



EARLY WARNING SIGNS: THE ROLE OF GEOGRAPHIC AND MARKETING CHALLENGES IN THE AKAM MICROINSURANCE EXPERIENCE

BY ANNE FOLAN

- ▲ **Access to information** about the HMI was found to be uneven, which means that a significant portion of the Ghizar population was unaware of the product.
- ▲ **Sales data** show that households more distantly located from the main hospitals were significantly less likely to buy the insurance.

MICROINSURANCE IS A WORK IN PROGRESS. The successes of the microcredit models that achieved prominence in the 1990s proved that even very poor people were viable customers for financial services. Since those early days, a substantial body of scholarship has demonstrated that poor people need not just credit but in fact a full suite of financial services. Microinsurance is especially vital since it aims to mitigate the economic shocks (serious illness, death of a breadwinner, extreme weather event, poor harvest, or other such disruption) to which low-income families are chronically vulnerable.

One of the most visible microinsurance start-ups was the Health Microinsurance (HMI) product launched in Pakistan in 2008. The HMI, a voluntary, private insurance, was designed and delivered by the Aga Khan Agency for Microfinance (AKAM) with support from the Bill & Melinda Gates Foundation. HMI's objective was simple: to prevent low-income families from falling into destitution as a result of catastrophic medical costs. In implementation, however, HMI's logistical complexities—along with its inherent riskiness—proved unworkable.

AKAM formally decided in March 2011 to discontinue the HMI. This decision followed months of mounting losses and the pull-out of key business partners. At the time of writing, the ultimate fate of the HMI is yet to be determined. New Jubilee Life (NJL), a commercial insurance company that is part of the Aga Khan Fund for Economic Development, had originally served as HMI underwriter and was considering taking over the program's administration in the wake of AKAM's decision to withdraw.

This Policy Brief draws on a Microfinance Opportunities (MFO) report¹ of field research carried out during 2008 and on interviews conducted during 2011 with key AKAM staff. The Brief focuses on two key factors that contributed to the HMI's failure:²

- the remote mountainous terrain that was home to the HMI target market
- AKAM's decision to use grassroots community organizations as the main marketing channel.

Both had been flagged as potential problems in the original report. AKAM's experience provides relevant lessons to the fledgling microinsurance industry as it looks for ways to serve isolated communities and assumes that insurance can be layered on to existing delivery channels.

In the specific case of AKAM's HMI, numerous unforeseeable developments, including extreme weather events and political unrest, adversely affected operations. However, as the 2010 report documented, some of the early warning signs were clear from the outset.

THE HMI IN REVIEW

To understand the program's ultimate outcome, it is important first to review its rationale and structure. Serious illness is the number one risk faced by poor households around the world (McGuinness, 2010). The coping strategies most often used by low-income households—drawing down savings, borrowing, selling off productive assets—are usually inadequate and can lead households into poverty or propel the already poor into destitution. The purpose of microinsurance, whether in the form of life insurance, business interruption coverage, weather-indexed crop insurance, or other policies, is essentially to reduce vulnerability by protecting against the chance of loss. Worldwide, health insurance is the most highly desired microinsurance product (Roth, McCord & Liber, 2007).

In Pakistan, despite the availability of a free-to-user, government-supported health and hospital system, 75 percent of all health-care expenses are met by out-of-pocket expenditures. This is due to a variety of factors, including low standards of care in government facilities. But the upshot is that the medical costs borne by households are significant (Seckhu & Savedoff, 2005 as cited in McGuinness, 2010).

Seen from a policyholder's perspective, the HMI offered families access to care at higher quality health facilities, including those belonging to the Aga Khan Health Services network of hospitals, usually with no cash outlay required. However, the HMI was perceived to be expensive. The annual premium was the equivalent of about \$6 per person (whether adult or child), or an average of about \$30 US³ for

¹ McGuinness, E., J. Mandel, with H. Korda and A. Tayyab (2010). *Assessment of Health Microinsurance Outcomes in the Northern Areas of Pakistan: Baseline Report*. College Park, MD: Assessing the Impact of Innovation Grants in Financial Services project. (Although originally intended as a baseline, this research actually looked at the status of the AKAM project and the target market several months after project launch. It will not be followed up by endline research or reporting.)

² The HMI experience will be analyzed as part of a forthcoming series of research papers to be produced by the Microinsurance Learning and Knowledge (MILK) program, an initiative aimed at documenting the lessons emerging from the nascent microinsurance field. MILK is a Gates funded research project headed by the MicroInsurance Centre.

