011).

The social protection strategy of the Government of Vietnam

The Vietnamese Ministry of Labour, Invalids, and Social Affairs (MOLISA) developed a comprehensive social protection strategy for the period 2011 to 2020 following the principles of universality, solidarity, equity, sustainability, and promotion of individual responsibility, as well as prioritising the poor. The current comprehensive strategy of social protection system (see Table 3) consists of four main pillars: (1) active labour market policies, (2) social insurance, (3) social assistance, and (4) basic social services and other measures (including poverty reduction programmes).

### Table 3: Overview of the social protection system in Vietnam

<table>
<thead>
<tr>
<th>Active Labour Market Policies</th>
<th>Social Insurance</th>
<th>Social Assistance</th>
<th>Basic social services and others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financed by tax &amp; contributions</td>
<td>Contributory (financed by contributions)</td>
<td>Compulsory Insurance</td>
<td>Voluntary Insurance</td>
</tr>
<tr>
<td>Poor_25_ &amp; disadvantaged groups_26_</td>
<td>Formal economy, public servants, defence/police</td>
<td>Informal economy</td>
<td>Poor &amp; special disadvantaged groups</td>
</tr>
<tr>
<td>Vocational Training</td>
<td>Pension</td>
<td>Pension</td>
<td>Regular assistance</td>
</tr>
<tr>
<td>Training</td>
<td>Survivor benefits</td>
<td>Survivor benefits</td>
<td>Emergency assistance</td>
</tr>
<tr>
<td>Credit</td>
<td>Sickness benefits</td>
<td>Health insurance</td>
<td></td>
</tr>
<tr>
<td>Labour mobility support</td>
<td>Maternity allowance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job introduction</td>
<td>Occupational accident/disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temporary/public work</td>
<td>Unemployment benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health insurance: contributory and subsidised for poor &amp; near-poor_27_</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Adapted by author from the NSPS 2011-2020 and the GIZ Vietnam glossary.

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25 Poverty line for poor (applied in 2011) in rural areas: VND 400,000/month, or EUR 15/month/per capita, in urban areas: VND 500,000/month, or EUR 19/month/per capita.

26 This group includes youth, rural workers, and informal sectors, redundant workers, workers with disabilities, and migrants (ethnic minorities).

27 Poverty line for near-poor in rural areas: VND 401,000–520,000/month, or EUR 15-20/month, in urban areas: VND 501,000—650,000/month, or EUR 19-25/month.
health insurance by 2014, but the deadline was postponed to 2020 by the Central Committee in June 2012.\textsuperscript{28}

**Benefits**

**The formal economy**

Compulsory social insurance: \textsuperscript{29}

Old age benefits are provided through compulsory pension insurance to workers of age 55 for women and 60 for men, with at least 20 years of contribution. Survivorship allowance (including funeral allowance) is provided if the deceased contributed for a minimum of 15 years. If the deceased contributed for less than 15 years, survivorship allowance is provided through a government grant. Other benefits include sickness leave and maternity allowance, as well as labour accident and occupational disease, temporary and permanent disability covering treatment and rehabilitation costs, and a disability grant. Unemployment insurance is mandatory for Vietnamese employees.

Since 2009, compulsory health insurance has formed a part of social insurance and provides a comprehensive list of inpatient and outpatient care (80-100% of the cost of, for example, treatment, screening, and early diagnosis of some diseases, rehabilitation, ante- and post-natal care, and drugs). Nevertheless, out-of-pocket payments remain high, although they have dropped from 65% in 2005 to 49.3% in 2009 (MOH and HPG 2011). Services such as routine checkups, family planning, and cases of work-related accidents, are not covered.

The informal economy

**Voluntary social insurance:**

Old age benefits (including funeral grants) are provided through premium payments equivalent to 16% of the annual incomes of laborers.

**Voluntary health insurance:**

The rest of the population can buy voluntary health insurance, which covers the same benefits as the compulsory health insurance. The government instituted a system that allows members to move easily from the compulsory scheme to the voluntary scheme and vice versa. The government fully subsidises health insurance cards for the poor, pensioners, beneficiaries of social assistance, vulnerable ethnic minorities, and children less than six years of age. Individuals receiving a partial subsidy (70% of insurance costs) include the near-poor (incomes up to 30% above the poverty line), middle- and low-income people operating in agriculture, forestry and salt (30%), schoolchildren, and students.\textsuperscript{30}

Social assistance distinguishes between emergency assistance and regular social assistance supporting, among others, elderly people in poor households, orphans, and non-poor people with severe disabilities who are unable to work.\textsuperscript{31} Social assistance includes cash or in-kind transfers, such as old age and family allowances (over 80 years old and single elderly people), health insurance cards, many preferential credit programmes for employment promotion and housing, lowering of the prices of staple food in times of crises. People affected by catastrophic events receive cash, food support, health cards, preferential loans and vocational training, including seeds and livestock.

More than 40 poverty reduction policies and projects are dominated by three large programmes: (1) the Socio-economic Programme

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\textsuperscript{28} Health Insurance Law No. 25/2008/QH12, Resolution No. 15-NQ/TW (June 2012).


\textsuperscript{31} Decree No.67/2007/ND-CP and 13/2010/ND-CP
for Extremely Difficult Communes in Ethnic Minority and Mountainous Areas, [2] the National Target Programme for land, and [3] the newly approved resolution (30a/2008/NQ-CP) supporting the Rapid and Sustainable Poverty Reduction Programme for the 62 poorest districts with a poverty rate above 50%.

Decree 30/2012 regulates the operation of social funds. Many NGO and microfinance projects use these forms of social funds at the provincial level if they are not registered as an MFI with the Central Bank. Funds can also be collected under social organisations, such as the Farmers’ Association. They are operated at the commune level and receive money from government agencies, private businesses, and individuals.

The microinsurance market in Vietnam

The microinsurance strategy of the Government of Vietnam

Similar to other countries, microinsurance in Vietnam assembled and built itself from the microfinance industry groundwork. In its Microfinance Development Strategy adopted in December 2011, Vietnam propagated microinsurance development through two decrees:

- Regulating the Establishment, Organisation and Operation of Mutual Insurance Organisations Operating in the Insurance Business Domain (Decree 18/2005/ND-CP)

- Organisation and Operation of Small-Sized Financial Institutions as the partner-agent model with the insurance industry (Decree 28/2005/ND-CP)

Despite these decrees, in practice no mutual insurance organisation has been licensed. To date, the registration of organisations for operating microinsurance has been a bottleneck for scaling up because licensing takes a long time. The major delivery channels are mass organisations—the Vietnam Women’s Unit (VWU) and three registered MFIs. In addition, there is a high degree of decentralised, sometimes informal, operation of microinsurance, either by “agents” selling products under registered organisations or applying for local government approval to operate microinsurance as projects. This hinders scaling up and the ability to share the lessons learned with the national government agencies MOLISA and MOH.

Microinsurance products

The market is dominated by credit life products, which are often mandatory when applying for a loan. Very few health insurance products are offered by the two registered MFIs and the VWU. Some of them are in collaboration with private insurance providers. This low supply is partly due to the availability of the inclusive health insurance provision by the government, the subsidised health cards for poor and low-income people, and the weak health-care delivery system. There are also gaps in livestock and crop insurance products against weather-related risks. These gaps are not filled by the few agricultural insurance products partially subsidised by the government.

32 One example is the Social Risk Fund by MOLISA and GIZ managed by local authorities. It provides benefits in the event of accident, death, traveling costs to the hospital, and costs for the caretaker—hence complementing the government’s health care services.

33 Decision 2195/2011/QD-TTg dated December 6, 2011 of the Prime Minister, Vietnam.
Conclusions and recommendations

Despite several shortcomings, the national social insurance programme is best able to provide social protection to the informal sector, especially if many of the workers become eligible for the compulsory scheme. Since the government has established a basic social protection package even for the informal economy (though, de facto, many people are still uncovered), microinsurance could complement and supplement these existing public social protection benefits. And, despite the decrees for setting up mutual insurance organisations and allowing registered MFIs to function as agents of commercial insurers, Vietnam has yet to promote or integrate microinsurance into the social protection framework. Since the government is striving for universal coverage of social protection by 2020, with the option of voluntary social insurance, it may not yet see the importance of additional microinsurance products, although microinsurance is mentioned in the Microfinance Development Strategy (2011).

Key recommendations for Vietnam

Extend social protection coverage to poor and low-income people

- At present, the compulsory social insurance participation rate is low in non-state enterprises (approximately 42.6% of private enterprises) because many private employers do not register their workers (VASS/ILO 2011). This calls for a stronger enforcement of the social Insurance law that encourages enterprises to register their employees.

- Even if employers are encouraged to register their employees, enterprises with fewer than 10 workers are not covered by the compulsory social insurance benefits. They could benefit from microinsurance, as could migrants and low-income people, especially those with seasonal income (e.g., farmers) because the coverage of the voluntary social insurance is limited (except health insurance).

Improve social protection benefits

- Missing from voluntary social health insurance are work injuries, disability, maternity, and death benefits. Adding simple products to existing social protection programmes could be an important step toward complementing and supplementing social protection benefits.

- Although the benefit package of social health insurance is relatively comprehensive, out-of-pocket expenses can be high. Health microinsurance could supplement voluntary health insurance to cover, for instance, costs of a patient’s caretaker or a maternity lump sum benefit. Problems pertaining to the inadequate health-care facilities prevail and limit the acceptance of health insurance.

