



PAPER No. 42

LEARNING FROM OTHERS' MISTAKES

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Aparna Dalal
International Labour Organization

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TABLE OF CONTENTS

Table of contents	2
Executive summary	4
1. Introduction	6
2. Case studies	7
2.1 Allianz Life, Indonesia	10
2.2 Alternative Insurance Company (AIC), Haiti	10
2.3 Cooperative Insurance Company, Kenya	10
2.4 First Microinsurance Agency, Pakistan	10
2.5 Fonkoze, Haiti	10
2.6 ICICI Lombard General Insurance Company, India	11
2.7 Microcare Insurance Limited, Uganda	11
2.8 Old Mutual, South Africa	11
2.9 La Positiva, Peru	11
2.10 Profin Foundation, Bolivia	12
2.11 Swayam Shikshan Prayog, India	12
2.12 Union des Assurances du Burkina Vie, Burkina Faso	12
3. Framework and root causes	13
3.1 Viability	13
3.1.1 Insufficient incentives or capacity of sales agents	13
3.1.2 Limited data, adverse selection and moral hazard	14
3.1.3 Poor performance monitoring	15
3.1.4 Insufficient financial resources	16
3.2 Client value	16
3.2.1 Inadequate awareness building	17
3.2.2 Complexity	18
3.3 Operations	19
3.3.1 Inefficient processes and lack of integration	19
3.3.2 Non-conducive organizational structure	21
3.3.3 Poor technology implementation	22
3.4 Partnerships	24
3.4.1 No business case for partners	24
3.4.2 Interests are not aligned	25
3.4.3 Lack of capacity of a partner	26
3.5 External	26
3.5.1 Limiting regulatory regime	26

3.5.2 Changing government priorities	27
4. Solutions	28
4.1 Solutions from cases	28
4.2 Five fundamental strategies to address challenges	30
4.2.1 Pilot carefully	30
4.2.2 Set intermediate (realistic) targets and activity-based goals that can be used to track progress	31
4.2.3 Match product with stage of market development	31
4.2.4 Provide value to each stakeholder	32
4.2.5 Make a long-term commitment and adopt a learning culture	32
5. Conclusion	34
References	35

LIST OF FIGURES

Figure 1. Framework and cases	13
Figure 2. SSP's claim management problems	16
Figure 3. The complex PWYC product	18
Figure 4. Claims pattern for ICICI Lombard	23
Figure 5. Leveraging health microinsurance to promote universal health coverage	27
Figure 6. Stages of market development	32

LIST OF TABLES

Table 1. Cases reviewed	8
Table 2. The complex Agropositiva Vida product	19
Table 3. Success factors and solutions	28

EXECUTIVE SUMMARY

The microinsurance sector has grown from 78 million policies in 2007 to 500 million in 2012 and the exponential growth is expected to continue, since the potential market is estimated at 3–4 billion policies. However, for every scheme that has succeeded, many more have struggled to reach scale, become viable or provide client value, and some have failed altogether. No one really wants to talk about these failures, even though analysing them is as useful – if not more – as examining successes. Many innovations have resulted from efforts to convert near-misses to successes.

This paper draws on the experience of 12 such attempts. Just like the broader industry experience, some of these succeeded, while others failed altogether. By examining their struggles, the paper strives to identify the most common challenges that are likely to cause severe disruptions or failure, if left unaddressed. They are organized into five clusters: Viability, Client Value, Operations, Partnerships and External. The main obstacles within each cluster are summarized below:

- Viability
 - i. **Insufficient incentives and/or capacity of sales agents.** This affected motivation and ability to increase take-up and renewals. When partnering with distributors, the insurance product competed with other products or services that agents (employed by the distributor) provided (e.g. loans in the case of MFI loan officers, or fast-moving consumer goods in the case of retailers).
 - ii. **Mispricing** due to limited data, **adverse selection** and **moral hazard**, resulting in claims incidence that was higher than expected, especially for health insurance.

The problem of high claims was exacerbated by **poor performance monitoring**, which prevented organizations from identifying claims trends during high-growth periods.

iii. **Financial resources** of a microfinance institution were not sufficient to bear the risk that was allocated to it during product design.

- Client value
 - i. **Raising awareness** proved a challenge in mature markets, when the insurer was attempting to diversify from standard operating models. In mature markets, it may be even more difficult to change client-buying behaviour, if customers are already accustomed to buying insurance in a certain way.
 - ii. Seemingly client-centric features, such as comprehensiveness and flexibility, which aimed to improve value, instead increased **complexity** and had adverse effects on client understanding and demand.
- Partnerships
 - i. For distributors, a partnership with an insurer must bear **financial results**, either directly through commission earned, or indirectly by supporting their core business. Cases that were not able to do this encountered serious challenges.
 - ii. Cases struggled to **align** objectives with partners, both as a whole and across levels within the organization.
 - iii. Not all distributors were **capable** of, or even interested in selling insurance.

- **External**

- i. As regulators try to balance innovation and consumer protection, they may enforce regulation that limits innovation.
- ii. Governments are increasingly trying to use insurance mechanisms to achieve policy objectives. This can create opportunities for partnerships, but it may also create competition, as experienced in some cases.

To address these challenges, organizations need to 1) pilot carefully; 2) set realistic targets and activity-based goals that can be used to track progress; 3) match product with stage-of-market development; 4) provide to each stakeholder and 5) make a long-term commitment and adopt a learning culture.

The long-term commitment must come from leadership and management. The key is to adopt a learning culture that allows people to make mistakes and provides a space for mistakes to be analysed and corrected. This culture – with due accountability but without unnecessary blame – has to come from leadership.

It is not always possible to wait and watch, while others take risks and make the mistakes. Waiting and refusing to take new risks can be as costly as ignoring the mistakes of the past. The organizations who will manage to serve the millions who are currently uninsured, will be the ones who try new things, inevitably face challenges and some failures, but overcome them and change course when needed.

1. INTRODUCTION

The microinsurance sector has grown from 78 million policies in 2007 to 500 million in 2012 (Churchill and McCord, 2012) and the exponential growth is expected to continue, since the potential market is estimated at 3–4 billion policies. More than 95 schemes have achieved scale and many are now viable or making progress. Clients have access to valuable products, and governments are increasingly partnering with insurers to achieve public policy objectives related to universal health coverage, food security and climate change.

However, for every scheme that has succeeded, many more have struggled to reach scale, become viable or provide client value, and some have failed altogether. The challenges experienced by various schemes have been uncannily similar, even though the contexts were different. This paper draws attention to the most common causes of failure to which organizations should pay attention. It goes beyond examining symptoms, to explore the causes of failure. This paper is not about not making mistakes per se. Instead, it is about how to avoid making the same mistakes.

No one wants to talk about failures, even though analysing them is as – if not more – useful as examining successes. Indeed, failures, or near-misses, provide valuable learning opportunities. Many innovations have resulted from efforts to convert near-misses to successes. This paper draws on the experience of 12 such attempts.

"Failure is an inherent part of the [design] process, because we'll just never get it right on our first try. In fact, getting it right on the first try isn't the point at all. The point is to put something out into the world and then use it to keep learning, keep asking, and keep testing."

Tim Brown, Founder, IDEO.org

The paper is organized as follows. Section 2 presents the case studies. Section 3 outlines the framework and provides examples from each category of challenges. Section 4 presents solutions and the fundamental strategies that all organizations should follow. Section 5 offers a conclusion.

2. CASE STUDIES

Since 2008, the ILO's Impact Insurance Facility has worked with more than 60 organizations to implement innovations in products, business models, technology and processes. This study draws on the experience of 10 Facility partners and two outside schemes. The cases represent a variety of geographies, institutional models and product types. Each one presents challenges experienced by the schemes when piloting a new product, partnership or technology.

The pilots were meant to be risky innovations aimed at changing the status quo and testing previously untried solutions. Challenges were expected and the emphasis was on learning from these experiences. The Facility supported each partner to conduct action research based on a jointly agreed upon learning agenda. The reflections offered by partners throughout the project time span provide a rich pool of information on the successes and obstacles encountered. The result is an analysis not just of the final outcome, but of the lessons learned along the way.

All the organizations learned a great deal from the projects. Just like the broader industry experience, some succeeded, while others failed altogether. About half of them terminated the projects, while the other half overcame most of the challenges, and continued to provide microinsurance products, either as part of the same initiative, or as part of new ones. Some organizations, such as ICICI Lombard and La Positiva, have been able to achieve significant successes after overcoming the initial challenges.

By presenting what happened during the project, this paper highlights details that might be missed or omitted if only the end result is considered. People who undergo a challenging experience, and succeed in overcoming the difficulties, tend to focus on the positive final result, ignoring any struggles encountered along the way. This tendency to reframe history makes it harder to identify challenges and, as a result, pinpoint solutions.

The study focuses on events within a specific time frame (typically the grant period), highlighting aspects of the project that proved the most troublesome. Much more information is available on each case in the Projects Lessons section of the Facility website. A summary of the case studies, and the challenges they faced, is presented in Table 1.

Table 1. Cases reviewed

Organization, country	Type of organization	Product	Distribution	Scale achieved during study period	Key challenges	Project status
Allianz Life, Indonesia	Insurance company	Endowment	MFI VisionFund Indonesia	363 policies (2 000 target)	Complex/ inefficient processes Rigid internal structure of distributor No business case for distributor Low incentives / capacity of agents Inaccurate pricing estimate	Terminated. Allianz Life is working with other partners to sell both mandatory and voluntary products
Alternative Insurance Company (AIC), Haiti	Insurance company	Funeral	MFI Sogesol	10 000 policies	Low incentives / capacity of agents Regulation limits innovation	Challenges overcome. Increasing sales.
Cooperative Insurance Company (CIC), Kenya	Insurance company	Composite (3-in-1 covering health, accidental death and disability, and funeral)	SACCOs, MFIs, artisans' associations, youth associations, welfare and faith-based groups	16 144 maximum lives, dropped to 8 279 lives	Complex product / process Misaligned interests Low incentives / capacity of agents Lack of capacity of partner	Terminated. CIC has launched other products for the low-income segment
First Microinsurance Agency, Pakistan	Non-governmental organization	Life and health	Village organizations, First Microfinance Bank	23 260 lives (health) 370 000 lives (life)	Partnership	Terminated
Fonkoze, Haiti	Microfinance institution	Catastrophe	Fonkoze staff (mandatory)	Around 60 000 microcredit clients	Inefficient process Complex / inefficient process High claims cost Competing priorities for partner	Terminated
ICICI Lombard General Insurance Company, India	Insurance company	Health – outpatient. (subsidized)	Distribution agents using household data provided by government	> 750 000 lives	Poor/expensive technology implementation Misaligned interests	Project is a success. Increasing sales