³ Figures shown reflect conversions from PKR to USD that were current at the time of the assessment report.

For those who could afford the premium, the HMI provided the following coverage:

- Inpatient treatment up to \$362 US per year, per family member.
- Life insurance coverage of up to \$362 US for one family breadwinner (selected by the family), between the ages of 18 and 60 years.
- One voucher per family member per year for a free consultation with a medical officer or consultant at certain specified facilities.
- Inpatient maternity care coverage of up to \$362 US per year.
- Comprehensive prenatal care.
- Postnatal checkups.

a family of five. This was the equivalent to approximately one-third of monthly cash income for families at the lower end of the middle-income range. Some families in the target area could afford this but many could not.

The pooled-risk business model for voluntary health insurance requires effective marketing. Marketers must sell enough policies so that the pool is deep enough (that is, that it contains enough sheer numbers of people among whom the risk can be spread). At the same time, marketers must manage *adverse selection*, which occurs when only those people who tend to get sick frequently purchase the insurance. As we will see, AKAM's decision to delegate marketing and enrollment to nonspecialist, grassroots organizations played a major role in the HMI's disappointing results.

COMMUNITY-BASED ORGANIZATIONS: THEIR PROMISE AND PITFALLS AS A DELIVERY CHANNEL

Health insurance is a complicated product with a lot of moving parts: underwriters, agents, brokers, reinsurers, hospitals, and pharmacies, not to mention the doctors and patients themselves. AKAM, through its subsidiary the First Microinsurance Agency (FMiA) of Pakistan, chose to use Local Service Organizations (LSOs) as their marketing channel. LSOs are essentially apex institutions that aggregate community-level groups known as Village Organizations (VOs, which serve the men of a given village) and Women's Organizations (WOs, the female-serving counterpart to VOs). Although LSOs had some direct interaction with end clients, they delegated much of the retail marketing outreach to the VOs and WOs. (See Figures 1a and 1b.)

AKAM/FMiA's decision to use these grassroots organizations seemed logical for several reasons. First, VOs and WOs have a substantial geographic footprint in the Northern Areas, and they are already "in the family" of the Aga Khan network. Established by the Aga Khan Rural Support Programme, VOs and WOs exist in virtually every village in Ghizar, one of the northern Pakistani districts where the HMI was introduced. Second, financial services were already among their main activities. VOs/WOs manage members' savings and provide them with credit. It was in this context of 25 years of community presence, development efforts, and financial services provision that AKAM introduced the health insurance product via the LSO / VO-WO channels.

FIGURE 1 (a) - HMI BUSINESS MODEL - ENROLLMENT PROCESSES

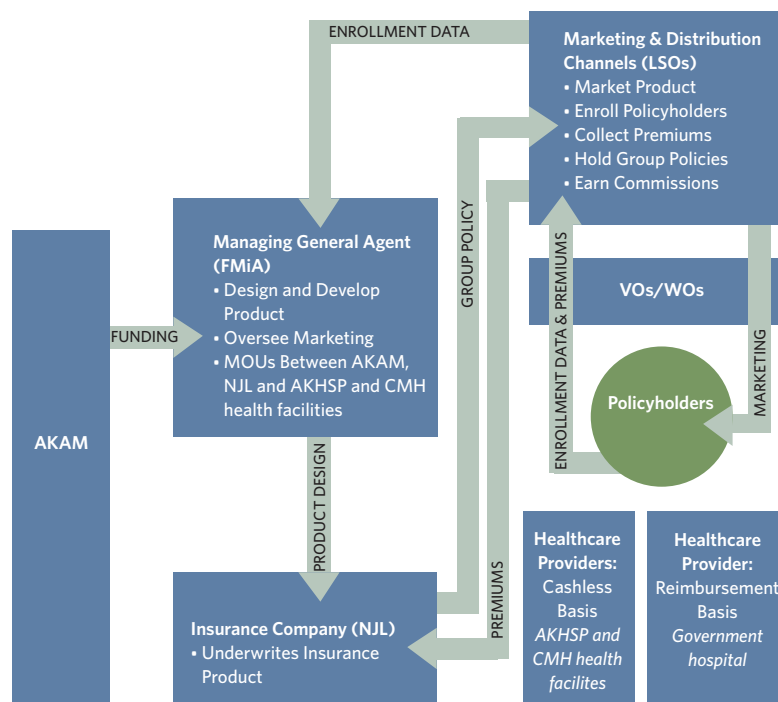


FIGURE 1 (b) - HMI BUSINESS MODEL (DETAIL): STRUCTURE OF LOCAL SERVICE ORGANIZATIONS (LSOs)



As described by McGuinness in the report, the HMI product was launched in Ghizar district with a marketing campaign beginning in summer of 2008. Launch had been delayed due to staff shortages, so the enrollment period, originally slated for the month of September 2008, was pushed to October, and then sales were extended through November 15th.