- Disability benefits under a microinsurance product can provide a bridge to meet livelihood expenses between the time of the disability event and the actual disbursement of social assistance. The disabled individual would not need to take out loans to pay for medical costs and livelihood support during the interim period.
- Although the Vietnamese government provides several loan products within its social protection programmes, credit life insurance products against loan defaults are missing. Funeral grants currently provided within social assistance and social insurance programmes could be a potential insurance product.

- Risk coverage against weather-related shocks is insufficient as the emergency relief compensates only approximately 10% of household damages. Weather-related insurance against livestock and property could reduce some of the damages caused by catastrophic shocks. The government has initiated a trial agricultural insurance programme (315/2011/QD-TTg) wherein the agricultural insurance (primarily for the rice crop) offered by the two state-owned insurers would operate in 20 provinces (two districts in each province). Although this programme is substantially subsidised, the current enrolment rates are low.

**Increase access to social protection and microinsurance**

- Vietnam has issued several decrees supporting mass organisations, non-profit organisations and communities in social protection and poverty reduction programmes. In practice, the focus is on mass organisations, especially the VWU. To date, only one organisation has applied for a mutual insurance organisation license; the process is pending. The other two registered MFIs deliver microinsurance under the partner-agent model. Other systems are officially not permitted. However, several organisations have applied for projects with local governments. If granted, they can implement various activities, such as microinsurance and social risk funds. Whilst this system can work at the local level, it lacks the potential for scaling up to more clients. It further denies the national government the opportunity to learn from these experiences and incorporate them into national social protection policies.

- The extremely low sales of the voluntary social insurance could be partially overcome by collaborating with the VWU, which happens only at the local level on the initiative of the VWU linking its members to the governmental Vietnam Social Security social health insurance. However, the Vietnam Social Security should be more proactive in approaching MFIs, such as TYM, whose health microinsurance product complements the government’s voluntary health insurance. TYM further assists its clients in enrolling in the government’s voluntary health insurance and organises preventive health-care measures, hence operating in support of Vietnam’s health policy.

- Shifting some risks to the insurance sector would have advantages, such as addressing cash flow constraints after catastrophic events and structurally addressing fiscal challenges, should voluntary and contributory insurance mechanisms take off. Commercial insurance providers like Manulife and Groupama are willing to further explore the low-income market.
Consolidated experiences from Brazil, Cambodia, and Rwanda

Over the past decade or so, many countries have come to acknowledge microinsurance (particularly health microinsurance) as an important risk management instrument for the low-income market. Cambodia and Rwanda developed systematic strategies of integrating health microinsurance into the national health policy in an attempt to work toward universal health coverage, whilst Brazil practices a two-prong policy (the lessons of the three countries are integrated into the ‘Lessons Learned’ section in the upcoming pages).

The Rwandan government decided upon a hybrid model that combines subsidised, mandatory public health insurance with a community-based institutional setup, resulting in a coverage of more than 95% of the population (in 2010). The CBHI delivery model is integrated into a pluralistic social health protection system with a minimum benefit package.

The government sees CBHI as a transitory path toward a unified, public social health protection scheme under one umbrella organisation—the Rwanda Social Security Board—even whilst private insurance schemes reach out to higher-income populations.

In the presence of government policy support and a health-care provider system, CBHI can deliver greater and faster population coverage. Despite this success, CBHI suffers slight challenges of equity, as patients are still required to pay for services at the point of care (co-payments) and the flat rate fee poses a higher burden on poor and low-income groups.

The Cambodian “Social Health Insurance Master Plan” is a pluralistic contributory and subsidised approach that incorporates various health insurance schemes: (1) compulsory social health insurance for the formal sector, (2) voluntary health insurance through CBHI for the informal sector of people who live above the poverty line (run and supported by local and international NGOs and development partners), (3) social assistance to the poorest through Health Equity Funds (HEF), and (4) tax-funded public health care (often with user fees) for those who can afford it.

The government’s multi-pillar approach to extending social health protection coverage is based on its intention to eventually merge all pillars into a single social health insurance scheme. They intend to then replace the HEF with membership in CBHI (informal sector people above the poverty line) and SHI (formal economy) for most of the population. However, the current indicators point in the opposite direction; whilst the HEFs have been very successful in extending coverage to the poor (and near-poor), CBHI schemes have struggled to increase coverage and continue to rely on donor support, meaning actuarial rates are higher than member contribution rates, and thus point...
to the limitations of substituting CBHI for social insurance.

A separate microinsurance law that reduces the entry criteria for new microinsurers has been attempted in Cambodia. A microinsurer (a separate insurance company) can be registered with a capital of USD 150,000. The Ministry of Economy and Finance issued a circular in June 2011, which enables temporary licensing of microinsurers that can be renewed on a yearly basis. A separate sub-decree on microinsurance was considered but is yet to be enacted.

Brazil's social protection system applies a different approach through the flagship Programa Saúde da Família (PSF) programme—one of the main strategies for achieving universal health care. The PSF covers over 96% of Brazil's population, focuses on families and not on individuals, uses an innovative approach of multidisciplinary family health teams formed by core medical professionals and community health agents. Tax financing, on which Brazil's PSF universal health-care programme is built, removes the need for expensive insurance administration systems. It has proved the most equitable system in terms of raising and distributing health resources fairly across the whole population. This is the reason why additional private health microinsurance faces strong headwinds.

In addition, Brazil has chosen a structured process for defining the role of microinsurance within its social protection system and financial inclusion policy. Brazil's government and regulatory bodies have stated that active support for microinsurance can be argued if it has relative advantages over other forms of social protection. However, the National Private Insurance Council's Consultative Commission on Microinsurance in Brazil reported that microinsurance contributes to achieving social inclusion by effective and efficient outreach to informal groups, partially resulting in reduction of fiscal contribution (which could be a sign of decreasing solidarity).

Brazil's Ministry of Social Development administers the Bolsa Família, a social cash transfer scheme that links social assistance with the financial system. It pays the recipients of the Bolsa Família through a (simplified) bank-based transfer system, thus promoting financial and social inclusion. The basic bank account would be the edifice for further financial interventions like microcredit and microinsurance.
Governments have increasingly recognised the need for social protection, especially for vulnerable people in the informal economy. Looking at the previous country studies, all the governments have established:

- Some universal programmes for all citizens, such as basic education, skill training, and basic health care, but struggle with problems of weak service quality and high out-of-pocket expenses.

- Statutory social protection for the formal economy, civil servants, and the military.

- Social assistance and other targeted social protection and poverty alleviation programmes for the poor, vulnerable around the poverty line, special groups like people with disabilities, ethnic groups, and relief programmes for affected people.

Some of the analysed governments provide social protection benefits to parts of the informal economy, for example health insurance through the CBHI model in Cambodia and Rwanda and broader benefits in India and Vietnam. In addition, private health insurance is available to the high income market, although often parallel to and not linked to the government strategy.

An analysis of the public systems revealed certain shortcomings and inconsistencies pertaining to coverage of underserved populations, benefits, and access to social protection.

**Population coverage**

- The poor, near-poor, and special groups are not fully covered because eligibility criteria differ across the many targeted programmes including people not organised in groups.

- Low-income people not eligible for targeted social protection earn too little to buy commercial insurance products.

- Seasonal workers occasionally fall between categories of targeted social protection programmes and lack access to statutory social protection.

- Migrant workers are often not covered under social insurance laws and face problems with registration at their place of origin.

- Regular (formal) workers in establishments below the defined number of employees (typically a threshold of 20) or working in enterprises not officially registered under “formal enterprises” do not receive statutory social protection benefits.

**Benefits**

- Low benefits of too many social protection programmes due to fragmentation of benefits.

- Weather-related catastrophic risks of agricultural and livestock losses are underrepresented.

- Extremely insufficient old age protection is offered by the state, if at all; client value of the few existing endowment insurance products is low.

- Insufficient health coverage is commonly observed. Poor public health care adversely affects acceptance of health products; most health microinsurance programmes focus on hospitalisation, resulting in high out-of-pocket expenses.
Access

- Fragmented systems of many programmes consume significant human and financial resources (expensive administration), result in low understanding of the programmes (by government officials and people), as well as ineffective delivery, and costly and time-consuming access to social protection programmes (benefits are often too marginal compared with the effort of applying).

- Problems related to “targeting” and “leakages” arise from defining effective eligibility criteria, identifying the poor and vulnerable population, and lead to abuse of the system.

Whilst the goal of social protection is to prevent, reduce, and eliminate economic and social vulnerabilities to poverty and deprivation, the reality looks different. Keeping the challenges in mind, the Social Protection Floor (SPF)—and in particular the ILO—promotes a more coordinated design and implementation of social and labour policies in order to guarantee a country-defined specific, basic set of social rights, services, and facilities that every person should enjoy. The SPF concept has been developed in the framework of the two-dimensional approach of the Global Campaign on Social Security for All, aiming at achieving universal coverage of the population:

- The horizontal dimension consists of a minimum package of transfers, rights, and entitlements which provide access to essential medical care and promises sufficient income to all in need of such protection.