Organization, country	Type of organization	Product	Distribution	Scale achieved during study period	Key challenges	Project status
Microcare Insurance Limited, Uganda	Insurance company	Health	Community-based organizations, MFIs and insurance broker	> 70 000 lives	Misaligned interests Poor performance monitoring Changing regulations	Terminated
Old Mutual, South Africa	Insurance company	Funeral	ShopRite, one of the biggest food retailers in South Africa	3 000 lives	Complex product / process Client have low understanding of product Not meeting market needs	Plan to relaunch a simpler version of the product with more sales support for distributor
La Positiva, Peru	Insurance company	Life	La Positiva's staff and National Board of Users of Irrigation Districts of Peru	8 000 lives in 2013	Complex product / process Lack of capacity of partner Low incentives / capacity of agents	On track with increasing sales. <i>La Positiva</i> has started partnerships with other distribution channels and the government
Profin Foundation, Bolivia	Non-governmental organization	Composite (Agricultural – Life – Property)	MFIs, credit and savings cooperatives	2013: 44 policies 2014: 2 400 policies	Complex product / process Misaligned interests Political environment changes	Terminated
Swayam Shikshan Prayog (SSP), India	Non-governmental organization	Health (inpatient care out-patient services)	Community health workers, staff	9 133 lives (30 000 target)	High claims frequency Poor performance monitoring (claims ratio) Inefficient claims processes (lack of timely claims submission)	Terminated
Union des Assurances du Burkina Vie, Burkina Faso	Insurance company	Savings with life and disability	UAB Vie sales staff with information technology partner	15 403 maximum policies, dropped to 10 603 policies	Poor / expensive technology implementation Lack of capacity of partner	Now focusing on improving MIS and front-end systems

2.1 ALLIANZ LIFE, INDONESIA

In 2010, Allianz Life Indonesia established a partnership with VisionFund Indonesia, an MFI, to offer TAMADERA a life insurance endowment product. Customers pay US\$1 per week for five years and when the policy matures, the premium is returned to customers in full, without interest or deductions, so long as no claim has been made. During the five-year policy term, customers are insured for death and five critical illnesses. TAMADERA was offered as a voluntary product to borrowers of VisionFund. Only 363 policies were sold. The partners tried many approaches to increase scale, but faced challenges in trying to prioritize insurance sales amongst the loan officers, due to limited incentives, and to ensure streamlined processes and prevent policy lapses.

2.2 ALTERNATIVE INSURANCE COMPANY (AIC), HAITI

In April 2009, the Alternative Insurance Company (AIC) in Haiti launched its first voluntary funeral microinsurance product (Protecta) in response to growing demand. AIC partnered with existing distribution partners of its credit-linked policies, banks and MFIs, to distribute the product. Initially, AIC considered setting up sales points to distribute the product, but with Internet, electricity, building security, rent and agent costs, this approach proved too expensive. Instead, AIC decided to use employees of existing institutions to sell policies, but this approach also had limited success, due to competing priorities for the sales agents.

2.3 COOPERATIVE INSURANCE COMPANY, KENYA

CIC formed a public-private partnership with the National Health Insurance Fund (NHIF) in Kenya to deliver a composite insurance product offering life, accidental death and disability and health coverage. The distribution partners were member-based organizations, including microfinance institutions and SACCOs. The project quickly reached more than 15,000 policy-holders, but the product was removed from the market after two years because of low renewals and operational challenges. The complexity of the product made it difficult to explain leading to low sales and lower renewals. The partnership also faced challenges related to claims processing and a change in government priority that led to NHIF requiring the product to provide cover beyond hospitalization.

2.4 FIRST MICROINSURANCE AGENCY, PAKISTAN

The Agha Khan Agency for Microfinance (AKAM) incorporated an independent microinsurance agency, First Microinsurance Agency (FMiA) in 2007, which partnered with New Jubilee Insurance to offer life and health microinsurance products. Distribution channels included village level organizations, and First Micro Finance Bank (FMFB), as well as other microfinance institutions (MFIs). Although innovative products were developed and distributed, contributing to significant market development for microinsurance in Pakistan, the programme had not achieved sustainability within the projected period of three to four years. While possibly not a realistic time frame to develop a new market, AKAM decided to end its participation in microinsurance. The operations of FMiA were discontinued in early 2011, and the microinsurance unit of AKAM wound down. The project was hampered by lack of insurance culture, poor affordability and a generous benefit design that did not offer sufficient controls for adverse selection (Rendek, 2012). The project also faced challenges with managing claims and health providers.

2.5 FONKOZE, HAITI

Fonkoze, the largest microfinance institution in Haiti, launched an index-based catastrophe insurance product (through MiCRO) to help its borrowers mitigate the impact of frequent weather-related and natural catastrophes. The product was mandatory for Fonkoze's borrowers and covered any outstanding loan balance, provided a cash payout of \$125, and pre-approved clients for a new loan. The index was based on rainfall, wind speed and seismic activity. When the parameters exceed a predetermined threshold, a payout was triggered. If payout based on the index trigger was not sufficient to cover actual losses of the MFI, MiCRO covered 85 per cent of the difference, up to \$1 million per year, with the remaining 15 per cent covered by Fonkoze. The actual loss was based on an assessment of clients'

losses, conducted by Fonkoze. Despite demonstrated client value, the product proved unsustainable during the second hurricane season, mainly due to the magnitude of the events that hit Haiti over a very short period of time. Fonkoze decided to withdraw the product until further reflection on a comprehensive and sustainable risk management strategy.

2.6 ICICI LOMBARD GENERAL INSURANCE COMPANY, INDIA

Health microinsurance initiatives at ICICI Lombard began in 2005, and as of March 2011, ICICI Lombard served approximately 7 million families across India. Rashtriya Swasthya Bima Yojana (RSBY) is India's national health insurance programme for below the poverty line (BPL) families. RSBY was launched with an inpatient (IP) benefit package. In 2011, in an effort to address demand for outpatient (OP) coverage, a pilot was implemented to add OP benefits to the existing IP benefit package. Ultimately, the project was a success, reaching more than 750,000 people over the course of the pilot. ICICI Lombard overcame a number of technology challenges related to the roll-out of the OP software and obstacles in persuading health providers to use the application.

2.7 MICROCARE INSURANCE LIMITED, UGANDA

Microcare's objective was to provide affordable access to quality health care through health microinsurance. When it started providing health microinsurance, no regulated insurer in Uganda was offering health insurance of any kind and the general view was that there was no business case for (regular or micro) health insurance. By the end of 2008, Microcare Insurance Limited provided affordable insurance to more than 70,000 people. However, it found itself in a regulatory vacuum, because regulators did not provide for health insurance as a unique class of business. Microcare was able to grow, so long as the regulator remained flexible about new approaches to developing its new market. However, when the regulator adopted a stricter approach, Microcare's business was severely impacted. Microcare's license was withdrawn in 2007. Microcare suffered from the combined consequences of unrealistic service provider expectations, unreliable reinsurers, weak public sector institutions, a breakdown in its internal controls, ineffective financial management and an unsupportive political climate.

2.8 OLD MUTUAL, SOUTH AFRICA

In 2011, Old Mutual, a leading life insurer in South Africa, and Shoprite, a large national grocery chain, launched a retail funeral product called Pay When You Can (PWYC). PWYC was designed to be flexible, with clients having the option to top up cover on an ongoing basis. But this flexibility also added complexity. The product was not able to achieve scale, covering only 3,000 lives, mainly because it was too complex and clients had difficulty in comprehending the waiting periods associated with the top-ups. The "passive" sales model, whereby the product was offered at a retailer without agents, also hampered Old Mutual's ability to raise awareness and understanding of the product. Old Mutual now plans to launch a simplified version of the product, supported by a new promotion and sales strategy.

2.9 LA POSITIVA, PERU

La Positiva partnered with the National Board of Users of Irrigation Districts of Peru (JNUDRP) to offer life insurance to farmers, rural workers and their families. JNUDRP represents 112 rural water boards throughout the country. It is entrusted with the national administration and management of irrigation for the agricultural sector. The water boards provided an established network of distribution points for La Positiva. Since most of the targeted population did not use banks or MFIs, the community-based water boards were selected as the distribution channel. In collaboration with JNUDRP, La Positiva analysed the risks faced and the cover needed, and generated awareness among distributors and consumers about the importance of insurance. The decision was made to add the premium to the irrigation water tariff collected from the farmers for easy premium collection. La Positiva faced a number of challenges in working with water boards, mainly related to developing capacity water board staff members and incentivizing them. By 2013, it had only managed to enrol 8,000 clients.

2.10 PROFIN FOUNDATION, BOLIVIA

Profin Foundation, an insurance intermediary/non-profit, formed a public-private partnership with insurers and regional governments in Peru to offer a composite product (Vida Agricola) that provided protection for agriculture, life and property and was bundled with technical assistance for non-financial risk management. The product was subsidized by the regional governments and distributed by public and private distribution channels. Profin faced a number of challenges working with the public sector, including withdrawal of subsidies and direct competition from a government agricultural insurance scheme. After a pilot in Taraja, the product was due to be expanded to other regions of the country, though these plans were put on hold as a result of a new subsidized government programme (SAMEP), which would have directly competed with Vida Agricola.

2.11 SWAYAM SHIKSHAN PRAYOG, INDIA

Swayam Shikshan Prayog (SSP) is a non-governmental organization in India that provides communities with access to social and economic opportunities through technical support. SSP piloted a comprehensive health product using a Community Health Fund. The product bundled in-patient health coverage along with discounted out-patient services and drugs supplied by a network of health providers. The product was underwritten by a public insurer. SSP used community health workers to enrol clients and provide health services. The project was terminated due to challenges related to partnership and claims management, performance monitoring and provider networks.

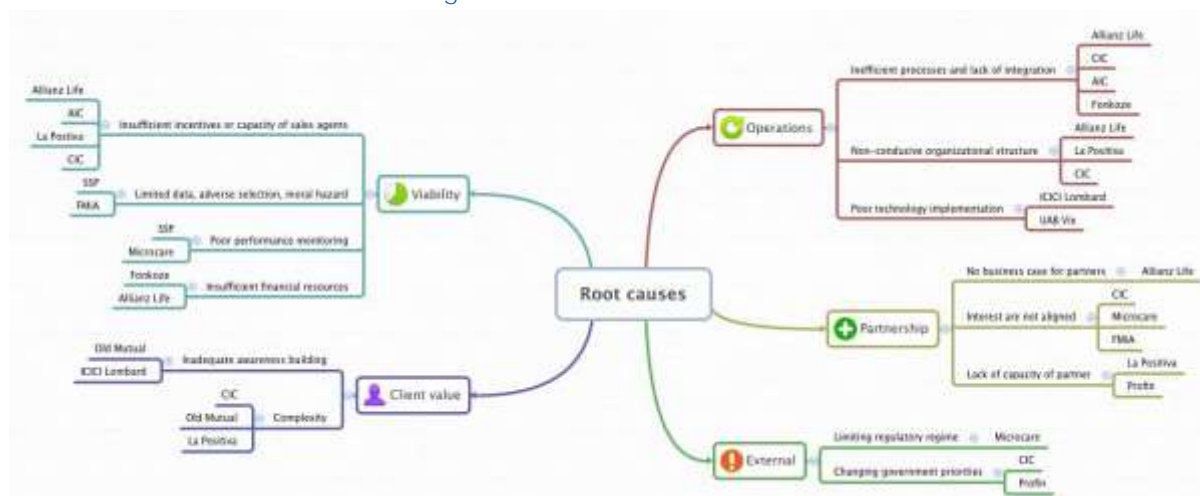
2.12 UNION DES ASSURANCES DU BURKINA VIE, BURKINA FASO

UAB Vie is an established life insurance company in Burkina Faso. In 2003, UAB Vie launched a life microinsurance savings product aimed at the population in the informal sector in Ouagadougou. The product consists of a contractual savings scheme and includes life and disability coverage in the case of accident. Policy-holders' premiums are collected each day by UAB Vie staff. The daily manual transactions performed by UAB Vie sales staff seemed to be holding back growth of the product and UAB Vie decided to automate the collection of premiums using mobile technology. A partnership with Telecel, a mobile telephone company within the UAB group, was set up. But by 2012, only 10,603 policies had been sold, mainly due to technology implementation challenges.