FMiA used a cascade approach for marketing and enrollment. As noted above, men generally belong to the VOs and women to the WOs. Those entities most often had the direct contact with end clients, and the LSOs would cross-check records to ensure that no households were double-counted for the purposes of establishing village-level eligibility, a complicated proposition described below.

So marketing information flowed from FMiA to the LSOs, then from the LSOs to the member VOs/WOs, then from the VOs/WOs to the end clients. Such an attenuated link between ultimate supplier and end purchaser might have been more successful in a more mature insurance market, where the value proposition and the basic concept of insurance were more widely grasped. But it is important to remember that in fact, the HMI was breaking new ground: it was the area's first health insurance product available for voluntary purchase by the general public.

In the end, on a district-wide basis, only four percent of the population purchased the HMI.

While the VOs/WOs may have been a good choice for their grassroots presence, they lacked the technical expertise to explain and sell what is an inherently more complex financial product than savings or credit. The inconsistent messaging resulting from the multiple layers of intermediaries no doubt contributed to the disappointing results as well. As described in the assessment report, one participant in a focus group discussion expressed that the second-hand marketing had indeed been a problem. *"We got the information through the LSO, but the insurance representative did not give us information directly. So we are concerned."* Another thought that their LSO must be lying because: *"How could some company pay our health expenses?"*

It is also possible that the marketing incentives were insufficient. The LSOs received the equivalent of \$0.17 per policy sold, and that small sum was divided between the LSO and the VO/WO.⁴ LSO and VO/WO commitment to market the insurance was unsurprisingly inconsistent, ranging from heroic effort to very little.

The eligibility criteria—highly complex, poorly understood (even by the administrators), and poorly communicated—were another major deficiency flagged in the assessment report. Within each LSO, VOs/WOs could either be eligible or not depending on whether 50 percent of their member households wanted to purchase the insurance. In practice, this meant that in many locations, families had to provide their completed paperwork and identification information to the VO/WO representative or directly to the LSO. Only after all the applications were received by the LSO was the determination made about whether or not the family's respective VO/WO was eligible.

Think about this from the point of view of the potential policyholder. She was pitched an unfamiliar and complicated product, and persuaded

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—FROM THE ASSESSMENT OF HEALTH MICROINSURANCE OUTCOMES IN NORTHERN AREAS, PAKISTAN - BASELINE REPORT

to apply for it, only to discover that it might end up not being available to her after all for reasons having nothing to do with her. Again, this may have been less problematic in a market where the concept of insurance had already gained traction. But the decision to use grassroots organizations, and to control eligibility at the level of those organizations, proved fateful. Although it may have reduced some administrative costs, also sowed confusion and depressed enrollment. The study findings suggest a self-perpetuating problem. The difficulty in achieving the VO/WO eligibility requirement was related to people's limited knowledge of the importance of insurance, which in turn was often a function of the ineffective marketing outreach on the part of the VOs and WOs.

Eligibility was made even more complicated by other factors, including the decision to enroll families rather than individuals (a strategy aimed at controlling adverse selection, but one which as implemented made it easy for parents to under-report the number of children). But fundamentally, the decision to rely on VOs/WOs made enrollment both too hard and too easy.

Too hard, because a client was not eligible unless his or her VO/WO was eligible. Too easy, because once that complicated but essentially arbitrary test was passed, the marketers did not have any incentive (even if they had had the expertise) to control for adverse selection. Their incentives, such as they were, were simply to boost numbers.

Along with its direct impact on AKAM's bottom line, the underperformance of the marketing campaign had an indirect negative effect on the potential beneficiaries who got left behind. Families who were never even made aware by their VO/WO representative of the HMI's existence were effectively denied access to a product that could have benefited them. The opportunity costs to such overlooked potential clients, unfortunately though they were, were less tangible than the obstacles confronting some of the actual clients. Now we turn to the second of the two main problem areas flagged in the assessment report, the Northern Areas' forbidding terrain, which affected policyholder families in a much more direct way.