- The vertical dimension provides higher levels of social security in line with the coverage and benefit requirements of the ILO’s Security (minimum standards) Convention (1952, No. 102) and more recent conventions providing for higher levels of protection.35

The SPF approach takes into consideration the national constraints of countries (vertical dimension) whilst promoting a basic universal level of social protection to all (horizontal dimension). The gradual implementation of the SPF-I is essential for the development and sustainability of a system that should extend the scope, level, and quality of benefits and services.

Within the context of the SPF, there is concern that microinsurance could jeopardise the principles of social protection and divert from the “normative approach” of social protection. This concern presents a challenge and has to be corrected by the respective governments through policy measures. The preferred situation is that contributory microinsurance plays a supplementary and complementary role, in conjunction with a broad range of basic social protection instruments. Still the questions remain regarding the quality of basic social protection benefits. On one hand, a very low standard would quickly force the people to buy microinsurance (less solidarity and equity), whilst on the other hand, a higher social protection standard creates incentives to remain within and contribute to the public systems, resulting in a higher degree of solidarity and equity.

The provision of basic services differs across the six countries and is far from ideal. Nevertheless, microinsurance could play an important role even if the products are not strategically integrated into the local social protection policies. There are strategies for the six countries (Bangladesh, Brazil, Cambodia, India, Rwanda and Vietnam) to deal with microinsurance within their social protection systems. The following sections present and analyse these approaches vis-à-vis the three social protection principles of universal coverage, equity, and solidarity whilst the upcoming Recommendations section elaborates on extending coverage, improving benefits and increasing access to microinsurance and social protection.

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35 www.socialprotectionfloor.org
Government policies to integrate microinsurance into the public social protection system

The strategies employed in the six analysed countries can be clustered as follows:

- Microinsurance as a transitory instrument toward universal health social insurance
- Separate social protection legislation for the informal economy, including microinsurance
- Defining the role of microinsurance in the context of social protection
- Absence of explicit microinsurance government policy but presence of other forms of extending social protection coverage to the informal economy

These strategies will be analysed with respect to the three social protection principles: universality, equity, and solidarity. In addition, access will also be analysed to evaluate the potential for increasing access to social protection and microinsurance services, since legal entitlements do not necessarily lead to access.

Whilst Table 4 presents all practices, the analysis focuses on public policies. Cambodia and Rwanda put energies into integrating health microinsurance into the national health policy. Both countries perceive microinsurance only as a transitory instrument toward comprehensive social insurance coverage (Wiechers 2013).

India created the Unorganised Sector Workers’ Social Security Act 2008, integrating microinsurance into the social protection system, but is implementing the Act in phases. Dominant in this strategy is the PPP arrangement between central and state governments, third-party administrators, private pension fund managers, and insurance industry that offers health insurance (RSBY), pensions (NPS), and a life insurance package. Alongside separate legislation for the informal economy, which includes microinsurance, India has additionally defined microinsurance as a separate segment within its insurance regulatory framework.

Brazil has chosen a structured process for defining the role of microinsurance within the social protection system and financial inclusion policy; only health insurance has a different system, as it is regulated by the National Agency for Supplementary Health and a government health programme is in place. The government will only actively support microinsurance if it has advantages over other forms of social protection.

The governments of Bangladesh and Vietnam have not yet developed such microinsurance policies, but they have initiated first steps. However, Vietnam offers the scope to enrol in voluntary social insurance (although with a lower benefit package than for the formal sector) and voluntary health insurance (with the same benefits as in the formal economy). Within the 2012-2032 Health Care Financing Strategy the Bangladeshi government explores the potential of the currently NGO/MFI-operated health microinsurance as a transitory instrument toward universal health coverage.

Microinsurance as a transitory instrument toward universal social health insurance

Cambodia and Rwanda started with a health microinsurance model and then integrated it into the national health policy striving toward universal health coverage (Wiechers 2013). Other health systems coexist.

Rwanda covers its population through different schemes that concentrate on distinct target groups; namely, social health insurance for civil servants/military, employer-based private health insurance for the formal economy, and mandatory CBHI for the general population in order to achieve universal coverage. The CBHI in Rwanda is a hybrid model that combines subsidised, mandatory public health insurance (especially for the informal and rural sector) with a community-based institutional setup. The gov-
### Table 4: Role of microinsurance within the social protection systems of countries studied

<table>
<thead>
<tr>
<th>Practices</th>
<th>India</th>
<th>Bangladesh</th>
<th>Vietnam</th>
<th>Rwanda (only health)</th>
<th>Cambodia</th>
<th>Brazil (only health)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government policies</strong></td>
<td>Unorganised Sector Act (including microinsurance); integrating microinsurance into welfare funds; integrating microinsurance into social assistance; subsidised microinsurance—PPP; specific microinsurance regulation and quota system</td>
<td>No integration of microinsurance into social protection policy but exploration of health microinsurance as a transitory mechanism for universal health coverage in the Health Care Financing Strategy</td>
<td>Voluntary social insurance</td>
<td>Microinsurance as step towards universal health care (setting standards for CBHI) (government pools)</td>
<td>Social Health Insurance Master Plan; Microinsurance/ CBHI as step towards universal health care (setting guidelines for CBHI)</td>
<td>Temporary license (with yearly renewal) for microinsurer is possible</td>
<td>Microinsurance as part of social protection (without setting limitations or standards); due to national tax-funded Family Health Programme, government issued strict rules on supplementary health microinsurance</td>
</tr>
<tr>
<td><strong>Other official microinsurance practices</strong></td>
<td>NGO/MFI and other official delivery channels for microinsurance</td>
<td>Microcredit Regulatory Authority Act provision to sell microinsurance to members of licensed financial institutions; draft microinsurance regulation</td>
<td>MFIs bundle credit insurance product, underwritten by an insurer</td>
<td>---</td>
<td>MFIs bundle credit insurance product, underwritten by insurer</td>
<td>Other health microinsurance offered by cooperatives; strict rules for supplementary health plans</td>
<td></td>
</tr>
<tr>
<td><strong>Other unofficial practices</strong></td>
<td>Community-based microinsurance schemes; full service providers</td>
<td>NGO/MFI operation of microinsurance (not licensed under MC Act)</td>
<td>Projects permitted by local government</td>
<td>---</td>
<td>NGO/MFI operation of credit microinsurance</td>
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</tbody>
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government perceives CBHI to be a transitory path toward a unified, public social health protection scheme under one umbrella organisation—the Rwanda Social Security Board (Wiechers 2013).

Cambodia’s Social Health Insurance Master Plan is a pluralistic contributory and subsidised approach that incorporates various health insurance schemes: (1) compulsory social health insurance for formal sector, (2) voluntary health insurance through CBHI (run and supported by local and international NGOs and development partners) for those informal sector workers and their families who live above the poverty line, (3) social assistance to the poorest through health equity funds (HEF), and (4) tax-funded public health care. The Guidelines for the Implementation of CBHI were passed in 2006 as part of the implementation of the SHI Master Plan aiming to establish a network of CBHI along common principles (WHO 2003 and Cambodia MOH 2008). The CBHI guidelines provide for some standardisation across the range of CBHI schemes, and shifts CBHI from a pure community-control model towards a government-supervised and -guided model. This is a logical reflection of the government’s commitment to integrate the CBHI schemes into a unified health insurance mechanism.

How does this approach contribute to the social protection principles?

- **Universality:** Both countries perceive microinsurance only as a transitory instrument towards comprehensive social insurance coverage. Microinsurance, due to its contributory premium component, cannot lead to universality by itself, as at any time there would be a section of the population who cannot afford premiums. However, in Rwanda, already 97% of the population has been covered since 2010 due to government support and its policy of making health enrolment mandatory. In this case, CBHI is not considered as a distinct additional instrument that competes with or complements other social protection programmes but as a means toward universal social health insurance. Currently, the CBHI delivery model has significant advantages in reaching broad segments of the population in contrast to the government social protection institutions.

In Cambodia, the voluntary CBHI has struggled to increase its coverage to half of the informal population. Overall, Cambodia demonstrates CBHI’s limitations in extending health insurance coverage in a society where the majority of the population is poor and where, as a result, precise targeting is difficult.

- **Equity:** Rwanda provides a basic health-care package with limited benefits due to financial constraints of the government. This, in general, is an equitable approach although the practice differs as high-income groups can afford private insurance and patients are still required to pay for services at the point of care (co-payments). The government matches contributions to CBHI in order to provide for services at higher levels of care. The CBHI flat rate contribution has led to a higher burden on the poor than on other income groups. The government has therefore decided to improve the balance of contributions by establishing payments according to ability to pay, regulating co-payments and allowing more flexible membership terms (Rwanda Ministry of Local Government 2011).

Cambodia lacks an equitable approach due to user fees, private insurance and health-care providers for those who can afford it. Since many informal workers can hardly afford the CBHI contribution, this results in heavy donor funding of CBHI and widespread health equity funds (social assistance program) providing tax-funded health care to the poor in more than half the Cambodian districts.

- **Solidarity:** Whilst Rwanda has introduced mandatory health insurance so that the risk pool covers almost the entire population and is in line with the solidarity principle, Cambodia has not yet reached this stage.