3. FRAMEWORK AND ROOT CAUSES

The framework outlines the most common challenges experienced by the cases reviewed in the study (see Figure 1). These are the challenges that are likely to cause severe disruptions or failure if left unaddressed. They are organized into five clusters: Viability, Client Value, Operations, Partnerships and External. The challenges can be thought of in terms of causes and symptoms. Symptoms are the manifestations of unaddressed challenges, or the end result. Symptoms may be low take-up, low renewals, failed partnerships or high losses. The symptom occurs because of a root cause (or multiple root causes) and to address the symptom, the underlying cause must first be identified. For example, if a scheme is experiencing low take-up, this may be caused by poor enrolment processes (CIC), no incentives for agents to sell insurance (La Positiva), or insufficient customer awareness (Old Mutual). It is only possible to cure the symptom once the cause has been identified.

Figure 1. Framework and cases



3.1 VIABILITY

Achieving viability hinges on three drivers of profitability: achieving scale, managing claims and keeping administration costs low (Angove and Dalal, 2014). The combined effects of low premiums, tight margins and high volumes require a well-trained and incentivized sales force, efficient processes and effective use of technology.

3.1.1 INSUFFICIENT INCENTIVES OR CAPACITY OF SALES AGENTS

Scale is perhaps the most important driver of profitability. A study shows that more than 95 schemes have achieved scale successfully, mainly through partnerships with distribution channels during the initial stages of mandatory products, and later through properly trained and incentivized agents (Thom et al, 2014). One factor inhibiting scale is the challenge of establishing a competitive incentive system for agents. When partnering with distributors, the insurance product competes with other products or services that agents provide (e.g. loans for MFI loan officers, or fast-moving consumer goods for retailers). These agents must be incentivized to sell insurance. Given low premiums of microinsurance, it may be difficult to establish an incentive structure that is competitive.

In the partnership between Allianz Life Indonesia and VisionFund, the selling responsibility for the endowment product (TAMADERA) was assigned to VisionFund's loan officers as an additional task to their routine microcredit activities. TAMADERA information was added as a component to VisionFund's customer education programme, and the moment of loan disbursement was identified as the best moment for enrolment, because customers would have sufficient cash on hand. A very limited incentive system, based on sales and persistency targets, was set up by VisionFund within the constraints of its

small commission. Even if a loan officer succeeded in enrolling as much as 80 per cent of their customers in TAMADERA, they would only have been able to increase their monthly salary by about 20 per cent. This was not sufficiently attractive. Furthermore, loan officers' sales of TAMADERA did not form part of their annual performance appraisal, which impacted motivation. Loan officers and administrative staff perceived TAMADERA as an additional burden to their daily job and did not see any personal benefits. Also, some loan officers did not feel confident about discussing insurance matters with customers. They found it much easier to sell loans, which were in higher demand, than to convince customers to join TAMADERA, for which demand was lower, and which needed to be built through repeated explanations.

AIC experienced a similar challenge when it chose to sell its funeral insurance policy, using the agents of its partner MFI, Sogesol. Loan officers were not selling many policies, as the incentives offered on the loan portfolio were higher than those for insurance. The incentives for credit were sometimes as much as double the base salary. AIC suggested adding indirect incentives, such as dinner coupons and airtime minutes, but these had a minimal effect. AIC realized that Sogesol had a culture of focusing on credit, and that AIC would be better using its own agents to sell Protecta in Sogesol's branches. In 2011, AIC's own agents started working from Sogesol offices to promote and sell the insurance products. In the first quarter, AIC sold more policies than the MFI agents had sold during the previous year.

Incentives for a distribution channel with national and regional levels need to be adapted to each layer. In the case of La Positiva and its partnerships with water boards associations, a commission of 5 per cent was initially to be provided to the national water board. However, the support received at national level was limited (ranging from offering space in some national assemblies to publishing information about microinsurance on its website). La Positiva proposed shifting this incentive to sales agents at the local water boards, who were in charge of collecting the irrigation water tariff. Sales agents received a commission of between 2 and 6 per cent, depending on the board. La Positiva considered this incentive very low, and believed that it could be raised an additional 5 per cent, provided that an agreement could be reached with the JNUDRP to abandon its 5 per cent commission.

In the case of CIC, it was not incentives, but lack of capacity of SACCO agents that prevented the project from reaching scale. SACCO staff did not have the skills needed to sell insurance and lack of the final 'selling push' was a major issue. Many enrolment applications, especially incomplete ones, were not processed. It was decided that SACCO staff needed training and refresher courses on an on-going basis. However, the cost of training 150 delivery channel staff in one area was equivalent to revenue from 200 policies, which was not sustainable, given the premium levels.

It is not surprising that insurers' agents are more highly motivated and have greater capacity to sell insurance. The question is whether sales volumes can sustain full-time insurance agents. For many schemes, volumes may not justify full-time agents, since low commission earned on each policy cannot sustain the salary of agents. Full-time agents are only possible if volumes are high, or if insurers have multiple products on offer that allow greater opportunity for cross-selling. An alternative to having full-time agents lies in providing greater support and oversight of the distribution channel agents, by assigning a regional insurance representative who supports the daily sales, but can also organize special events to boost sales. This strategy has been used by various insurers, including Hollard in South Africa, Don Juan in Mexico and Bradesco in Brazil.

3.1.2 LIMITED DATA, ADVERSE SELECTION AND MORAL HAZARD

In the cases reviewed, higher than expected claims incidence was caused by mispricing due to limited data, adverse selection and moral hazard.

For SSP, limited health incidence data resulted in inaccurate estimates. SSP found that the incidence of hospitalization was more than double that which had been expected (11 per cent vs. 4 per cent), resulting in a claims ratio in excess of 300 per cent. Adverse selection also played a role. A drive for increased

scale led SSP to expand into 210 villages, instead of its original plan to pilot in 120 villages. The result was a lower coverage ratio in each village, and consequent adverse selection, as clients with the greatest needs were most likely to sign up. Furthermore, approximately 40 per cent of hospitalizations were due to highly preventable common waterborne diseases that could have been addressed by better access to outpatient care. When SSP changed its claims payment from cashless to reimbursement, claims costs fell by about 30 per cent, suggesting overcharging by the health providers or over-utilization by clients (see Figure 2).

For FMiA, high claims incidence, driven by the maternity benefit, resulted in claims costs that could not be supported by the premium levels. FMiA was unable to negotiate premium increases to make the product sustainable.

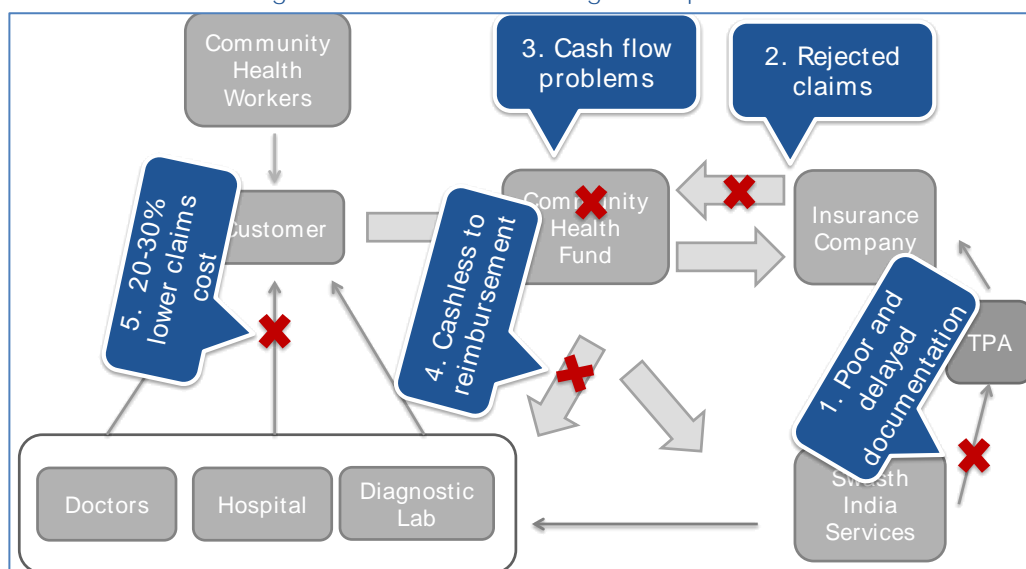
To achieve viability, schemes need to ensure that claims incidence and cost fall within the priced limits. Angove and Dalal (2014) found that getting claims within the priced limits was the driving force behind insurers moving from loss to profit. The insurers achieved this through better pricing, by reducing adverse selection through restricted enrolments, and through better performance monitoring.

3.1.3 POOR PERFORMANCE MONITORING

The problem of high claims is exacerbated by poor performance monitoring. Performance measurement is especially challenging for microinsurance since it entails processing large volumes of transactions through systems that may not provide real-time information and with partners that may not be inclined or motivated to report data in a timely manner. To ensure that claims controls are working effectively, it is important to have a system that monitors claims and expenses, and produces reports based on triggers and trends analysis.

In the case of SSP (see Figure 2), delayed performance monitoring had severe consequences. SSP's expansion into 210 villages – instead of the 120 planned – overstretched resources and meant that the attention was focused on increasing enrolment, rather than claims management. SSP did not track claims performance until it was too late. Of 329 claims submitted, 60 per cent were rejected due to failure to submit the claim within the seven-day limit stipulated by the third-party administrator. The root cause here may not be just poor monitoring, but agreeing to the seven-day stipulation in the first place. However, poor performance monitoring exacerbated the problem because SSP did not monitor the rejection ratio on an on-going basis, and the volume of rejected claims ended up being too high. SSP felt obliged to pay these claims on behalf of the insurers, which it did by dipping into its own reserves that had been set aside to provide health value-added services to members.