RUGGED GEOGRAPHY AND INDIRECT COSTS

The Northern Areas of Pakistan do not seem an obvious choice to pilot a product like the HMI. Isolated for centuries due to its high elevation and rough mountainous terrain, the area continues to be politically and economically marginalized today (Malik & Hunzai, 2005 as cited in McGuinness, 2010). The Northern Areas' ethnically- and linguistically-diverse population of one million is scattered over 73,000 square kilometers. They are heavily dependent on agriculture, which the region's

⁴ To put this figure into context, monthly incomes for average families range from \$87 to \$174, or the equivalent of about \$3.63 to \$7.25 per day assuming a standard six-day workweek. So assuming that the individual VO/WO-based marketer kept the entire 50% split of the commission (\$0.08) after the LSO took its cut, he or she would have to sell 45 policies per day to achieve even the low-end of average daily income.

harsh terrain and climate make difficult to practice beyond the subsistence level, and they suffer from illnesses related to the cold climate as well. All in all, the population of the Northern Areas tends to be poorer, in worse health, and more geographically isolated than the average Pakistani citizen.

The field research documented in the assessment report took place in Ghizar district, the westernmost region of the Northern Areas located west and upstream of the capital of Gilgit. Average per capita income among Ghizar's roughly 130,000 inhabitants was \$301 in 2005 (the most current figures available at the time of the report), lower than the Northern Areas and much lower than the \$745 average for all of Pakistan. Ghizar, in other words, is a poor district within an already poor region.

So why did AKAM choose this impoverished, isolated, and harsh environment to pilot the HMI? One of the most significant reasons was that AKAM believed that the Ghizar population, more than 80% Ismaili, would be more receptive to the product due to their loyalty to the Aga Khan and his institutions. A related reason is the presence of the Aga Khan Health Services network of health-care facilities throughout the region which policyholders could access.

In addition, the Northern Areas has been expanding economically, albeit from a low starting point, thanks in part to various development initiatives implemented by agencies within the Aga Khan Development Network. Viewed in this light, the decision to offer the HMI in one of the poorest areas made moral sense—after all, the whole point was ultimately to alleviate poverty—as well as practical sense, as a logical product to layer on to an existing family of integrated development programs.

However, the HMI's benefits covered only direct hospital expenses. In the Northern Areas hinterlands, the time and costs involved in travelling to medical care are high, especially relative to income. The perverse result for HMI policyholders is that the poorer a policyholder was, the more he paid out of pocket (since the poorest people are also those who live farthest away and who thus have the highest transportation costs).

The report showed that in the remotest locations of Ghizar district, travel costs posed an absolute barrier. From Sandi, for example (see Figure 2), private car hire to Gilgit costs \$58 one-way—a significant amount for those households. Public transportation is cheaper but not suitable for patients needing urgent care.

Although transportation costs are often the first obstacle to obtaining health care for many families, they are not the only indirect cost. Patients who must travel to seek health care often need to be accompanied by a family member who can look after them en route, during the treatment, and on the way back home. That attendant's expenses also contribute to indirect costs as do the opportunity costs (time away from work and other productive pursuits) incurred by both the patient and the attendant.

The report estimated that direct costs of treatment accounted for between 42-68% of the total cost to the patient of a trip to the hospital (depending on the type and location of hospital, the village of origin, and type of transportation). As distance to the hospital increased, direct costs of actual medical care declined as a share of total cost, regardless of hospital type (government or private).

In sum, the HMI covered as much as 86%—or as little as 42%—of hospital care depending on these variables. For those at the low end of

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—FROM THE ASSESSMENT OF HEALTH MICROINSURANCE OUTCOMES IN NORTHERN AREAS, PAKISTAN - BASELINE REPORT

FIGURE 2 - MAPS OF PAKISTAN WITH NORTHERN AREAS HIGHLIGHTED AND THE GHIZAR DISTRICT WITH NORTHERN AREAS INSET



the value proposition-spectrum, for whom indirect costs were greater than the direct costs of treatment, a transportation subsidy of some sort could have made a significant difference in HMI's uptake and thus ultimate fate. Such a subsidy could have taken the form of direct provision of transport (ambulances existed but these were cost-prohibitive in many cases), a voucher system, or even post-facto cost reimbursements (although the latter would not help those families for whom the upfront costs posed an absolute barrier).

The most obvious truths are often the easiest to miss. In the case of the HMI, the program's design failed to factor in the reality that people will not sign up for a service they cannot use, no matter how valuable it might theoretically be. They also cannot purchase a product if they do not know about it. The performance of the VO/WO marketing channel, already very uneven as noted above, was particularly ineffective in the remotest communities for different reasons.