- **Access:** The current systems promote a basic social health insurance but apply a CBHI delivery model which increases the access to insurance. Given the economic situation of both the countries, this approach has its advantages, as the members trust their system and enrol. As can be seen from the examples, the community-based system does not automatically increase access. In contrast to the compulsory model in Rwanda, the voluntary
system in Cambodia faces problems with members’ affording premium and enrolment. CBHI prepares beneficiaries for health-related risks, builds greater health awareness, and creates institutional capacity. However, Cambodia’s experience shows the limitations of using CBHI as a substitute for social insurance, in particular when the government is committed to building universal coverage of social health insurance. The major obstacles are related to the large number of poor people and the affordability of insurance premiums. For greater solidarity, a one-model approach could work, e.g., moving from the HEFs to a more insurance-based health protection model and directing subsidies toward CBHI membership for the poor. This would also enlarge the risk pool of the CBHI schemes. The Bangladesh Health Care Financing Strategy 2012-2032 explores using CBHI and other microinsurance models as interim mechanisms toward universal health coverage—which, if achieved, is the most promising way.

Separate social protection legislation for the informal sector

In 2008, India passed the Unorganised Sector Workers’ Social Security Act. The Act recommended formulation of social security schemes, specifically life and disability cover, health and maternity benefits, old age protection, and any other benefit for unorganised workers, as could be determined by the government. As a follow-up to the implementation of the Act, India established the National Social Security Board in August 2009. It has since recommended extension of coverage of social security schemes, namely, JBY, RSBY, and IGNOAPS old age protection, which apply to certain categories of unorganised workers. The Act is being implemented in phases and should cover all registered informal workers. In addition, India offers a significant number of private microinsurance products that are partially supported by the government (see ‘Role of microinsurance defined in the context of social protection’).

How does this approach contribute to the social protection principles?

- **Universality:** Theoretically, universality is attempted by the Indian government for the informal economy once the Act reaches all registered informal workers. However, the criteria and the practice of registration would need to be critically analysed at a later stage and, perhaps, given the size of the Indian population, work with a scalable, technology-assisted solution. As the three schemes are not offered as a package, their outreach differs; the IGNOAPS is only available for old age destitute applicants, the JBY could benefit all rural landless households and the subsidised RSBY (as part of the social assistance system) enrols over 40 million families.

- **Equity:** If all registered informal workers were enrolled, equity would still not be ensured, and the government supports various other partially subsidised microinsurance products and tax financed social protection programmes with different benefits. Moreover, the formal economy, with the statutory benefits and occupational groups covered under the welfare funds, receive better benefits, and the high income population can afford private systems.

- **Solidarity:** If the schemes are extended as planned, the problem of redistribution is reduced (not abolished) as the risk pool is much larger than it is with voluntary, contributory, stand-alone microinsurance, which is often designed for a select customer group. Solidarity is strengthened because the products are publicly subsidised for the poor and those marginally above the poverty line.

- **Access:** The weakness of the Unorganised Sector Workers’ Social Security Act is fragmentation of the products and outreach to the entitled people. Access could be enhanced if the offering were harmonised, embedded with the technological system of Aadhar biometric cards for premium payments. Claims settlement could be linked to the no frills

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36 It would exceed the scope of the paper to discuss the successes and challenges related to RSBY that are debated internationally.
bank accounts. These could be offered as a holistic package, perhaps with the exception of old age benefits for the destitute above 65 years. Improving access would require the national and state level Social Security Boards to work together with stakeholders and grassroots NGOs. At the time of writing, not all Indian states have constituted a Social Security Board, which hampers the goal of providing the state’s poor citizens access to the schemes.

In addition, the Indian government has developed welfare funds for selected occupations. These are not in the form of contributory microinsurance, although some of the welfare funds contain RSBY and a life microinsurance package. In terms of assessment vis-a-vis social protection principles, welfare funds score low on universality, as the coverage is restricted to select occupations. Solidarity is achieved as basic social protection and is provided in the welfare funds benefits and contributory microinsurance supplements coverage. However, equity is not fully possible due to the restriction of benefits to only selected occupations and different action (and inaction) under a federated government structure i.e., some state governments have not galvanised welfare funds.

Role of microinsurance defined in the context of social protection

Brazil has chosen a structured process for defining the role of microinsurance within its social protection system and financial inclusion policy but without setting limitations or standards for microinsurance. The exception is health insurance (including microinsurance), which is regulated by the National Agency for Supplementary Health that promotes the tax-funded Family Health Program. The Programa Saúde da Família (PSF) is the most important national health programme for primary care, with the aim of enabling universal access to health services under the basic principles of universality, equity, comprehensiveness, and community participation. As the MOH supports the PSF, the government regulation imposes strict rules for supplementary health plans in order to achieve equity in access to care. These rules make health microinsurance expensive compared with non-health microinsurance policies. This puts health microinsurance out of reach of the low-income segment, although benefits added to non-health policies, like hospital cash benefits and drugs cost reimbursement, are popular even for the low-income market (Bester et al. 2010).

Brazil recognises microinsurance as an important element of its social protection system and states clearly that it will actively support microinsurance only if it has advantages over other forms of social protection. The Brazilian market also has a huge number of private microinsurance products (including those for the higher low-income market) within the defined government policies.

Apart from policies such as the Unorganised Sector Workers’ Social Security Act, 2008, the Indian government applies a number of policies and interventions for the promotion of microinsurance:

- Subsidised products based on insurance principles for the poor as a part of social assistance or weather-related relief programmes. This market-based approach of targeted social protection transfers some risks to the insurance industry [e.g., RSBY and the index product WBCIS] and reduces constraints on the fiscal budget by smoothing the government’s cash flow whilst ensuring benefits for the respective population (particularly subsidised agricultural index insurance, which is mandatory for borrowers from banks and voluntary for other farmers regardless of land holding).

- PPPs, especially in the area of health care and health microinsurance. For instance, the Andhra Pradesh state government covers the premium of more than 36 million insured within the Rajiv Aarogyasri Community Health Insurance Scheme in partnership among the Aarogyasri Health Care Trust, the insurance industry, the service providers, the district administration of the state, and the federation of self-help groups who appoint health workers.

- Specific microinsurance regulation and the rural and social sector quota systems exist
for the insurance industry. The Indian regulator has notified microinsurance regulations by defining benefit caps and lighter licensing for microinsurance distributors (NGOs/ MFIs/ SHGs/ banking correspondents). These policies have further stimulated the insurance market, which offers a wide range of microinsurance products. Community-based schemes and in-house insurance schemes are not officially recognised or supervised by the regulator.

How does this approach contribute to the social protection principles?

- **Universality:** As the Indian products are voluntary, they cannot contribute to universal coverage but play a complementary and supplementary role to other social protection programmes. However, the IRDA microinsurance regulation and its quota system has increased the range of products and has contributed to the promotion of microinsurance. Well-designed and properly monitored PPPs, in collaboration with self-help groups and NGOs, can improve health-care services and subsidised health microinsurance for the local poor, but not for larger parts of the society. Ideally, the government would provide a basic social protection system, but due to lack of a consistent package and lack of coordination between the central and state government apparatus, the fragmentation remains within the Indian system.

In the case of Brazil, the PSF is one of the main strategies for universal health care and has covered almost 70% of Brazil’s 200 million inhabitants (Oxfam 2013). It is understandable that the government introduced strict regulations on additional health microinsurance and only promotes it when health microinsurance offers advantages over the PSF. The other microinsurance products do not contribute, nor are they intended to defer to universality. They play a supplementary role.

- **Equity:** Just defining a role for microinsurance within social protection would not normally lead to equitable impact. The Indian systems are still too diverse to commit to an equitable policy. The numerous microinsurance products available in Brazil are voluntary and not standardised, hence they do not contribute to equity. The strict rules for “supplementary health plans” like microinsurance are imposed in order to achieve equity in access to public care.

- **Solidarity:** The policy of defining the role of microinsurance is not meant to solve the problem of redistribution, especially when products are voluntarily offered. But if a basic health or social protection system is in place, a supplementary or complementary role would not contradict this principle.

- **Access:** Brazil’s PSF, which promotes community participation in planning, implementation, and evaluation of actions has contributed to high enrolment but is still incomplete in most cities. This may be due to weak organisation of people in community groups. The positive role of civil society and community-based organisations in providing social insurance access is identical in India. These examples highlight the crucial role civil society has to play when microinsurance is defined in the context of social protection.

If governments define the role of microinsurance systematically in the context of comprehensive public social protection, microinsurance can play a very important complementary and/or supplementary role, assuming basic protection is available. However, this is only applied in the Brazilian health insurance system (even if it leads to a restricted policy on health microinsurance). The vibrant microinsurance sector in India provides significant protection, but is still largely uncoordinated and not harmonised with the current government policies. They could mutually benefit each other when considering that major lifecycle and income risks such as health, disability and property losses are not offered by microinsurance providers because of the inherent complexities of these products and the regulatory uncertainty. The same applies to the social insurance receivers, who receive social security benefits only for some of their risks.
No explicit government policy on microinsurance

The governments of Bangladesh and Vietnam have not yet developed microinsurance policies. Their strategies for social protection differ significantly. Vietnam has, to some degree, extended the benefits for the formal economy workers to the informal workers and offers the ability to enrol in voluntary social insurance (although with a lower benefit package than for the formal sector) and voluntary health insurance with the same benefits as in the formal economy.

The Vietnamese government is currently not actively promoting microinsurance as a part of its social protection system. It strives for universal coverage of social protection and has introduced voluntary social insurance, including voluntary health insurance for the informal economy (which can be transferred from formal to informal economy workers). The existing legal provisions for mutual insurance organisations and the broader scope for partner-agent microinsurance delivery are not actively promoted by the government. The very few local risk funds are operated independently of the public social protection system but require permission from the respective local governments—a missed chance, as some products could supplement and complement current social protection system (e.g., the preferential credit programmes of the government, which are not insured).