Figure 2. SSP's claim management problems



Microcare experienced a different type of challenge with claims management, which led to a significant rise in claims costs in 2008. The increase, which occurred despite extensive claims controls, was due to: 1) restructuring of Microcare and its sister companies to comply with the regulator's directive created bottlenecks in claims processing. This also created gaps in the control system, which allowed claims that were not compliant with the rules to slip through; 2) fraud between some service providers and a small group of clients; and 3) the mismatch between premiums, which were fixed annually in advance, and the escalation in claim costs, which was far greater than had been anticipated.

3.1.4 INSUFFICIENT FINANCIAL RESOURCES

In the case of Fonkoze, the benefits design and the risk allocated to Fonkoze made the product unsustainable. The product design stipulated that if the payout based on the index trigger was not sufficient to cover actual losses, Fonkoze was responsible for at least 15 per cent of the difference (more if the losses exceeded the yearly basis risk with MICRO, the insurer). Both the reinsurer, Swiss Re, and the insurer, MICRO, had established annual overall limits on how much they would pay, but Fonkoze's commitment to its clients was unlimited. In the first year, payouts from the parametric index and the damage assessment by Fonkoze were almost the same, resulting in no basis risk for Fonkoze. However, as a result of a series of disasters in 2012, the difference between the loss based on satellite images and the actual damage to clients was \$1.7 million. Though its losses were ultimately offset by grants, Fonkoze was forced to stop offering the product in its existing form. Fonkoze decided to focus on its core business (lending) to ensure long-term viability of the organization.

Insurance benefits provided for the Allianz Life product TAMADERA were financed by interest gained on the deposits of saving customers. The actuarial calculation assumed net interest rates of 6 per cent per annum. However, the interest rates fell to 4-5 per cent, which jeopardized the financial viability of the product.

3.2 CLIENT VALUE

Client value is necessary for long-term sustainability of an insurance scheme. Client value is affected by many factors, not just benefits and price, and providers need to take a holistic perspective of what can improve or prevent client value (Matul and Dalal, 2014).

This section presents three common factors that reduce the value proposition of products for clients: lack of awareness, complexity and unmet client needs. Value is also affected by processes that determine access and experience, but these issues are discussed in the Operations section.

3.2.1 INADEQUATE AWARENESS BUILDING

Lack of awareness or poor understanding can be important causes of poor take-up and renewals. Poor take-up is not necessarily a result of poor awareness or understanding. Insurers may be biased in attributing low take-up to poor understanding, but they need to be careful when doing so, since low take-up may be – and often is – a result of clients making a conscious decision not to buy a product that does not meet their needs, or is simply too expensive.

Nevertheless, raising awareness is a challenge, especially in new microinsurance markets, with no insurance culture. Raising awareness can be a challenge even in mature markets, particularly if the insurer is testing an approach that is completely different from standard operating models. In mature markets, it may be even more difficult to change client-buying behaviour if customers are already used to buying insurance in a certain way.

Old Mutual faced this challenge when it decided to sell funeral insurance through a supermarket. In South Africa, funeral insurance is typically sold by agents or burial societies. Old Mutual tried a purely passive selling model, using a retail channel, on the assumption that since clients are already familiar with the funeral product, they would not need much education at the point of sale. However, in six years, Old Mutual was only able to sell 4,000 policies out of a potential market of 11 million. It found that 72 per cent of the market was unaware that funeral cover was available at a supermarket. Of those who were aware of supermarkets selling funeral cover, only 37 per cent were open to the idea of buying funeral cover through that channel, making it very difficult for Old Mutual's retail channel to achieve scale. Other South African insurers have been more successful in selling insurance through retailers, especially white goods stores, where insurers have supported products through more active sales strategies, such as sales drives conducted by agents located at the stores.

India, also a mature market, provides another example of the challenges of raising awareness. During the pilot of the outpatient component of the RSBY schemes, ICICI Lombard found that awareness-building must be on-going in order to promote a long-term understanding of RSBY benefits. Initial awareness campaigns were successful in creating a buzz about RSBY OP benefits, but they were too complex, and did not result in sufficient understanding of the benefit package by health-care providers or clients. In particular, many clients misunderstood the fact that the OP benefits included a range of common drugs prescribed during an OP visit, at a specified level per visit. Instead, they thought that they were entitled to receive the total benefit amount for drugs over the allowed number of OP visits per year. The misunderstanding caused confusion and resentment, when clients discovered that the benefits were not as extensive as they had thought.

Awareness will not spread by word of mouth until a critical mass of clients has experienced the benefits of cover. ICICI Lombard found that information did not spread as quickly as hoped, due to low levels of product use. This problem was compounded by health-care providers' poor understanding of the benefits. These were therefore unable to give the clients accurate information, causing confusion, even where information did spread by word of mouth.

Awareness-building and client education need to continue beyond enrolment. Providers should complement broader financial education campaigns with specific information about the product, its value and processes. The content can be sequenced. Clients need to understand the key issues at the beginning and learn about other features as time goes on (Matul et al, 2013).

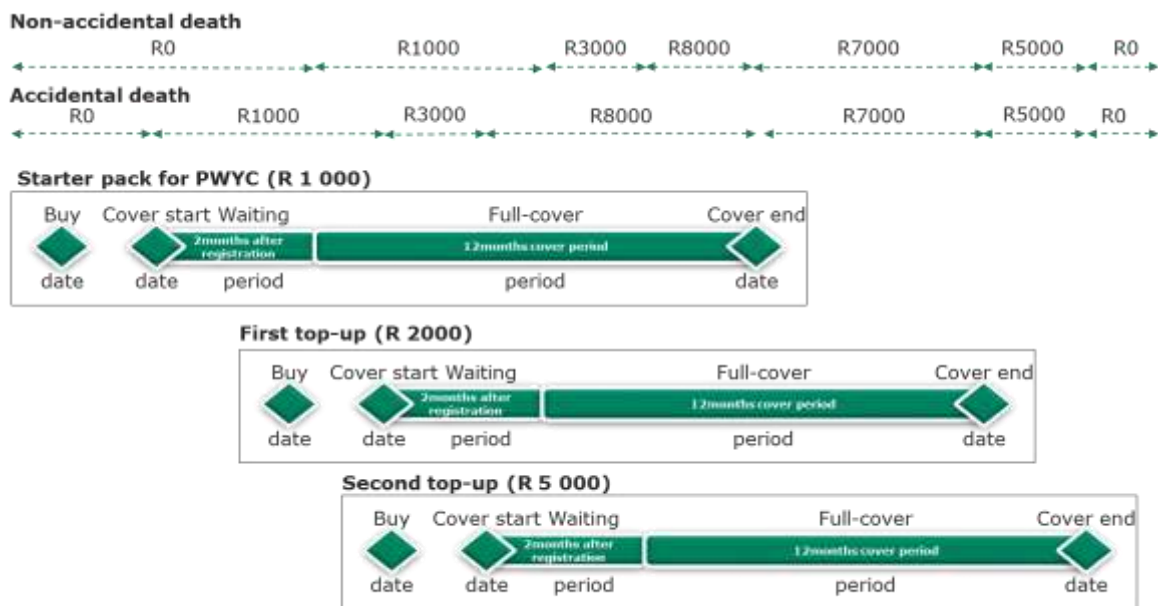
3.2.2 COMPLEXITY

Seemingly client-centric features, such as comprehensiveness and flexibility, which aim to improve value, can have adverse effects if not put into effect with due care.

The Kenyan Financial Diaries project (Zollmann, 2015) revealed that households face many moderate frequency and moderate severity risks, such as fire and theft. The diversity of moderate risks makes it difficult for low-income people to insure against the entire range of risks simultaneously, especially with single risk cover products. Composite products that combine a number of risks may be attractive, as they provide cover for multiple risks at lower costs (due to low transactional costs). However, four out of five Facility partners who tried to implement a composite product failed in the attempt, mostly due to difficulties in selling and administering the product. CIC's example is a case in point. Its composite health and life insurance product proved difficult to explain and administer. SACCOS, its distribution partners, struggled to explain the product adequately during initial sales and found it difficult to process renewals (see 3.3.1), resulting in the product being removed from the market after two years.

Old Mutual also faced a complexity problem during implementation of its PWYC product. PWYC was designed to be flexible, with clients having the option to top up cover on an on-going basis. The intention was to make the product affordable and match the design with clients' cash flow. After making an initial contribution, clients were able to top up as and when money became available. However, the top-up mechanism was confusing (see Figure 3) and it was difficult for clients to determine exactly how much cover they had at any given point due to the waiting periods associated with top-ups, leading to questions and confusion on the part of customers.

Figure 3. The complex PWYC product



Complexity: The first 2 months after registration and every top-up. During this time you only have Cover for accidental death.

La Positiva also found that increased flexibility, which resulted from incorporating farmers' feedback, actually added confusion. Farmers asked La Positiva to raise the maximum age and to include medical care. La Positiva included an advance benefit covering 50 per cent of costs of terminal illnesses and staggered the benefits (see Table 2). The policy was a family product with staggered coverage in the first three years. The insured amounts were differentiated depending on whether the claimant was the policyholder, the spouse or a child, and with different levels of coverage, depending on whether the insurance was contracted between the age of 18 and 70 years or between 70 and 80 years. It was hoped that staggering would encourage the insured to continue with the system and avoid anti-selection. However, it

made the product confusing and difficult to explain.

Table 2. The complex Agropositiva Vida product

Coverage	Coverage amounts insured (in PEN)		
	First year	Second year	Third year
1. Policy-holder			
1.1. Natural death	2 260	2 900	3 750
1.2. Death due to pre-existing illnesses	750	970	
1.3. 50% advance for illnesses	1 130	1 450	1 875
1.4. Accidental death	4 520	5 800	7 500
2. Spouse			
2.1. Natural death	1 400	1 770	2 350
2.2. Death due to pre-existing illnesses	460	590	
2.3. 50% advance for illnesses	700	885	1 175
2.4. Accidental death	2 800	3 540	4 700
3 Children (maximum 6)			
3.1. Natural death	690	880	1 400
3.2. Death due to pre-existing illnesses	230	290	
3.3. 50% advance for illnesses	345	440	700
3.4. Accidental death	1 380	1 760	2 800

For further insights on how to improve client value, see Matul and Dalal (2014), which highlights ten strategies that practitioners can follow to move towards more valuable products.

3.3 OPERATIONS

Many microinsurance innovators struggle with actual implementation and basic, day-to-day project management. The pressure of unrealistic targets – partly due to donor expectations, but mostly due to the organization's own expectations – prevented organizations from sticking to plans. A number of organizations were also constrained by inefficient processes, organizational structure and technology.