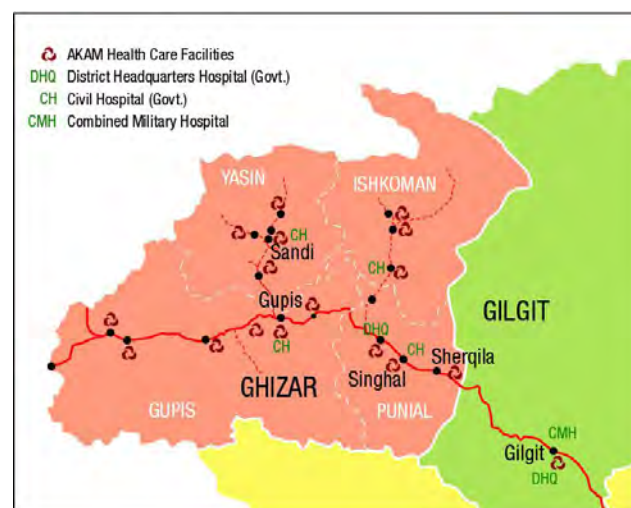
LESSONS LEARNED FOR THE MICROINSURANCE INDUSTRY

Distance and travel costs are not issues that microinsurance studies typically consider, but the AKAM experience suggests that in fact they can make a decisive difference. Some means to defray travel costs for the beneficiary population would likely have improved uptake, though they could also have been cost-prohibitive for the provider. The other early warning sign, the challenges of relying on grassroots groups for marketing, were also visible at the time of the field research. But the expense associated with a more robust marketing operation could also have driven the cost structure beyond viability.

Both of those added costs might have been manageable had the time horizon been longer and the expectations more modest. As noted above, staff shortages and turnover meant that the marketing effort, already structurally flawed, also got off to a late start. It never fully recovered from the rush-to-market scramble despite mid-course corrections that included radio and other mass-media outreach.

The assessment report also noted that for insurance policies with a one-year duration, a two-year pilot test period, which would have allowed for one full year's results to be studied, would be more effective.

FIGURE 3 - MAP OF GHIZAR DISTRICT



“The fundamental mistake providers made was to equate microinsurance with microcredit. With microcredit, the client walks out with money in her pocket, and you have to trust her. With microinsurance, it’s the other way around.”

—AKAM EXECUTIVE PETER WREDE, INTERVIEWED FEBRUARY 2011.

AKAM key staff interviewed during winter 2011 concurred, describing the HMI's enrollment and financial projections as unrealistic and based on insufficient data.

The Microinsurance Learning and Knowledge (MILK) program will produce in-depth reporting and analysis on the HMI experience. One preliminary hypothesis expressed by AKAM key leadership is that AKAM's experience in microcredit may have led them to assume too great a degree of comparability between microcredit and microinsurance, without fully appreciating the features of microcredit that are critical to making that model work. Microinsurance programs that retain microcredit's emphasis on group solidarity and mutual obligation—even down to claims processing by village committee—may hold important clues for successful microinsurance product design.

Microinsurance carries multiple risks. Insurance is an inherently risky business (hence the multiple players across which the risk must be spread), and financial service provision of any sort is riskier when the target market is poor. All the health and other microinsurance models that AKAM and others are trying to innovate remain experimental at this point.

“Failure” in such a context is an imprecise term. Provided that circumstances allow for rapid response, a formative assessment such as MFO's 2010 report can be one powerful tool to increase the chance for success. But, like microcredit before it, microinsurance will likely continue to proceed by trial and error, with a few players stepping up to take the early plunges for some time to come.

REFERENCES:

McGuinness, E. & Mandel, J. (2010). “Assessment of Health Microinsurance Outcomes in Northern Areas, Pakistan - Baseline Report.” Washington, DC: Microfinance Opportunities, Assessing the Impact of Innovation Grants in Financial Services Project.

This study is part of the **Financial Services Assessment** project, undertaken by the IRIS Center at the University of Maryland and its partner, Microfinance Opportunities. The goal is to assess the impact of grants provided by the Bill and Melinda Gates Foundation to microfinance organizations for the development of innovations in financial services.

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FUNDING

Financial Services Assessment is funded by a \$6 million grant from the Bill & Melinda Gates Foundation.

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This report is part of a series that will be generated by the Financial Services Assessment project. The reports are disseminated to a broad audience including microfinance institutions and practitioners, donors, commercial and private-sector partners, policymakers, and researchers.

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