In Bangladesh’s public social protection system, insurance solutions are lacking even for catastrophic risks, which render a significant strain on the government’s budget. However, many credit life microinsurance products are sold independently by MFIs and NGOs. Only a few NGOs offer health microinsurance products and link their members to public preventive health care, else there is no official process of integrating microinsurance into the public social protection system and, hence, few lessons are generated at the national level. Recently, PKSF—the semi-governmental organisation that provides funding to MFIs as a part of the government’s social assistance credit policy, started to develop microinsurance products and may be officially regulated for microinsurance. Whilst the MFI/NGO microinsurance sector is totally uncoordinated and lacks cross-fertilisation for improving microinsurance services, the PKSF initiative could overcome this currently fragmented microinsurance sector whilst also taking cognisance of the role of MFIs/NGOs as delivery channels. There may be some scope for better coordination if the government within its Health Care Financing Strategy 2012-2032 explores microinsurance as an interim mechanism for the informal economy until universal health coverage through the Social Health Protection scheme is achieved.

How does this approach contribute to the social protection principles?

- **Universality:** Vietnam is aiming towards universal health coverage by 2020, but the voluntary social health insurance enrolment for informal economy with very low coverage is far from being a universal system. This is primarily a weakness of the distribution system (see Access below). The very few risk funds operated at the local level are insignificant when compared with the public social protection system.

  In its attempt to expand social protection and develop an integrated national social protection strategy, Bangladesh has approved the Health Care Financing Strategy aiming to achieve universal health coverage. In this context the government will explore microinsurance as an interim step towards coverage of the entire population. To date, only initial steps were taken by the semi-governmental PKSF. The diverse NGOs/MFIs products cannot contribute to universal coverage.

- **Equity:** Vietnam’s health coverage, through the voluntary Social Health Insurance ranks high on equity, as it offers the same benefits as the formal economy. The problem remains for social insurance (pension, accident, disability etc.) as the benefits differ between formal and informal economy. Notably, full premium is paid by informal workers, regardless of their income and without benefiting from any employer share applicable to the formal economy. The current NGO/MFI microinsurance practice in Bangladesh is too small and too diverse to contribute to equity.
- **Solidarity:** The Vietnam voluntary Social Health Insurance introduced a range of subsidies based on the income and vulnerability of people. It follows a solidarity approach, as it reaches a substantial segment of the population. Redistribution poses a major challenge to the current microinsurance practice in Bangladesh, but may be improved in the area of health coverage once the Health Care Financing Strategy 2012-2032 will achieve broader results.

The few existing microinsurance products in Vietnam are not conceptually drawn up to complement or supplement the government benefits to low-income people, but if designed systematically, they could provide additional protection to the currently underserved people offering benefits not envisioned within the present social protection system. A restrictive microinsurance policy as currently practiced in Bangladesh does not contribute to the three social protection principles but, nevertheless, can provide important benefits to people.

- **Access:** Vietnam faces severe problems with voluntary enrolment, which somehow jeopardises the positive aspects of policy. The involvement of civil society would significantly enhance coverage and thus bridge the gap between the conducive government policy and low-income people. In contrast, Bangladesh MFI and NGO members have access to microinsurance, but do not gain from shared lessons about enhanced benefits and services. Since the Bangladeshi government realised its weakness in reaching out to the population, it established a semi-governmental institution, PKSF, which acts as the apex funding organisation for microfinance. PKSF’s role is embedded with the Social Safety Net Program and since 2012 it has taken initial steps to develop microinsurance. Depending on the policy, a more integrated approach would build on the strength of civil society organisations combined with a national structure that could consolidate the lessons and potentially revise microinsurance practices toward enhanced client value and outreach.
Situating microinsurance in social protection - Lessons from six countries
RECOMMENDATIONS

These recommendations are based on the findings of the six country studies and are of general nature for potential replication in other country settings. They take into consideration the fact that social protection, including microinsurance, should be in line with—or at least contribute to—the three social protection principles (universality, solidarity, and equity) and the roles microinsurance could play for public social protection.

Microinsurance is limited in scope and most successful in two scenarios: (1) in combination with other risk management measures, namely prevention, mitigation, and coping strategies operated by informal, private, and public institutions, and (2) when integrated into a comprehensive social protection policy within an adequate legal framework (including microinsurance or inclusive insurance regulation).

Microinsurance is only suitable for risks which are insurable: death, accident and disability, and illness. Despite weather-related catastrophic risks (e.g., crops, livestock, and other property), which are not part of the key social protection provisions, they are included because they contain a severe risk for agricultural smallholders and microinsurance products are available. Old age income security is categorised more as a financial than insurance product, although a few endowment products with a lump sum payout are sold by the insurance industry. Without an adequate government policy, poor and low-income people are unable to take care of sufficient old age protection, and neither microsavings nor microinsurance alone will solve this inherent problem. Small savings are, however, useful.

Microinsurance can provide protection to underserved people of the informal economy and also complement and supplement other forms of social protection for the low-income formal sector. But if basic public social protection systems are not available, contributory voluntary microinsurance jeopardises the principle of solidarity. As stand-alone protection, microinsurance contributes to neither universal coverage nor to equitable access; it cannot provide universal coverage for all citizens.

In the Country Studies section, the government policies of six countries were analysed with respect to (1) their social protection policies focusing on vulnerable informal workers, (2) the role of microinsurance for social protection, and (3) the government strategies to integrate (or not integrate) microinsurance into social protection interventions. This analysis was driven by an affirmation that at least basic social protection should be available to all people according to the principles of universality, solidarity, and equity following the pragmatic stepwise recommendation from the ILO to the SPF-I (as described in the Lessons Learned section).

The following recommendations are based on the assumption that:

- Although some countries strive toward universal health coverage, it has not yet been achieved (except in Rwanda, with basic benefits). Hence, the paper offers suggestions for extending coverage to the presently underserved population and describes a role for microinsurance.

- In all countries, several basic, targeted-, social assistance programmes are provided, but most benefits are so marginal that additional coverage is required. Hence the paper recommends ways of improving benefits, especially for the upper poor or other vulnerable groups who could either afford contributory microinsurance or subsidised microinsurance, knowing that it is the role of the government to provide adequate protection. The strategic question remains whether governments should invest in microinsurance subsidies.
(and, if so, what would be smart subsidies?), invest in increasing the social assistance benefits or apply a mix of both. There is no one single answer and the decision has to be taken on a case-by-case basis.

- As legal entitlements do not automatically ensure access to services, the paper recommends measures for increased access and superior delivery of social protection and microinsurance.

These three categories of recommendations refer broadly to two levels:
- Level 1: Microinsurance integration with social protection
- Level 2: General technical issues for improving public social protection and microinsurance practices

The following recommendations stem from the experiences of each country. They are a result of observations and so may not fully adhere to the ideal social protection practices.

Extending coverage to underserved population

Summary

- Provide a mix of targeted social assistance and contributory microinsurance for the upper poor and special groups within categories of social assistance receivers.
- Reach out to individual customers (in addition to group policies).
- Pay special attention to low-income people.
- Provide policy support to health microinsurance (including CBHI) as an eminent interim mechanism toward universal coverage.

In the absence of universal coverage—which should be the ultimate goal—microinsurance could provide some protection for neglected or underserved people. But even if basic social protection is provided, microinsurance could supplement or complement those social protection benefits. Through the following mechanisms, these groups could be reached.

- Provide a mix of targeted social assistance programmes and contributory microinsurance.

To support vulnerable people around the poverty line, a mix of targeted social protection programmes and contributory insurance systems could be an option, particularly for the upper or near-poor and the special groups category, such as ethnic minorities, single parent households, and people living in disaster-prone areas, who could buy products assuming they provide client value. Even people below the poverty line (social assistance receivers, but not the extreme poor) are willing to pay for insurance products of value. Such microinsurance products would complement or supplement existing targeted programmes.

- For clients with health insurance, additional benefits are useful, as most of the products provide only reimbursement of hospital treatment costs up to a predefined maximum amount. Microinsurance products providing coverage for additional expenses such as laboratory tests, special drugs, caretaker costs, loss of income, and hospitalisation transport are in high demand.

- Although the Vietnamese and the Bangladeshi governments provide many loan
products within their social assistance, poverty reduction, and market policy programmes, one missing is credit life insurance against loan defaults in the event of death. Straightforward initiatives that wrap a credit life insurance product with government loans would not only enhance the existing social protection benefit but, when executed with government support, could lay the foundation of an insurance culture.

- **Reach out to individual customers.**

  Microinsurance started with group insurance policies where affinity groups would enrol their potential customers and, in turn, educate and facilitate their members on the value of insurance. These groups still dominate the market, but large sections of the population are neither organised into groups nor linked to NGOs or MFIs. For microinsurance to significantly enhance its scale, these individuals need to be covered as well.

  In more mature markets such as Brazil, or when reaching out to better-off but vulnerable people, individual policies are increasingly available. Problems with adverse selection need to be reduced through other measures, such as waiting periods or co-payments if the insured event happens soon after buying the policy. Technology could reduce administration costs, allowing customers to pay premiums by mobile phones, ATM, or smart cards. What proved to be effective and efficient for product administration may be insufficient for selling microinsurance and must be complemented by institutional structures that can raise awareness and help individuals select and access appropriate microinsurance and social protection mechanisms.