3.3.1 INEFFICIENT PROCESSES AND LACK OF INTEGRATION

Behavioural economics says that people's actions are influenced, sometimes disproportionately, by seemingly inconsequential features of their environment (also called "channel factors"). When designed properly, channel factors can be effective in translating intentions into actions, but if ignored, they can lead to inaction (Dalal and Morduch, 2010). Allianz Life Indonesia faced this issue where small details, such as having forms and pens on hand, prevented loan officers from renewing clients who wished to do so. VisionFund's loan officers did not carry enrolment forms and pens with them during their weekly meetings, with the result that even clients who wanted to enrol could not do so. There was little time for follow-up visits, which meant that interested clients who wanted to consult with their husbands before signing up, were often ignored. Also, loan officers were unsure of when best to explain the insurance product.

Channel factors contributed to CIC's problem of low renewals. The renewal rate was just 25 per cent, in spite of high satisfaction and a stated renewal preference of 60 per cent. The low rate of renewals was probably due to lack of information, as well as the absence of renewal incentives for agents and lack of follow-ups. During the renewals period, SACCOS did not have a system to send reminders, or even to

process renewals when clients asked for them. CIC eventually established a system of renewal reminders and established a centralized customer care phone line. These mechanisms had a limited impact on renewals, due to lack of integration with similar systems of delivery channels. Members preferred to first interact with their contact at the delivery channel, which usually had no capacity to deal with their request. With high acquisition costs, it was hard to sustain microinsurance business that brought in a mere 25 per cent renewal rate.

The majority of lapses of clients for Allianz Life Indonesia were due to problems with premium collection and data entry, rather than unwillingness to pay on the part of customers. Weekly collection sheets generated by SisTam (MIS system) were not used by loan officers and branch administrative staff. This led to confusion about whether customers had paid, when they had paid and the amount of premium paid. Numerous enrolments were not entered into SisTam, even though loan officers had already started collecting the premiums.

AIC experienced problems due to an unclear premium allocation process with its partner MFI, Sogesol. Clients had a single bank account for both loan repayments and insurance premium payments, and there was no way to designate what the deposits were for. If someone was to deposit their Protecta premium a few days before it was due, and had a loan repayment due before the Protecta premium, the loan repayment would automatically deduct the necessary amount from the account, regardless of the premium due the next day.

Fonkoze faced particular difficulties in ensuring quick claims processing while maintaining claims controls. In its second year of operation, frequent and severe disasters strained the claims process. More than 28,000 clients were paid out as a result of multiple events which hit the country that year. These included tropical storm Isaac (in August 2012) and Hurricane Sandy (October 2012). Just 11 specially trained management staff were available to cover more than 1,100 centres affected by the disasters, and waiting for them to facilitate decisions inevitably delayed claims. As a result, when Hurricane Sandy struck, Fonkoze decided to drop the requirement for management staff to carry out facilitation meetings with the centres. As long as Centre Chiefs identified fewer than half of the clients as victims, the claims were paid without further investigation (Solana and Merry, 2014). While this process ensured faster claims settlement, it is possible that it led to inflated loss assessment.

Any programme that offers some form of catastrophe coverage, or could anticipate a large number of correlated claims occurring at the same time, should have a contingency plan to deal with extreme events. Fonkoze's flexible staffing system allowed it to manage most of the variability in its claims frequency. AIC was also able to leverage a difficult period (see Box 1).

Box 1: When life gives you lemons, make lemonade

AIC's implementation of Protecta in Haiti was interrupted at various stages by an earthquake, elections, riots and a cholera outbreak. AIC worked hard to maintain its reputation during these difficult periods. After the earthquake of 2010 in Haiti, under the policy contract AIC was only obliged to provide a funeral service and, in some cases, an additional benefit. AIC was unable to offer funeral services for individuals who had been dead for several days, never found, or sometimes had already been buried. Its approach was to encourage claims – to the point that it explicitly decided to pay claims even where there were valid contractual grounds for repudiation. AIC believes that this challenging time actually made the company stronger and reinforced staff's commitment to serving the low-income market.

Tim Brown, Founder, IDEO.org

Claims management is particularly challenging for microinsurance providers, who must deliver similar products and services as mainstream insurers, while working with smaller margins and a greater volume of transactions. Client satisfaction hinges on receiving the insured benefit or service. Rendek et al (2014) outline eight guiding principles for practitioners to improve their claims management processes (Box 2).

Box 2: Principles to improve claims processes

1. Leverage existing social capital and distribution channels.
2. Ensure that the claims notification and submission process is simple and easily understood by clients, claims managers and intermediaries.
3. Balance claims documentation requirements; requirements should be sufficient to minimize fraud, but not excessive.
4. Pay attention to turnaround time and remember that from the client's perspective, it is not the internal processing speed that matters, as much as the total time from loss to payment.
5. Implement efficient and streamlined workflow processes and evaluate them regularly.
6. Remember that a loss event is a difficult time for the client, and the process should be fast and simple and address the client's needs.
7. Maintain control over data and processes. Ensure investments in technology are well thought out and will result in the desired improvements.
8. Balance business and client perspectives and set clear management perspectives in order to focus the claims operations.

3.3.2 NON-CONDUCTIVE ORGANIZATIONAL STRUCTURE

Innovating and developing client-centric products and processes is rarely possible without making substantial changes to business models. Organizations often need to change their standard operating procedures and internal structures, as existing structures may not be suitable for microinsurance products. Indeed, as a first step, an insurance company needs to be willing to make a sufficient investment – even before the premium income can justify it – in staffing and work towards inculcating a new culture. Among partners, the microinsurance initiative did not develop rapidly when allocated as a small part of a staff member's responsibilities. Working with the low-income requires new thinking and someone needs to be doing this as a core part of their role.

Similar challenges exist within distribution channels, especially where they do not have in-house insurance expertise or widespread interest in providing insurance. A channel's capacity to integrate insurance operations varies. Not all channels can be easily adapted to the sale and distribution of microinsurance. Distribution channels' organizational structure and administrative systems need to support insurance. VisionFund needed to integrate the Allianz Life product into its performance indicators, target letters and promotion criteria. For instance, a newly appointed microinsurance field coordinator had to be integrated into the overall administrative reporting structure and supervision, but this was not done properly, leading to the coordinator being sidelined and subsequent failure to mainstream the insurance product within VisionFund.

In the case of La Positiva, the rural water boards did not view the sale of microinsurance as an opportunity; these were not-for-profit associations focused on the distribution and sale of irrigation water to users. This is the first time they had taken on a "commercial" activity, so it was necessary to seek their political, social or economic interests in getting involved in microinsurance.

In the partnership between CIC and NHIF in Kenya, the various levels of hierarchy within the government organization, and the lack of sufficient communication between them, meant that commitment from management did not translate into commitment at operational level (Rendek, 2012).

3.3.3 POOR TECHNOLOGY IMPLEMENTATION

Large volumes of transactions, coupled with low margins for each transaction, mean that microinsurance processes need to be ultra-efficient. Technology can be the solution, as seen in the case of Allianz Life (see Box 3).

Box 3: Improve efficiency using technology

To minimize transaction costs for TAMADERA, a microinsurance endowment product, Allianz developed and piloted a web-based administration system (SisTam) that features a simple automatic underwriting logic based on the health and age of applicants. SisTam enables distribution partners to independently perform administrative functions such as enrolment, claims submission, MIS reporting and premium, limiting Allianz' administrative tasks to: 1) approving claim payments directly in SisTam, based on documents scanned by the partner, and 2) reconciling automatically generated invoices with actual premium transfers from the partner.

Through SisTam, Allianz Indonesia offered external parties a direct interface with its information systems for the first time. Building on the successful pilot of the system, Allianz Life replicated features of SisTam in its commercial group health business, allowing corporate customers to register and maintain data for their insured members directly online. While its microinsurance pilot was not successful, it provided Allianz with an opportunity to develop and test innovative processes, systems and protocols that benefited its core business.

However, as many of the cases in the study revealed, achieving a successful mix can be a challenging process. The first question that has to be asked is when to invest? Legacy systems of insurers are often not flexible, and cannot be customized to handle the technical requirements of microinsurance products. This may be due to a large volume of transactions, size of transactions, flow of premiums or information amongst partners. An insurer may not want to make the investment in new systems for untested products with small premiums, and the work needed to make arrangements during the pilot phase can often cause high administrative burdens.

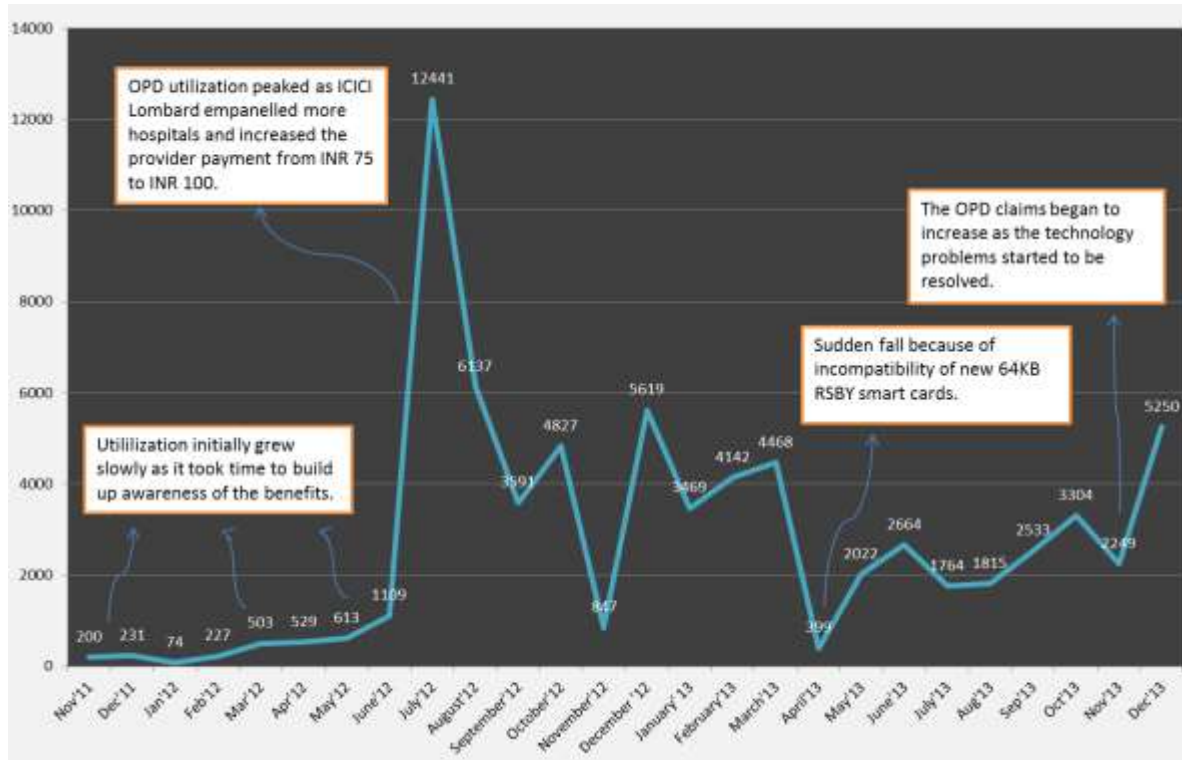
Even when companies decide to make the investment, technology implementation can be hampered by limited technical capacity on the part of insurers, as well as complexity, high expense and the risk that the technology will become obsolete by the time it is implemented. Insurers often struggle to find suitable technology partners. Furthermore, poor connectivity and unreliable electricity have made it challenging for insurers to make the best use of their technology solutions. Mobile technology holds promise, both in terms of reaching scale and in streamlining processes and making them less expensive.

