The MicroInsurance Centre

Microinsurance
Demand & Market Prospects
Lao People's Democratic Republic



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Table of Contents

TABLE OF CONTENTS ..... **I**

ACKNOWLEDGEMENTS: ..... **II**

EXECUTIVE SUMMARY ..... **III**

ABBREVIATIONS ..... **VI**

NON-ENGLISH WORDS AND PHRASES ..... **VII**

BACKGROUND **1**

A. MACROECONOMIC SNAPSHOT OF LAO PDR 2
B. BASIC STRUCTURE OF THE LAO PDR INSURANCE INDUSTRY 3
C. BASIC STATUS OF INSURANCE AND/OR MICROINSURANCE LEGISLATION 4

MARKET ANALYSIS **5**

A. MICROINSURANCE "INDUSTRY" DESCRIPTION, SCOPE AND TRENDS 5
B. THE GOVERNMENT AND SOCIAL PROTECTION 12
C. BANKS AND OTHERS 17
D. MAJOR CUSTOMER PROFILE 18
E. PROBLEMS, OBSTACLES AND OPPORTUNITIES 25

MARKET STRATEGY **26**

A. QUALITATIVELY ESTIMATE POTENTIAL DEMAND AND MARKET POTENTIAL FOR MICROINSURANCE 26
B. DISTRIBUTION SYSTEMS 27
C. MARKETING CONSIDERATIONS 27

PRODUCT AND/OR SERVICES – SPECIFIC **28**

A. PROTOTYPE 28
B. LIFE CYCLE 29

OPERATIONS **30**

A. CAPACITY NEEDS 30
B. OTHER RESOURCES REQUIRED 31
C. LEGAL STRUCTURE 31
D. FINANCIAL 31

CONCLUSIONS **35**

APPENDIX 1: THE TERMS OF REFERENCE **37**

APPENDIX 2: METHODOLOGY AND RESPONDENT STATISTICS **47**

APPENDIX 3: PEOPLE MET DURING THE VISIT **50**

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Executive Summary

Lao People's Democratic Republic (PDR) is a landlocked, mountainous country in Southeast Asia with a population estimated at 6.2 million. Ranked 135 (out of 177) on the Human Development Index (2002), Lao PDR is one of the least developed countries in Asia. It is a young country with 55% of the population below the age of 20 and only 17% above the age of 40. It is also a predominantly rural country with eighty-three percent of the population in rural areas. Subsistence agriculture accounts for half of gross domestic product (GDP) and provides 80% of total employment.

It is in this context that GTZ, Allianz, and UNDP selected a team to visit Lao PDR to identify potential for microinsurance. The research was intended to understand and estimate the demand for microinsurance in Lao PDR, as well as the potential supply of microinsurance in terms of risk takers (regulated insurers, the government, and others) as well as various delivery channels. The resultant information should lead to an understanding of the options available for undertaking pilot initiatives, if indeed there is current potential, or what would be required to generate and service microinsurance potential. In the long-term, the research and implementation of the findings should relate to the development of sustainable livelihoods through the availability and access to microinsurance by the workers in the informal sector. It should also lead to the exploration of the use of microinsurance as a safety net mechanism to reduce livelihood vulnerability of low-income populations.

The team of three spent about four person weeks in two areas of the country. They studied demand through focus group discussions and key person interviews. Supply and potential were assessed through discussions with donors, available relevant government officials, and others. Most of the visits were conducted in the Capital, Vientiane, with some demand research conducted in Louangphrabang.

Demand research identified several potential gaps in the risk management strategies being implemented by low-income households. Although the demand was somewhat weak, there was evidence of a need for cover to manage the high expenses of inpatient healthcare, especially in the case of long-term illness. Such risks can completely de-capitalize many households.

Currently, the predominant form of risk management is self-insurance. People use savings, borrowings, or other means to pay the costs of the risks they face. Monetization is rather limited, especially in the rural areas, so households maintain savings in the form of livestock (as well as gold). This helps them hedge against inflation and generate a healthy return. This leads to the second most important risk of the people interviewed for this study – livestock illness.

Third, people identified the death of a breadwinner as the next most significant risk. This type of loss dramatically reduces the household income as well as their long-term income generating potential. Assistance in both the funeral costs and the ongoing adjustment might be appropriate for microinsurance.

With only one insurer in Lao PDR and two individuals in the Bank of Lao overseeing insurance, it is clear that even traditional insurance remains in a nascent state.

Supply side potential was difficult to assess. Appointments with government officials in Lao PDR were extremely difficult to obtain reportedly because of the layers of approval required. Even meeting with staff from the sole insurance company was made impossible. Others relevant

people were interviewed, but there is a serious limitation to assessment of capacity given the limited availability of key players in the market. However, this may also prove an indicator of their interest.