- **Pay special attention to low-income people.**

  Low-income people who are neither covered by statutory social protection nor entitled to social assistance fall beyond the social safety net. They constitute the main customers for microinsurance and bear the full burden of its protection costs, which in turn jeopardises the solidarity and equity principle of social protection. If governments are not yet in a position to provide basic benefits, they need to pay special attention that the contributions for the low-income population are in line with payments proportionate to other population groups. Usually, governments address this issue by partially subsidising insurance premiums, which, in turn, causes the challenge of targeting.

  India introduced welfare funds for defined occupations. This is one model for providing social protection to workers in the informal economy regardless of worker income—though these occupations are usually low paid. The welfare funds are set up by the central government and are financed out of taxes collected on manufactured products (e.g., cigarettes and mining products) or 1-2% taxes on the construction costs of a building (benefiting construction workers). If the government could overcome the significant diversity of occupation-based funds, a consolidated system would contribute tremendously to the protection of low-income workers. Since the workers have basic protection provided from welfare funds, additional contributory microinsurance could supplement coverage and would not cause a problem with the principle of solidarity.

  Low-income, formally employed workers can benefit from microinsurance products that supplement or complement existing social protection or products that play an alternative role because existing social protection mechanisms may not be sufficiently customer-oriented or easily accessible.

- **Provide policy support to health microinsurance (including CBHI) as an eminent interim mechanism toward universal coverage.**

  Policy support of health microinsurance is a stepping stone toward universal health-care coverage. But, as the examples in Rwanda and Cambodia reveal, only when legally required can mandatory insurance lead to significant coverage (as in Rwanda, with over 90%). The voluntary system in Cambodia faces great challenges with affordability and enrolment. In economies where governments lack the fiscal and technical resources to implement a full-scale social health programme,
government policy supporting CBHI or other microinsurance models as a foundation to universal health care could be beneficial. The government’s role in building the capacity of underwriters, distributors, and providers would result in enhanced professionalism and larger risk pools.

Improving benefits

Summary

- Strive toward convergence and standardisation of social protection programmes and insurance products.
- Provide microinsurance as a bridge until public benefits come into effect.
- Offer more complex products or packages demanded, including Takaful Islamic products.
- Provide gender-sensitive benefits (and services) as necessary.

Existing social protection benefits span the risks of income and asset protection, including agricultural insurance, death, accident and disability, and health care, apart from many other uninsurable situations of crisis. Except for health protection in Rwanda and Cambodia, all countries have shown a high degree of fragmentation and inconsistencies in public social protection systems, resulting in small benefits and high administrative costs. Even so, in microinsurance, extreme segmentation of products is just as confusing as having too many fragmented public social protection programmes exist (the exceptions are Rwanda, Cambodia, and Vietnam).

Highly diverse and inconsistent public programmes make access difficult for the population and for the state administration to gain suitable overview. The situation could be improved through convergence of schemes, which could result in higher benefits.

Customer-oriented insurance products are required, but it is doubtful whether the huge diversity of products always creates additional value to customers. Some standardisation of products would be useful and need not compromise client-value. Standardisation would also be attractive to the insurance industry, for which the design of multiple, highly-specified products for a limited number of clients would be too expensive. This standardised approach could add to economies of scale.

Target-specific coverage in terms of exceptionally risk-prone groups or specific demands (rotating saving plans in particular) could be complemented by informal, but professionally operated, risk pools that people use regardless of their access to formal mechanisms.37

- Provide microinsurance as a bridge until public benefits come into effect.

Social insurance and social assistance provide benefits for people in critical situations (e.g., disabilities caused by accidents). As the process from the time a person becomes

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37 Research on informal and formal use of financial systems revealed that, even if people have access to formal mechanisms, they continue with informal risk management strategies (e.g., community savings and borrowing) [Samit Ghosh, 2013].
disabled to the time of the first payment from the public social protection system may be lengthy, disability microinsurance could address the gap so that the victim need not take out loans to pay for medical costs and loss of livelihood during the interim period. Similar critical situations occur in other circumstances. Such provisions could release the present burden of obtaining additional funding. For continuous financial support in the events of disability or old age, microinsurance would not be a solution.

- **Offer more complex products or packages demanded.**

  Although a large variety of simple credit life microinsurance products dominate the market, health hospitalisation insurance is increasing. More challenging benefits and product packages are in demand and could complement or supplement existing social protection programmes. For example:

  - **Income protection against agricultural losses.** With the poor living in predominantly rural areas, there is a severe lack of products insuring harvest failure and livestock or property losses. Transferring the risks to the insurance industry via index microinsurance could reduce unforeseen budget constraints in the event of natural calamities. These products need to be appropriately designed and operated so that basis risks are reduced.

  - **Products for special occupational groups.** Accident and disability covers for truck and rickshaw drivers and fire and catastrophic risks for small and medium enterprises are in demand.

  - **Takaful Islamic insurance.** This type of insurance may be perceived as more people friendly because of the important role Islamic banks play in rural areas (at least in Bangladesh).

  - **Old age.** Old age protection is one of the most severe gaps of social protection. It is usually restricted to retired formal sector employees and civil servants. Even for them, additional coverage could be useful. The small allowances provided through social assistance are not sufficient for livelihood with inflation chipping away the real benefit. From a social stability standpoint, it is noteworthy that some elderly people in receipt of a social protection benefit feel better, as they can marginally contribute to the household’s income, but in terms of livelihood the benefit is negligible. Although a few endowment products exist, with dubious value for the insured, old age security cannot be improved through microinsurance. Governments need to take supportive action, such as the Indian example of technology-driven, low-cost pension programme shows (Box 1).

**BOX 1**

**Example of pension scheme for informal sector**

To extend old age coverage to the weaker sections of society, the Indian government launched the National Social Pension System “Swavalamban Yojana” (with individual policies/ ’NPS Lite’ group policies) for the informal sector and economically disadvantaged sections of the population. It is a voluntary, contribution-based, defined contribution pension scheme, which provides small government subsidies in order to promote small savings for old age. Since microinsurance endowment policies for low-income people often do not provide valuable benefits, this government initiative seems to be a good alternative with collateral positive effects of financial education. In Vietnam, the government offers voluntary social insurance with pension benefits to members who contribute for at least 20 years. Micropension products could provide life pension benefits to such people who could not contribute for 20 years.
- **Gender perspective.** Women are more exposed to risks from working in unregulated, hazardous environments and more susceptible to illnesses due to sexually transmitted diseases, low nutrition status, and complications around pregnancy and childbirth. Hence, several governments have issued policies to enhance the situation of women and all governments implement programmes specifically supporting women and girls (e.g., scholarships for girls, loan programmes, skill training, etc.). Microinsurance could contribute to these efforts. Product design, if drawn from gender-specific demand studies, can help to reduce infant mortality and maternal death if current product exclusions are abolished and outpatient and preventive medical and gynaecological checks and pregnancy related issues are integrated into the healthcare benefits. Door-to-door premium collection and new technology (e.g., mobile phones and smart cards) provide access to microinsurance especially for women who cannot leave their homes. Simplified documentation for claims submission would be a prerequisite, as women are often less familiar with official written procedures and suffer a low social status resulting in lesser negotiating power on documentation (Ramm and Ahmed 2006).

### Increasing access to social protection and microinsurance

#### Summary

- **Bridge the gap between the government and low-income people.**

- **Train microinsurance agents and brokers.**

- **Pay attention to the practice of promoting insurance penetration by relaxing sales conditions.**

- **Support national microinsurance structures and knowledge exchange.**

- **Promote standardisation of CBHI model through government intervention.**

In general, delivery of public social protection programmes for the informal economy is still suffering from a lack of effectiveness. Even if a lean administrative structure exists (as in Vietnam), coordination amongst government departments is not optimised and the vertical linkages lack the involvement of actors who could reach out to the population.

Sustainable social security systems are a key element in promoting productive economic growth with equity (ILO 2011). If access to social protection benefits is difficult or denied because of poor delivery, the existence of improved products hardly matters.

- **Bridge the gap between the government and low-income people.**

When compared with government administration, trained civil society organisations have often succeeded not only in achieving greater reach, lower transaction costs, and better services in microinsurance, but also in social protection activities such as sanitation and health—provided they were appropriately trained and equipped with basic resources. In countries with a strong civil society sector like Bangladesh, there may be a tendency for NGOs and MFIs to implement programmes, which otherwise is the government’s responsibility. If both actors are willing to build upon each other’s strength, the government needs to institutionalise the supportive function of civil society organisations, clarify the roles and responsibilities of all stakeholders at all levels, authorise the civil society’s mandate, and arrange financial compensation for delegated tasks—without interfering in their internal matters. In contrast to microinsurance, where some regulators have defined the role
of civil society organisations and regulated microinsurance delivery (including financial compensation), similar developments have not yet taken place in other social protection systems.

- **Train microinsurance agents and brokers.**

  When cooperating with the private insurance industry, microinsurance delivery is dominated by agents, which limits the relationship to one insurance provider. As a result, customers are not able to choose between products from different insurance companies. This is not in the interest of the clients and runs counter to market principles. Only a few brokers have entered the low-income market—an opportunity which should be further explored. In addition, regulators could develop regulations for microinsurance brokers, enabling NGO/MFI delivery channels to obtain a licence for selling microinsurance products from multiple insurance providers. This would give their customers a choice—a practice which is occasionally applied by NGO/MFI agents without supervision but which needs more systematic and formalised development.