ICICI Lombard has effectively used technology to monitor claims in real-time to improve efficiency and reduce fraud. However, it initially struggled to get health-care providers to adopt the software to record outpatient transactions. This was due to challenges with connectivity, but also due to an inherent resistance to change and technology adoption. The health-care providers had problems uploading claims data using the OP software. A system to make transactions offline was developed. Data cards were used to improve Internet connectivity, but these problems and issues with electricity persisted, slowing implementation. In addition, some of the devices stopped functioning after a few months, and required reactivation. When devices malfunctioned, claims had to be processed manually. This led to delays in claims payment, causing some providers to simply turn clients away. Finally, a mobile transaction application was developed to replace the web application.

Technology can disrupt, rather than improve processes. In the case of ICICI Lombard, the government was concerned that there was not sufficient space on the biometric identification cards to store all the client data that might be required to accommodate multiple government schemes in the future. It therefore decided to enhance the memory capacity of the cards from 32KB to 64KB. However, this caused many problems for the OP pilot. The new cards were not compatible with the existing devices. As

a result, many OP clinics could not access the technology platform to record client visits and submit claims. The hardware had to be replaced, and it took months to finalize the new software and install it in the clinics. In the meantime, most private facilities – which are often the closest and most accessible for clients – began turning RSBY clients away or asking them to pay for services out-of-pocket. This led to a reduction in claims, and a loss of trust among those clients and health-care providers who were affected (see Figure 4).

Figure 4. Claims pattern for ICICI Lombard



UAB in Burkina Faso experienced similar challenges with connectivity that affected the effectiveness of its mobile-based premium collection system. At the time of the launch in 2011, UAB Vie realized that the extent of connection problem in the collection zones was greater than the tests had revealed. The tests were carried out in a limited number of zones (in order not to interfere with the collection process). As a result, UAB Vie underestimated network connection problems. UAB Vie updated its offline procedures: it updated the messages to be sent to sales staff on the status of transferring the funds they collected and manual receipts were issued to clients for each premium collection to ensure that customers' balances were tracked properly. UAB Vie learnt that it was useful to maintain the old procedures in parallel with the new operational methods, in order to have a backup of information in case of problems.

Poor connectivity was only part of the problem for UAB Vie. From the start of the project, there were implementation challenges. UAB Vie's first technology partner was not selected through a tender process. The partner's ability to respond to requirements, and its lack of transparency, emerged only after the technology was acquired. UAB Vie had to end its partnership with its first IT supplier because of non-delivery of equipment and poor communication. A tender process was used to select its second supplier, but the delay meant that the technology solution was delivered two and a half years after the project was initiated. UAB Vie did not have capacity within the organization to assess partners and proposed solutions. When selecting a second supplier, it used a remote consultant to help better define needs and identify solutions. The presence of an experienced consultant lent weight to its decision not to sign any document until it fully understood the proposed solution. This allowed UAB Vie to avoid a second mishap.

3.4 PARTNERSHIPS

Partnerships are crucial for any microinsurance business. A study of microinsurance schemes that have achieved scale revealed partnerships as a key driver of scale (Thom et al, 2014). Problems in partnerships arise when there is not a business case for each partner, when there is a serious power imbalance or when interests are not aligned, leading to distrust. Most common partnership challenges occur between insurers and distributors. But a microinsurance scheme typically involves many other partners, for instance technology providers, third-party administrators and healthcare providers. It is important to keep all partners in mind – failure might not originate from the primary partnership between the distributor and insurer (as seen in the EcoLife example in Box 4 from Leach and Ncube (2014)).

Partnerships with governments, perhaps structured as a PPP, pose an opportunity to achieve universal health coverage, improve food security and manage impacts of climate change, but they also pose unique challenges and must be set up and managed carefully (Solana, 2015). These partnerships are particularly sensitive to changes in the political environment and priorities. Elections and changes in the political climate can cause disruptions as new bureaucrats may be appointed and budgets revised to address political mandates.

Box 4: EcoLife Zimbabwe, a failed partnership

In 2010, Zimbabwe's largest wireless network operator Econet established a life insurance product called EcoLife. The scheme provided life insurance to all Econet customers who enrolled by sending an SMS. Policies were activated as soon as customers spent a minimum of US\$ 3 on air time. In less than one year, the scheme had reached a total of 1.6 million people. Ecolife was provided through a tripartite partnership between Econet, First Mutual Life, a Zimbabwean insurer, and Trustco, a Namibia-based technology service provider. In 2011, 7 months after the launch of the product, Trustco terminated its agreement with Econet due to a dispute concerning royalties payable to the former. This limited Econet's ability to manage the product and add additional subscribers to the Ecolife service. As a result, it stopped providing the Ecolife product. Around 62 per cent of its clients were not informed, generating widespread mistrust and accusations of dishonesty. The impact was so negative that 63 per cent of those affected ruled out the use of similar products in the future.

The Ecolife Zimbabwe case highlights the risk involved in partnership and the importance of aligning incentives of the various partners engaged in the provision of a product. Ultimately, the difference in objectives among partners may have implications for the sustainability of a product. It is therefore important for all partners to align objectives or at least incentives, to ensure that insurance cover can be provided over the longer term and partners' reputations are not risked.

3.4.1 NO BUSINESS CASE FOR PARTNERS

For distributors, a partnership with an insurer must bear financial results either directly through commission earned, or indirectly by supporting their core business. For instance, a mobile network operator, retailer or microfinance institution may choose to offer insurance as a value-added service to its customers, in order to increase average spend per user, reduce churn or attract new clients. A business case analysis for distribution partners must take into consideration these adjacent benefits (Leach et al, 2014), particularly because the direct commission earned may not be enough of an incentive and these adjacencies may have a more significant impact.

Allianz Life Indonesia and VisionFund designed TAMADERA with high customer value in mind. As a consequence, the product brought few returns for Allianz and VisionFund. This proved to be a key obstacle to its success. VisionFund's management knew from the beginning that TAMADERA would not be a profitable undertaking for them, but they were motivated by the social impact of the programme as borrowers had been demanding additional protection and savings services, which could be met by this endowment product. While management was motivated by the social benefit, staff did not see the same benefit and this impacted their motivation to sell the product (see section 3.4.2).

3.4.2 INTERESTS ARE NOT ALIGNED

The many examples below show how difficult it is to keep all interests aligned in a partnership. Aligning objectives does not imply that the organizations need to have the same objectives. It is natural for partners to look out for their own interests, especially as a partnership might become more challenging. However, the partnership needs to add value to the core business of each partner. Objectives need to be aligned at different organizational levels – operational as well as management – in order to ensure effective implementation. Partners may wish to ask the following questions during the initial phase of the partnership to clarify the interests of each partner: Do the partners understand each other and their core businesses? Is there a shared vision or purpose? Will this partnership add sufficient value to the core business of each partner? Could this partnership harm the core business of any partner, even inadvertently? Do the partners have the same expectations for growth and profitability? (Rendek, 2012).

The CIC-NHIF partnership ruptured when NHIF made a unilateral decision (due to a bill issued by the parliament) to include outpatient cover, which made the overall cost unsustainable from CIC's point of view, and ultimately led to the termination of the partnership. Further, the decision was made after a major advertising campaign by CIC, potentially hurting its brand. CIC was just one of the distributors of the NHIF policy and hence had little say, the imbalance of power was too great. CIC felt that the MoU with NHIF was not detailed enough, particularly with respect to the roles and responsibilities of the partners. Operational issues and lack of clear lines of responsibility slowed down decision-making processes and created issues with client service. The terms also were not clear with respect to how products could be amended and by which party (Rendek, 2012).

Microcare found it challenging to align interests with its health-care providers. Careful tracking of claims patterns among individual health providers and among clients is critically important and must be proactively managed. Aligning the interests of providers, patients, and the insurer through incentives and risk sharing may be a more effective way to control claim costs than elaborate control mechanisms alone (Greyling, 2013). Microcare's increase in claims costs in 2008 showed that control measures were not always successful in preventing over claiming and over servicing. As a result of an in-depth claims audit, Microcare introduced additional controls, such as pre-authorisation of high-cost diagnostic tests, and revised its products and pricing. It also notified certain service providers that it planned to reverse some payments previously made. This caused a strong reaction and some of the affected service providers started refusing services to clients. It should be noted that five of these service providers had started to operate as health maintenance organizations and were actively trying to persuade Microcare's key clients to move their business to these institutions.

In the case of FMiA a common social mission and organizational network hid the fact that the organizations involved were not always aligned with the objectives of the microinsurance programme. Despite partnering with organizations within the Agha Khan Development Network, the multi-stakeholder partnership proved challenging to manage. The local entities were not used to cooperation and had their own objectives. The insurer did not have sufficient incentive to police and enforce underwriting sustainability, as the product development was done elsewhere and the reinsurance stop-loss facility removed a large portion of the risk from the insurer. Participating hospitals had an incentive to maximise services to their patients, in direct opposition to the risk carrier and claims adjudicator, whose objectives including managing claims costs. For the MFI, initially the product was mandatory for its borrowers, which, rather than providing a competitive advantage, was used by competing MFIs to draw clients away by promising lower loan costs. The decision to make the product mandatory was made jointly by the partners in order to address adverse selection and increase scale, and while the risks were identified, neither the microinsurance agency nor the MFI anticipated the backlash from loan officers who reported erosion of their loan books due to rejection of the mandatory insurance coverage. In order to address the issue, the MFI pressed for a premium reduction, which in turn generated underwriting losses that were unacceptable to the insurer (Rendek, 2012).

3.4.3 LACK OF CAPACITY OF A PARTNER

Section 3.1.1 highlights the challenges that sales agents of distribution channels may face due to a lack of capacity. The same challenges may be prevalent across the entire organization.

La Positiva had to take an active role to train, incentivize, and manage the water boards who distributed their product, due to their limited experience with providing any financial services. Organizationally, the water boards differ from traditional distribution channels (microfinance bodies, banks, NGOs). The boards are structured to collect payments for irrigation water and do not normally offer services unrelated to that activity, nor do they have well-developed marketing capabilities. The initial commercial strategy showed that the boards and councils of water services did not have the capacity or the motivation to include insurance sales in their regular activities. A programme to develop the water boards and councils as strategic partners had to be developed. The programme was intended to improve these capacities and maintain a permanent relationship with the water boards, and in particular with the workers that made up the insurance sales teams.