In most countries, it is helpful to have a reasonably well-established microfinance provider (MFP) network to work with in the development and implementation of microinsurance. In Laos, this is glaringly lacking given that the largest MFP only has 1,500 clients. Many institutions (donors and development organizations) work with the Lao Women's Union (LWU) and their network to distribute their "products". Given interest and capacity issues, this may not be appropriate in Lao PDR.

There are major efforts being made now and in the near future to improve the financial sector, as well as the microfinancial sector (at least in terms of credit and savings) through technical assistance, legislative assistance, and capacity building. New microfinance legislation is likely in the short-term and this supports MFPs acting as agents for insurers.

Although the government is fully supporting the current reforms and the extension of the schemes, the Social Security System is still rudimentary. Attempts to link up the government's three different schemes are currently limited to applying comparable procedures of membership administration and purchaser-provider relationships[1]. Furthermore, even users covered under the existing statutory schemes complain about the low reimbursement rate and the slow claim settlement.

Due to substantial fiscal constraints, poor people are still not exempted from out-of-pocket healthcare payments, as laid down in Decree 52 from 1995. Neither do social security schemes of any significance exist for the informal economy, nor is any formal framework in place addressing overall policy issues of social protection for all sections of the population. Moreover, the rural population is largely unaware of the few protection measures and risk management methods available to them, other than relying on the family and village network that are not sufficient to cope with the major risks. The consideration to introduce the Health Equity Fund linked to the Community Based Healthcare Initiative (CBHI), which is pilot-tested in a modified form in Nambak, could contribute to providing healthcare to poor people. Microinsurance will be a critical component in successful social security.

Three options might be possible for generating commercial microinsurance:

- Insurers might work with some form of CBHI apex that could accumulate premiums and link these to the insurer who would be better placed to manage the insurance risks.
- Consideration of the development of a mutual benefit association that would be managed by professional insurers, but owned by the membership on a very large scale.
- An insurer could develop a network of intermediaries to act as agents selling the microinsurance policies of the insurer.

In terms of development expense, the last option is likely the most efficient. If this were to be done, potential products could include: a life linked endowment policy, a healthcare cover, and then livestock insurance.

[1] J. Hohmann, unpublished paper on the linkages of social security schemes in Lao P.D.R., Vientiane 2005

This potential for microinsurance in Lao PDR is a future potential. Currently, the financial systems are nascent, and microfinance is still weak in terms of best practices. The infrastructure of intermediaries is not available and much capacity building is necessary. Finally, the demand remains rather weak. It is not likely that commercial microinsurance would be profitable at this time. Virtually every official visited in the Lao PDR noted microinsurance as premature in this market. Once the financial systems are stronger and there are healthy intermediate organizations with relatively large client bases and control over their portfolios, this will be the time for microinsurance. Such a level of preparedness is likely at least a year or more in the future.

Abbreviations

ADB	Asian Development Bank
AFD	Agence Francaise de Developpement
AGL	Assurance Général du Laos
APB	Agricultural Promotion Bank
BTC	Belgian Technical Cooperation
BoL	Bank of Lao
CBHI	Community based health insurance
CCSP	A type of credit cooperative
DFID	Department for International Development (UK)
EC	European Commission
EU	European Union
FC	Fonds Cooperatifs
GDP	Gross Domestic Product
GOL	Government of the Lao People's Democratic Republic
GTZ	Deutsche Gesellschaft fuer Technische Zuammenarbeit GmbH (Germany)
HASPM	HIV/AIDS and STD Prevention and Project Management
IFAD	International Fund for Agriculture Development
ILO	International Labour Organisation
JICA	Japan International Cooperation Agency
LAK	Lao PDR Kip (currency)
LFTU	Lao Federation of Trade Unions
LVCA	Lao Village Credit Associations
LWU	Lao Women's Union
MAF	Mutual Assistance Fund
MBA	Mutual Benefit Association
MFI	Microfinance Institution
MFP	Microfinance Provider
MoF	Ministry of Finance
MoH	Ministry of Health
MOLSW	Ministry of Labour and Social Welfare
MoPH	Ministry of Public Health
NEM	New Economic Mechanism
NGO	Non-Governmental Organisation
p.a.	Per annum
PDR	People's Democratic Republic
QSL	Quaker Service Laos
ROSCA	Rotating Savings and Credit Associations
SCB	State-owned commercial banks
SCN	Save the Children Norway
SME	Small and medium (sized) enterprises
SSO	Social Security Organization
STD	Sexually transmitted disease
SOE	State Owned Enterprises
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USD	United States Dollar
WHO	World Health Organisation

Non-English Words and Phrases

ex ante	Before the event
ex post	After the event
Houia	Local rotating savings and credit associations (ROSCA)

Microinsurance: Demand & Market Prospects - *Lao PDR*

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Background

Lao People's Democratic Republic (PDR) is a landlocked, mountainous country in Southeast Asia with a population estimated at 6.2 million. Ranked 135 (out of 177) on the Human Development Index (2002), Lao PDR is one of the least developed countries in Asia. It is a young country with 55% of the population below the age of 20 and only 17% above the age of 40. It is also a predominantly rural country with eighty-three percent of the population in rural areas. Subsistence agriculture accounts for half of gross domestic product (GDP) and provides 80% of total employment.