- **Pay attention to the practice of promoting insurance penetration by relaxing sales conditions.**

  The attempt by regulators to scale up microinsurance using agents who may be insufficiently trained will not enhance the insurance awareness of the low-income market and may potentially lead to unethical sales behaviour. For example, India’s regulator, IRDA, tightened product definition, benefit disclosure, and market conduct guidelines after heavy consumer activism against faulty selling of life insurance savings products. Similarly, members of delivery channels, who reach out to individual clients via over-the-counter selling, call centres, and mobile phone companies, may have received little training on broader risk pooling strategies. If their orientation focuses on the product to be sold, it is unlikely to provide sufficient assistance to customers. On the other hand, there are countries (e.g., Vietnam) who apply complicated licensing policies for agents hampering the distribution of microinsurance. Although conditions differ across countries, regulators have made little progress in setting quality standards for members’ microinsurance delivery (channels) which would be reflected in training curricula.

- **Support national microinsurance structures and knowledge exchange.**

  Especially in countries with an active civil society involved in microinsurance and poverty reduction and with dispersed community-based schemes, a systematic information exchange about client value of products and cross learning is underdeveloped. National institutions would be in a position to contribute to more clarity about the variety of products and obtain information on client value, potentially leading to adjustments of products and services in favour of the clients. Decentralised delivery channels would still be important due to proximity to potential customers.

  A combination of national and local structures would also allow leveraging of capacity development and delivery effectiveness. Government support for creating national community-based structures in Rwanda and Cambodia is a positive example. Taking the initial step explored by the Bangladeshi government—the idea of giving the national PKSF a more prominent role in microinsurance—would contribute to overcoming the extreme diversity in Bangladesh. It would further create a link between microinsurance and social protection when such a body is established as a semi-governmental apex funding organisation for microfinance activities as part of the government’s SSNP.

  At the international level, a product database of good practices and critical issues would create transparent indicators and could be instrumental in product development. One should understand that each market is different and a product or its strategy that is successful in one country may not be replicable in another. Whilst the lessons emanate from a cross section of countries, the execution has to be customised locally.
- **Promote standardisation of CBHI structure, contributions, and benefits through government intervention.**

Standardisation could lead to an integrated health-care setup. The Rwandan government has introduced guidelines for the CBHI structure, contributions, and benefit package, and the Cambodian government also passed implementation guidelines. This standardisation shifts CBHI from a purely community control model to a government-supervised and guided model. Such policies reflect the governments’ commitment to integrate the CBHI delivery structure into an integrated health-care setup and are positive examples of addressing challenges of community-based insurance practices. The challenges include little potential for scaling up, absence of professional product pricing, questions on consumer protection, and implementation issues leading to insolvency.

### General recommendations

#### Summary

- **Transfer risks to and collaborate with the insurance industry through PPPs.**
- **Stimulate microinsurance regulation and supervision: overregulation has its constraints; lack of regulation can be an issue as well.**
- **Support capacity development at all levels and actors.**
- **Decide carefully on subsidies and targeting.**
- **Encourage industry to enter the low-income market.**

In addition to the recommendations pertaining to extended coverage, improved benefits, and increased access to social protection and microinsurance, a few general observations that would increase the quality of microinsurance products and services and their integration with social protection are discussed below:

#### Transfer risks to and collaborate with the insurance industry through PPP.

Whilst social (health) insurance or tax-financed benefits are often organised by national funds or para-governmental organisations, the risk can also be shifted to the private insurance industry for leveraging resources of the public sector with potential effectiveness and efficiencies of the private sector.

According to the social protection definition used in this paper, public interventions can also be carried out by, for instance, the insurance industry or civil society organisations. Collaboration with the industry—and civil society—can be implemented in various ways, as the following examples show:

- Under the fully subsidised social health insurance RSBY, the Indian government pays insurance premium to insurance providers who operate the health insurance programme. This collaboration can enhance effectiveness and efficiency due to greater competitiveness of service delivery but needs robust monitoring (as is important for any government delivery).

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38 From Deblon Loewe (2012), “...the total set of public action to address vulnerability or chronic poverty. These interventions can be carried out by the state or other actors such as commercial companies, charitable organisations, self-help groups, etc.”
In the event of weather-related catastrophes, a risk transfer to the insurance industry has its advantages. However, instead of promoting insurance, the governments of Bangladesh and Vietnam focused on directly compensating people for losses caused by natural disasters e.g., farmer compensation or loan waiver on crop losses arising from natural disaster. Such an approach tends to cause uncertainty to fiscal budgets and poses liquidity constraints after catastrophic shocks. Alternatively, the risks on fiscal budgets could be reduced by transferring weather- and pandemic-related risks to the insurance industry, which simplifies fiscal outflow planning. The Indian government has transferred agricultural loss risks to the insurance industry (WBCIS) and the Vietnamese government commissioned a trial agricultural insurance programme in 2011 to be operated by two state-owned insurers. Both programmes are primarily financed by government subsidy.

- Improve health-care services through government, industry, and civil society organisations. In India, a number of health-care and insurance programmes are operated on a PPP basis often with great success as presented in Box 2.

- **Stimulate microinsurance regulation and supervision.**

All of the countries that actively promote microinsurance have either regulated it or defined government guidelines for operating microinsurance so that it fits within the overall social protection system in the country. It is debatable how strict regulation should be and what it should contain. Whilst overregulation poses constraints, lack of regulation can be an issue as well.

- **Definition of microinsurance:** The way the Indian regulator defined product features of microinsurance curtails product flexibility and often leads to the development of products that do not fall within the IRDA range prescribed for microinsurance. It seems that the strict product parameters may be counterproductive. This has not hindered the design of microinsurance in itself, but they are not reported as microinsurance. The result has been that the regulator is unaware of the product and underwriting organisation’s diversity (including mutual insurance) and is therefore unable to supervise them.

Box 2

**Health insurance scheme operated under a PPP arrangement**

The Arogya Raksha Yojana (ARY) Trust health insurance scheme targets individuals below the poverty line and provides discounted pharmaceutical products, ambulatory transportation services, and an accessible health-care provider network (launched in 2004). In addition, the trust conducts preventive health education, improves sanitation, and builds village health centres with the support of the Yeshasvini Trust. The ARY health insurance scheme is an example of a PPP focusing primarily on women’s and children’s health in partnership between public hospitals, the government of Karnataka, Biocon Pharmaceutical Company, and ICICI Lombard General Insurance. It offers assistance to other states for replication.

“Microinsurance product means an insurance product that is designed to meet the needs of low-income customers, where the amount of premiums, computed on a daily basis, does not exceed 6% of the national daily minimum wage rate and the maximum guaranteed benefits do not exceed 600 times the national daily minimum wage.
rate. In the case of a bundled product, the maximum amounts of premiums and guaranteed benefits apply separately with respect to each component of the product” (A2ii 2013).

- Supervision of delivery channels: Many delivery practices are difficult to supervise and are not regulated, even in countries with a legal framework (e.g., community-based microinsurance schemes in Bangladesh, India, and Vietnam). The heterogeneity of the mutual organisations poses massive implementation issues, geographical reach is often a problem, and governance standards can materially vary amongst the community-based insurance organisations. On the contrary, in Cambodia and Rwanda, the CBHI delivery model is promoted and regulated, as it serves as a transitory social health insurance with basic benefits towards universal nationwide social health insurance. It is a challenge not to overregulate modest member-based organisations with a small risk pool (who can play an important role even if their members access formal insurance) and it is almost impossible to supervise them. It is different with large NGO/MFI-in-house risk carriers, like those in Bangladesh, who are not regulated as insurance providers and hence not supervised, thus posing a potential risk for the customers.

- Regulations and reporting should be harmonised: It is difficult if, for instance, the insurance industry is overseen by the insurance regulator, MFIs report to the Central Bank, and social funds or NGOs act according to a different ministerial regulation. The harmonisation of legislation would smoothen reporting for the organisations and enhance communal supervision of microinsurance operations whilst adhering to the principles of proportionality.

- Consumer protection: To date, many insurance products for low-income people are available, disseminated by a broad range of channels. However, not all products provide value to customers; instances of bad delivery or problems with claims handling happen. This becomes increasingly relevant for non-insurance delivery channels reaching out to individual customers without effective supervision of their services. Countries need to develop a legal framework with appropriate grievance mechanisms that are accessible to clients, especially for the semi-literate and rural population.

- Support capacity development.

Across all countries, awareness building amongst potential customers, capacity enhancement of delivery channels, orientation of the yet unfamiliar insurance industry and strategic policy actions of governments are essential for successfully operating microinsurance. Demand-based capacity building that is affordable and provides recurrent programmes needs training facilities in the vicinity of the respective organisations. To date, there are only a few local training institutions that could enhance the capacity of civil society organisations and other relevant stakeholders to operate microinsurance in all its complexity, let alone its integration into a comprehensive framework of social protection and other risk management mechanisms.

- Decide carefully on subsidies and targeting.