Profin also found it challenging to manage its PPP with SAMEP. Profin did not receive the support that it expected from its public partners. This was largely due to an inadequate ability and willingness of private and public actors to engage in constructive partnerships. Profin experienced high staff turnover, which made it difficult to build and sustain good relationships between Profin and public actors. Moreover, the public sector's institutions were instable and sometimes lacked the political will to seek closer ties with the private sector.

3.5 EXTERNAL

The success of a scheme (or its failure) can be determined by many external factors that insurers have very limited control over. The question for insurers is whether it is possible to anticipate these challenges and prepare for them.

3.5.1 LIMITING REGULATORY REGIME

As new models emerge to deliver insurance to previously under-served groups, new risks also emerge. Regulators therefore face the tough task of balancing the need for innovation and the need for consumer protection (Fonseca and Dalal, 2014).

In many ways, Microcare paid the price for being the first regulated specialist health insurer in Uganda, as it was required to comply with a regulatory regime that was not designed for health insurance. Microcare was not a registered insurer, but perhaps because of this it was flexible enough to meet the needs of the health microinsurance market. While such flexibility existed Microcare was able to grow, but when it was removed Microcare faced insurmountable problems.

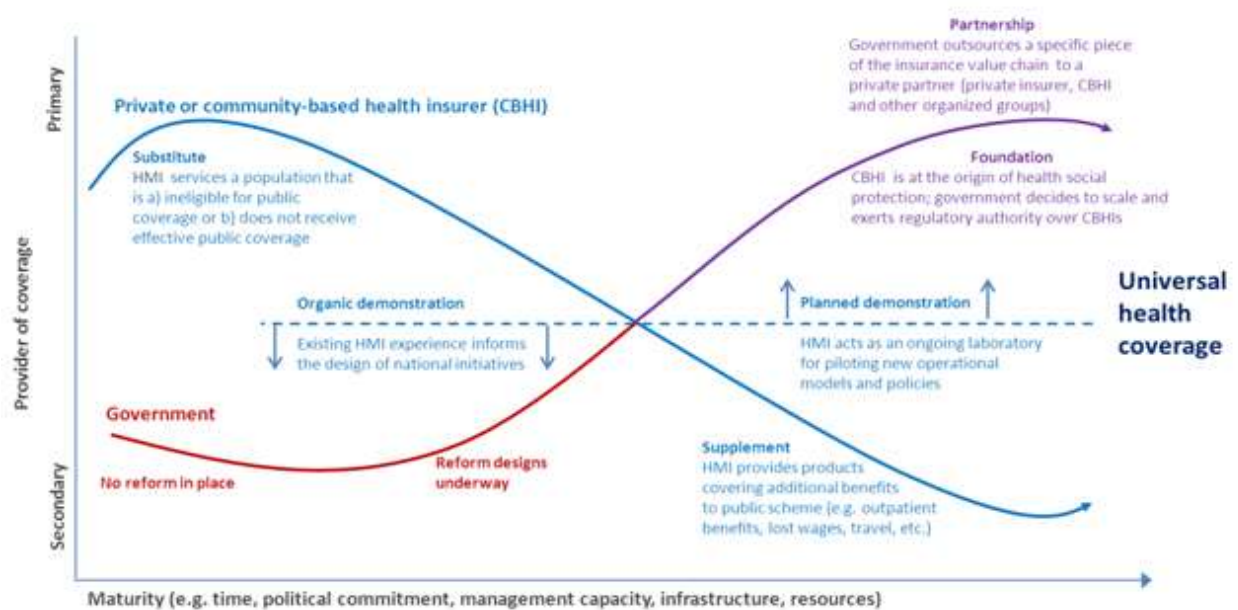
In 2009, due to conflicts with and conflicting interests of service providers (explained in Section 3.4.2), a group of eight service providers launched an application for a winding-up order against Microcare in the High Court. The application was timed to coincide with the renewal of insurance licenses for 2009 and to undermine Microcare's credibility with the regulator. The negative publicity caused by the application resulted in a loss of trust in Microcare, which caused a significant loss of business. It also created panic among many of its creditors, including the contracted service providers. Microcare was forced to settle outstanding debts much sooner than normal, whilst debtors became difficult to collect from. This caused serious cash flow difficulties that impacted negatively on its solvency margin. The lesson from the Microcare seems to be, when pioneering new approaches in insurance, stakeholders must work closely with the regulator, ensuring continuity in their relationship and keeping detailed records of decisions by the regulator allowing a more flexible interpretation of regulations or accepted practices (Greyling, 2013).

3.5.2 CHANGING GOVERNMENT PRIORITIES

CIC's partnership with NHIF faltered when the Kenyan Parliament issued a bill that required the NHIF to include outpatient benefits as part of its benefit package. Profin's agricultural insurance product faced competition from SAMEP, a public programme – a 100 per cent subsidized programme for catastrophic insurance for the 70 poorest municipalities. As more governments pursue policy objectives using insurance mechanisms, it is possible that public schemes will compete with private ones. Private actors will need to find ways to supplement, rather than compete with public schemes, perhaps by covering different risks or providing complementary benefits. For instance, CIC is now offering products that complement the NHIF package. Insurers need to continue dialogue with government agencies to understand possible changes to social protection policies, so that they are ready to strategically adapt their offerings at the right time rather than in reaction to changes.

A review of countries (Kimball et al., 2013) pursuing universal health coverage suggests roles in which private health microinsurance schemes can be leveraged: substitute, foundation, partnership and supplement. A similar framework could be applied to the policy objective of achieving food security, where private agricultural insurance schemes can serve to extend or supplement public agricultural or livestock development programmes.

Figure 5. Leveraging health microinsurance to promote universal health coverage



4. SOLUTIONS

The schemes included in the paper used a number of solutions to resolve their challenges. The solutions, highlighted throughout this paper, are summarized in this section along with suggestions on other solutions that the schemes could have tried. This section also highlights five fundamental strategies that organizations can follow to avoid and deal with these root causes of failures.

4.1 SOLUTIONS FROM CASES

Table 3 summarizes solutions implemented by the organizations featured in this paper. These are mapped to success factors derived from a number of thematic studies that the Facility has conducted over the past six years.

Table 3. Success factors and solutions

Success factors	Challenge example	Solution example
Viability		
Claims management incorporates cost controls	SSP: Hospitalization incidence more than double that had been expected (11% vs. 4%) resulting in a claims ratio in excess of 300 per cent.	Approximately 40 per cent of hospitalizations were due to preventable water-borne diseases that can be addressed by better access to outpatient care. Improving coverage ratio per village could reduce adverse selection.
Reasonable incentives for sales agents	La Positiva: Sales agents received a commission of between 2 per cent and 6 per cent, which was too low.	La Positiva proposed shifting the incentives from the water board to the sales agents to raise the commission by 5 per cent.
Consider financial viability of all partners to ensure long-term commitment	Fonkoze: The product was discontinued and Fonkoze decided to focus on core lending activities to ensure long-term viability of the organization.	Given its financial situation, Fonkoze is focusing on a variety of strategic priorities essential to the long-term viability of the organization.
Regular performance monitoring	SSP: The organization did not track claims performance until it was too late - 60% were rejected due to failure to submit the claim within the seven day limit.	SSP would have benefited from monitoring key performance indicators such as its claim ratio, but its focus was on increasing outreach.
Price products appropriately	Allianz Indonesia: The business model assumed net interest rates of 6% per annum; however, the interest rates fell to 4-5%.	New Allianz microinsurance products will be based on more appropriate assumptions with regard to expected returns from investments.
Dig deeper: Paper No. 28: The moment of truth: Claims management in microinsurance Paper No. 32: Business case for microinsurance part II: Follow-up study on the profitability of microinsurance		
Client Value		
Start simple with partial, single, mandatory cover	Profin: The integration of three different products and two legal entities involved was a great challenge to create a single policy for the composite offer.	A marketing campaign was conducted to raise awareness about Vida Agricola.
Match product with	Old Mutual: the PWYC product	OM is redesigning the product and plans

Success factors	Challenge example	Solution example
stage of market development	provided a top up option with complicated waiting periods. Market research as well as low sales showed that the market didn't fully understand the new concept.	to initiate a more active sales process at the retailer.
Ensure great client experience through claims and servicing	Fonkoze: the delay in paying claims on Kore W (around 45 days) eroded the total value of the product as clients still had to seek alternative short-term financing, usually through informal mechanisms.	Fonkoze completely changed its claims process. Center chiefs performed claims assessment for their respective centers, filled out forms, and reported claims to their respective branches.
Dig deeper: Client Value Brief No. 2 Creating client value: Ten blueprints for microinsurance providers		
Operations		
Set intermediate targets and process oriented goals that can be used to track progress	SPP: The project expanded its geographic coverage to 210 villages as opposed to the planned number of 120. This strained the implementation team's resources, resulted in low penetration, made raising awareness more difficult, and may have encouraged adverse selection.	The program was refocused in 70 villages where there was high potential. SSP also made renewed efforts to reduce the time for hospitals to fulfill documentation requirements for claims submission.
Integrate insurance operations into systems and processes of partners	Allianz: The position "Field Coordinator" was not successful because the position holder was not well integrated into the overall administrative reporting structure at VisionFund.	The field coordinator position must be integrated into the administration system.
Efficient use of technology	UAB Vie: After launching the product, UAB Vie realized that the extent of connection problem in the collection zones was greater than the pre-launch tests had revealed.	UAB Vie hired a technology expert consultant to analyse and document sales procedures, compare technological alternatives, carry out a financial analysis, and evaluate the business and accounting software.
Pilot carefully	La Positiva: La Positiva ended up piloting in too many areas as it wanted to test the programme in water boards that were diverse in terms of size, geographical location, tariff and payment systems.	La Positiva believes that it would have been better to have initially chosen one or two boards at most to test the product and processes, rather than eight.
Dig deeper: Paper No. 30 Scale: Thinking big		
Partnerships		
Build business case for all partners	Fonkoze: Fonkoze had to discontinue the product as the financial risk borne by it (15% of all payouts not covered by the index) was too high and unsustainable.	Assess the ability of each partner to bear the risk. If the product is not sustainable for even one partner, the project will fail.
Align interests and objectives	CIC: NHIF unilaterally modified the health benefits included in the composite product, which made the overall cost unsustainable from CIC's	Review of the CIC-NHIF relationship by a local consultant Identified that both CIC and NHIF put in effort to build a successful partnership. However, some

Success factors	Challenge example	Solution example
Selection of suitable partner to fill a defined capacity gap	point of view, and ultimately led to termination of the partnership. UAB Vie: the partnership with the first information technology supplier ended due to its failure to deliver the equipment and poor communication.	risks were not identified in a timely manner and were not managed effectively. UAB Vie used a tender to select the next supplier and used a consultant to help them evaluate the options resulting in better partner being selected.
Dig deeper: Paper No. 15.Managing microinsurance partnerships		
External		
Establish effective public-private partnerships	Profin: Initially the local government in Tarija fully supported the project and agreed to subsidize the premium. Later the local government decided to stop subsidizing premium forcing a reduction in the insured amount and a premium rise.	After this experience the organization has learned how to approach the support of the government, particularly when resources are involved. It is important to involve all stakeholders, including farmers associations.
Dig deeper: Client Value Series Brief No. 3 Creating an enabling environment to improve client value		

4.2 FIVE FUNDAMENTAL STRATEGIES TO ADDRESS CHALLENGES

The solutions listed above are for the most part, well-known. The question, then, is why so many organizations make the same mistakes. Perhaps projects are simply too difficult to execute. Organizations may be overly optimistic in their assumptions and have unrealistic expectation of their own staff and partners. Or is the industry simply difficult to operate in, whether due to resource constraints, lack of demand, staff capacity or lack of leadership commitment? Addressing such challenges requires a combination of better planning and execution. The five strategies outlined below provide ideas on how to do so.

4.2.1 PILOT CAREFULLY

The best-laid plans come to nothing if they are not followed. This is a common theme amongst programmes that do not stick to plans due to pressure from their Board, donor, partner organization, or management to meet aggressive (often unrealistic) targets, causing organizations to skip the fundamentals and make mistakes.

Sticking to plans during pilots can be particularly problematic. How many and what geographies should the pilot run in? La Positiva ended up piloting in too many areas as it wanted to test the programme in water boards that were diverse in terms of size, geographical location, tariffs and payment systems. Choosing a large number of boards made it difficult to implement the communication plan effectively and efficiently. In hindsight, La Positiva believes that it would have been better to have initially chosen one or two boards at most to test the product and processes, rather than eight. On the flip side, UAB Vie only piloted its new technology in select areas and did not identify the problems with connectivity until it was too late.

The general recommendation is to limit the size of pilots to one or two locations because the objective during the pilot is to closely monitor the reaction to the product and to refine processes before scale-up. However, it is important to identify the key factors that can lead to a scheme failing and make sure that the pilot sites represent these factors. Hence, in the case of UAB, since connectivity issues could have important implications, UAB Vie should have chosen at least one pilot site in a rural area with poorer connectivity to test how the technology performed in that area.

4.2.2 SET INTERMEDIATE (REALISTIC) TARGETS AND ACTIVITY-BASED GOALS THAT CAN BE USED TO TRACK PROGRESS

Another important strategy to avoid undue pressure at the initial stages is to set intermediate targets to monitor performance and progress against a business plan. The targets should be realistic. Targets need not be linked to output measures such as policies sold or premium collected, but can instead be linked to activities, such as education campaigns conducted, villages reached etc. We have seen the example of SSP which spread itself too thin by expanding to 210 villages, even though the initial target had been 120. This strained the implementation team's resources, resulted in low penetration, made raising awareness more difficult, and encouraged adverse selection as it seemed likely that only the sickest families from each village were enrolling. This push for scale also meant the SSP's management was fully focused on outreach and did not pay attention to claims management. It therefore failed to identify and address problems with the claims rejections rate when the issue was emerging.

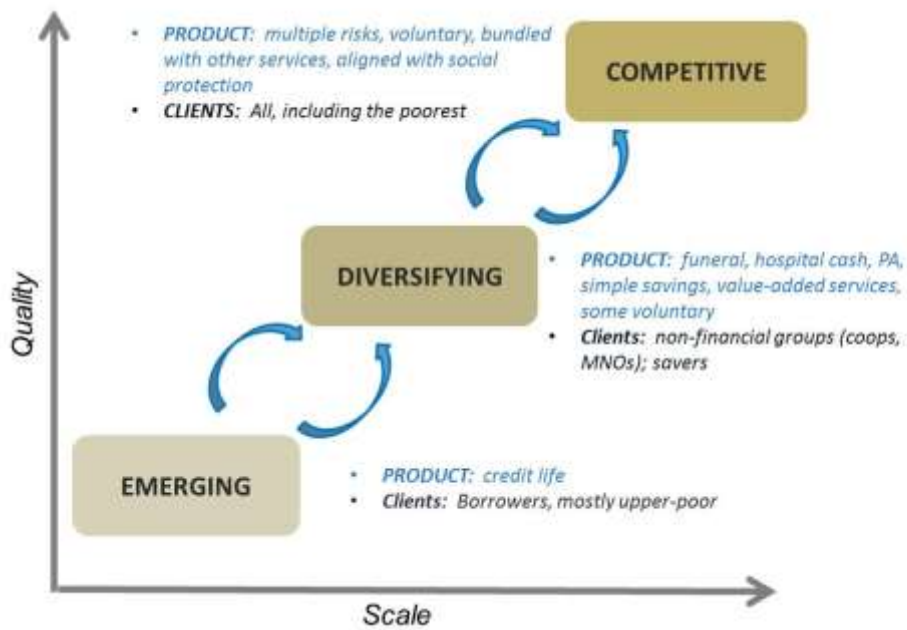
Establishing key performance indicators and tracking them requires quality data collection and reporting systems. For health claims for instance, insurers need to manage trends on a per person, per period basis to unmask adverse trends during a growth period. At this time looking at aggregate trends alone may hide the real issues. FMiA, Microcare and SSP were late in identifying such issues.

4.2.3 MATCH PRODUCT WITH STAGE OF MARKET DEVELOPMENT

The key to achieving long-term success is to lay down strong fundamentals at the beginning and then to gradually innovate, enhancing products. Research on client value and scale has identified the need to match products with the stage of market development (see Figure 6). In the Emerging stage, starting with simple products may make sense as long as the products provide clients with a good experience through effective promotion, efficient claims settlement, and customer care. Providers need to pay special attention to building trust and monitor all customer touch-points to ensure that every interaction with the customer is geared to building trust.

Products are likely to become more complex as markets move to the Diversifying and Competitive stages. Old Mutual, CIC-NHIF and La Positiva struggled with complexity. While the products were innovative and probably met client needs, they were not easy to sell, even in the seemingly advanced microinsurance markets of South Africa, Kenya and Peru. Clarity in product and process design is important not only for clients, but also for distribution partners, many of whom may be selling this type of insurance for the first time. Products that are not ready to be adopted by consumers or are too difficult to administer, or do not create a positive first-time experience, can do more harm than good, and may delay progress for several years.

Figure 6. Stages of market development



To understand what stage the market is at, insurers must invest in market research. It is important that this is a company-wide effort. Cross-functional market research teams expose organizations to the needs of low-income persons. At least part of market research and data analysis needs to be done in-house for organizations to be able to extract the details that can make their products successful (Matul and Dalal, 2014).

4.2.4 PROVIDE VALUE TO EACH STAKEHOLDER

As the case of Fonkoze shows (and many insurers already know), a microinsurance scheme can only survive if the distributor is benefiting from the scheme. This benefit may be in the form of direct commission earned on a product, but more often it is through a contribution that the insurance product makes towards the core business of the distribution channel.

Providers also need to partner with regulators and governments to build a client-centric environment. A government can be an important partner (La Positiva), sponsor (ICICI Lombard) or competitor (Profin). These partnerships pose unique challenges and can be difficult to manage given changing priorities. Still, for microinsurance to succeed, especially in areas of health, agriculture, and climate change, government partnerships are going to be a must.

Partnerships will succeed only if interests are aligned and the stakeholders find ways to collaborate to achieve a common goal. Schemes need to be designed with a win-win-win scenario in mind. It is not possible to ignore any part of the partnership.

4.2.5 MAKE A LONG-TERM COMMITMENT AND ADOPT A LEARNING CULTURE

Microinsurance is a long game. Insurers need to decide what to invest and when. Does it make sense to invest in technology or human capital? Does it make sense to establish a special team or unit dedicated to microinsurance? If not enough is invested, you won't see results. But, what comes first investment or results?

An organization's mind-set regarding investment and returns horizons plays a critical role in whether challenging programmes fail or succeed. Several failures and setbacks may occur before profitable models are found. Failure is essentially about timing – when should an organization “give up”? The cases from this study that terminated did not have the adequate resources to see the project through its initial

stages of challenges. It is completely possible that results could have been reversed with adequate investment. In this sense, projects that are part of established insurers are more likely to receive the investment needed to survive the test of time. This is why viability studies show that integrated schemes are more likely to survive than standalone programmes.

In the schemes reviewed, AIC, Allianz Life Indonesia, ICICI Lombard and La Positiva have stuck with microinsurance and learnt from these experiences to succeed in the microinsurance sector. Allianz, for example, has 45 million low-income clients worldwide. In Indonesia Allianz has made great strides and is now offering voluntary insurance as a top-up to its basic credit life portfolio. AIC believes in the long-term viability of microinsurance and was willing to make the upfront investment. It faced a difficult time when dealing with the multiple disasters in Haiti in 2012, but has come out stronger from the experience and feels that working in that environment has in fact made its culture and commitment to this market stronger. It was able to weather the storm because of its leadership's commitment and long-term vision. ICICI Lombard has grown its microinsurance portfolio, including health and agriculture, and is one of the largest private insurers active in this sector in India. Similar, La Positiva saw the investment in this project as part of a broader engagement strategy in the rural space. It has taken the lessons from this experience to form other PPPs with the government in agricultural insurance.

Long-term commitment must come from leadership and management. The key is to adopt a learning culture that allows people to make mistakes and provides a space for mistakes to be analysed and corrected. This culture – with due accountability but without unnecessary blame – has to come from leadership.

Benefits go beyond financial returns, and include building brand recognition, gaining access to the consumers of tomorrow, and learning how to implement an innovation that can be applied in other businesses.

5. CONCLUSION

“Creativity always comes as a surprise to us; therefore we can never count on it and we dare not believe in it until it has happened. In other words, we would not consciously engage upon tasks whose success clearly requires that creativity be forthcoming. Hence, the only way in which we can bring our creative resources fully into play is by misjudging the nature of the task, by presenting it to ourselves as more routine, simple, undemanding of genuine creativity than it will turn out to be.”

Albert Hirshmann

If the cases were able to foresee all the challenges and costs in a crystal-ball at the start of the project, it is possible that many may never have embarked upon such daunting journeys. But, if asked now, many would say that they are grateful for the experience, having learnt lessons that are being applied in other projects.

Readers should not be disheartened by these experiences but see them as opportunities to learn from others in order to 1) avoid these challenges altogether or 2) correct course if they are already facing these challenges.

It is not always possible to wait and watch, while others take risks and make the mistakes. Waiting and refusing to take new risks can be as costly as ignoring the mistakes of the past. The organizations who will manage to serve the millions who are currently uninsured, will be the ones who try new things, inevitably face challenges and some failures, but overcome them and change course when needed.

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