Debate has grown around several issues concerning subsidising microinsurance. For instance: should microinsurance be subsidised at all or operated only for the extreme poor as a means of social assistance or should it be a mix of both (e.g., subsidised for the extreme poor and contributory for the above-the-poverty-line people)? If subsidised, should it affect the premium amount or other types of “smart” subsidies? Are public investments in subsidising microinsurance the best option for protecting the poor or should the funds be used for tax-based social protection programmes with higher benefits? It is difficult to provide a general recommendation. Instead, the decisions must be made on a case-by-case basis with consideration of the international social protection debate and within the country context.39

39 The Microinsurance Network has commissioned a paper on subsidies that covers this issue in detail.
Subsidies are usually linked to targeting. Targeting criteria and the process of means-testing poses challenges across all the countries and causes problems with (1) identifying the poor and vulnerable population, (2) defining effective eligibility criteria, and (3) corruption and leakages within the system.

- Encourage industry to enter the low-income market.

Though the quota system of the Indian regulator to the private insurers has raised a debate about market interference, it contributed to increasing the number of insurance products for the low-income social sector and the provision of insurance in rural areas. Another option is a carefully designed incentive system, not only for the insurance providers, but also for intermediaries, e.g., brokers. Often, when starting with microinsurance, the economic trade-off is negative. On the one hand, the private insurers have high investments for exploring the unknown market, developing educational material, identifying new delivery channels, and building their capacity. On the other hand, the economic gains will usually be small, at least initially. If the government applies the same conditions as for products for the middle- and high-income market (e.g., fixed indirect tax rates or fixed licence fees for agents), the viability for distribution of micro-insurance is at stake. Brokers are confronted with a similar situation when reaching out to individual clients—their efforts are in no way compensated by the small commission implied by the low ticket premiums of micro-insurance products. As the brokerage structure would be more suitable for potential customers, the political decisions of creating incentives would add value to the customers e.g., breaks on indirect and direct taxes for brokers’ earnings from insurance products sold to the low-income market.

Problematic industry practices taint the reputation of commercial insurers. Robust supervisory monitoring and evaluation is needed, especially when premiums are paid by the government. Consideration could be given to defining some standards for private insurers, such as benefit package containing basic illnesses, effective delivery measures, cap on costs loaded to premium, and viable but ethical approach pertaining to profits for the low-income market. Such standards may be counterbalanced by the increased number of clients, particularly if the government makes some part of health insurance mandatory.
CONCLUSIONS

Taking into account that approximately 75% of the world population is not adequately protected and approximately 40% lacks even basic protection, the ILO calls for a pragmatic, stepwise approach to social protection, defining some minimum social security benefits that should be extended as soon as conditions allow.40

Microinsurance is one possible instrument to mitigate risks and to reduce the vulnerability of poor and low-income households, particularly of the informal economy. Microinsurance is not conceptualised as a mechanism that competes with or replaces public social protection systems, but it is most effective when embedded into a comprehensive social protection framework that goes beyond public social protection measures and includes informal, private, and other public risk management strategies of preventive measures, mitigation and suitable coping strategies.

Within this context, there is concern that microinsurance could divert the focus from the normative approach of social protection. This viewpoint is a challenge and has to be corrected by the respective governments through policy measures. The preferred situation is that contributory microinsurance plays a supplementary and complementary role, an add-on within a broad range of basic social protection systems, otherwise contributory (voluntary) microinsurance jeopardises the principle of solidarity. As voluntary stand-alone protection, microinsurance contributes neither to universal coverage nor to equitable access. It cannot substitute the concept of universal coverage for all.

There is an ongoing debate about subsidising microinsurance. For instance, should microinsurance be subsidised at all or only for the extreme poor? If subsidised, should it affect the premium amount or other types of smart subsidies such as public investments in hard and soft infrastructure? There is no one single answer to the strategic discussion about whether governments should invest in microinsurance, use funds for (potentially) enhancing social assistance and other social protection benefits, or apply a mix of both. For instance, the same product can be subsidised for the extreme poor (within the social assistance policy) and remain contributory for above-poverty-line people. The decision has to be made in the context of the country after analysing, for instance, existing institutional and fiscal strength, capacity of service providers (including insurers and hospitals), and learning from what has worked within and outside the country.

Governments have increasingly recognised the need for social protection, especially for vulnerable people in the informal economy. As expected, the strategies used were diverse and can be summarised as follows:

- Viewing microinsurance as a transitory instrument towards universal health social insurance
- Separating social protection legislation for the informal economy, including microinsurance
- Defining the role of microinsurance in the context of social protection
- Absence of explicit microinsurance government policy but presence of other forms of extending social protection coverage to the informal economy

Vietnam’s policy of extending formal economy benefits to the informal workers has huge po-

potential. Keep in mind this approach does not consider a role for microinsurance and assumes the delivery of voluntary social insurance becomes more effective. Rwanda made important progress using a CBHI delivery model to extend government supported mandatory basic health insurance to 97% of its population. A similar approach is promoted by Cambodia, but it has voluntary CBHI with severe difficulties in scaling up and sustaining the system. India formulated a social protection law through the Unorganised Sector Workers’ Social Security, adding microinsurance to the benefits. India has also implemented the subsidised basic health-care scheme (RSBY) but needs to overcome the fragmentation caused by the many other social protection interventions. Brazil follows a two-pronged approach. Firstly, the government promotes the universal health coverage through the national Programa Saúde da Família. Secondly, the MOH of Brazil enforces very strict rules on additional health plans (including microinsurance), whilst specific standards are not set for non-health microinsurance products. Bangladesh is in the process of developing a comprehensive social protection strategy and took initial steps in supporting microinsurance, though to date it has not integrated microinsurance into the social protection policy except in the Health Care Financing Strategy 2012-2032 which explores microinsurance as an interim mechanism until universal health coverage is achieved. The many microinsurance products operated by MFIs and NGOs are not connected to the Bangladeshi government policy and prevent lessons on client value from being learned across products.

Coverage of individual customers (vs. group policies) could be enhanced through a combination of technology and institutional structures that can raise awareness and help individuals to select and access appropriate microinsurance and social protection mechanisms. To support vulnerable people around the poverty line, a mix of targeted social protection programmes and contributory insurance systems could be an option, particularly for low-income people and the special group category, such as ethnic minorities or people living in disaster-prone areas.

Enhancing benefits would be more successful if the fragmented social protection programmes converged into a consistent system. Some standardisation of microinsurance products would be useful to the clients and the insurance industry, for which the design of multiple highly specified products for a limited number of customers would be too expensive.

Civil society and non-profit organisations are instrumental for increasing access to microinsurance as well as social protection programmes, provided they are appropriately trained and equipped with basic resources. The emphasis on microinsurance agents runs counter to market principles because customers cannot choose products from different insurance providers. Brokers could overcome this limitation but need incentives to enter the low-income market.

Finally, a microinsurance strategy embedded within social protection needs to consider the existing public programmes and other informal and market-based risk management mechanisms. The strategy needs to create a multi-dimensional and conducive environment at different levels. Such a framework is not restricted to regulatory issues and consumer protection but includes PPPs, promoting national structures for generating lessons across all actors linked to comprehensive capacity development. As with any strategy, the role of microinsurance for social protection needs to be visualised for the long-term—how will microinsurance’s role change over time pertaining to the country’s overall development?
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The Microinsurance Network is a member-based network of organisations and individuals active in microinsurance. The mission of the Network is to promote the development and proliferation of good-value insurance products for low-income persons by providing a platform for information sharing and stakeholder coordination.

The Social Protection Working Group aims to increase the knowledge about the different roles of microinsurance within social protection frameworks, and its potential and possible contribution to an enhanced access to social protection.

For more information on the Microinsurance Network visit www.microinsurancenetwork.org

Any feedback or comments can be sent to info@microinsurancenetwork.org

About the authors

Gaby Ramm has been working as a senior advisor in the areas of comprehensive risk management strategies, social protection, and microinsurance to GIZ, the UN, and the insurance industry since 2001. She is a Steering Committee member at ILO’s Microinsurance Innovation Facility and a member of the Advisory Board of the Munich Climate Insurance Initiative (MCII) at the United Nations University (UNU-EHS). Prior to that she was GTZ’s Program Director in India, heading poverty alleviation projects of microinsurance and microfinance among other topics, and was the Representative of the Friedrich Naumann Foundation in Nepal and Pakistan responsible for the training of environmental journalists, educational programs, and dialogue platforms with the government, the industry, and civil society. She is a founding member of the Microinsurance Network, where she is heading the Capacity Building Working Group and is a member of the Agriculture Working Group.

Mayur Ankolekar is an independent consultant and a teacher-volunteer. Originally trained as an accountant and lawyer, he has over two decades practitioner and business experience. He handled a range of functions with two employers in the Indian manufacturing and financial services industry. In his last employment assignment, he led a growing insurance business in Southern India. Over the past five years, Mayur has worked as an actuarial consultant with insurers, regulators, NGOs, microfinance companies and multilateral organisations in Bhutan, Cambodia, Egypt, India, Jordan, Nepal and Vietnam. His practice areas are in general insurance and pensions; he has handled several microinsurance projects with the Micro Insurance Academy. Mayur is a Fellow of the Institute and Faculty of Actuaries, UK and the Institute of Actuaries of India. He presently sits on the International Actuarial Association’s Actuaries Without Borders Committee and the Institute of Actuaries of India’s Advisory Group on Microinsurance and Microfinance.