An estimated 39% of the population of Lao PDR is poor[2]. In 2001 prices, households considered poor are those with cash or in-kind income of less than LAK 82,000 (USD 9.16)[3] per person per month. For urban households the amount is LAK100,000 per person (USD 11.17) per month.[4] The prevalence of poverty is higher in rural areas at 41%, while in urban areas only 27% of the population is poor. Poverty is also differentiated by region with the northern region the poorest in the country (53% poor and accounting for 45% of all poor households in country) with the lowest human development indicators. The Vientiane municipality is the wealthiest region of the country with only 24% living under the poverty line. This region is followed by the central and then the southern regions in terms of wealth. The Louangphrabang province, one of the sites of our research, is located in the north of the country. It is 49% poor.

Poverty in Lao PDR is also differentiated by agricultural or topographic zone. Lao PDR is made up of at least two distinct zones based on topography and production systems. The lowland areas along the Mekong River and its tributaries produce the bulk of the nation's food supply. The rolling hills and mid-level mountains are characterized by shifting or swidden cultivation. Subsistence farming is the norm in this zone. Poverty is higher and is increasing in these mid-level areas as competition for arable land increases.

The topographic zones are also distinguished by ethnic group. Generally speaking, the Lao Loum, the predominant group in the country (68% of the population) tend to live in the lowlands or rice lands. The Lao Theung (22%) live on the mountain slopes. The Lao Soung (9%) made up of various sub-ethnic groups including the Hmong, traditionally live in the high mountains. The poorest groups are the minority ethnic groups most of whom practice swidden cultivation. The minority groups have significantly lower human development indicators than the Lao Loum group with poverty and illiteracy rates highest for the Lao Soung peoples.

Poverty in Lao PDR is characterized by a lack of infrastructure with the poor having lower access to all-weather roads, electricity, piped water, and basic health services, among other things. Only 38% of the poor have access to all-weather roads. On average, the poor are 13 km

[2] Based on the 1997/98 overall poverty line that was the cost of acquiring 2100 calories per day plus 20% for non-food essentials. This was estimated to be LAK 15,218 per person per month at 1997 prices. P.22 Lao PDR – National Growth and Poverty Eradication Strategy (NGPES), June 2004.

[3] The exchange rate in 2001 was LAK 8954.58 to USD 1. Source: CIA, World Fact Book, www.cia.gov.

[4] P. 30. Lao PDR – National Growth and Poverty Eradication Strategy (NGPES), June 2004. (Available on IMF website.)

from a road, making it difficult to get products to market. Women tend to be poorer than men, and women have lower literacy rates, 59% versus 82% for men.

To aid in improving the household financial conditions there are efforts by the Asian Development Bank (ADB) and others to develop and improve the volume and capacity of microfinance providers (MFPs), in this case with credit and savings products.

Recognizing these efforts and the importance of protecting the savings and credit gains people make through appropriate microinsurance products, the United Nations Development Programme (UNDP), Allianz Group, and Deutsche Gesellschaft fuer Technische Zuammenarbeit GmbH (GTZ) have come together to contract this study exploring the potential for microinsurance in the Lao People's Democratic Republic.

The research was intended to estimate the demand for microinsurance in Lao PDR, as well as the potential supply of microinsurance in terms of risk takers (regulated insurers, the government, and others) and various delivery channels. This information should lead to an understanding of the options available for undertaking pilot initiatives. Details of the full Terms of Reference for this study are included in Appendix 1.

In order to consider the demand for microinsurance it is necessary to identify the needs and demands of the low-income market. In doing this, the research included substantial qualitative research among the members of the reported largest non-governmental MFP in Laos. Details of the demand research methodology and the organization through which clients were identified, are included in Appendix 2.

The supply side research was conducted through the extensive use of key person interviews. Among them, the team met with key informants of government, civil society, and the private sector. A list of persons met is included in Appendix 3.

A. Macroeconomic snapshot of Lao PDR

The Laos PDR is a relatively small country in terms of population, landmass, and overall economic power. Key financial, health status, and educational indicators for Lao PDR are provided below in Figure 1.

Figure 1: Key Indicators - Lao PDR

Category	Value
GDP PPP (USD Billions)	9 (2002) (World Development Report 2004)
Population (millions)	6.2 (July 2005 est.) (USA Central Intelligence Agency)
Population density per km^2	24 (2002) (World Development Report 2004)
Percentage urban population	21.6% (2005 estimate http://globalis.gvu.unu.edu/indicator_detail.cfm?IndicatorID=30&Country=LA 08.23.05)
PPP GDP/Capita (USD)	310 from 2002 (World Development Report 2004)
GDP Growth Rate	6.5% a 2004 estimate (Asian Development Outlook, 2005)
Inflation	10.6% a 2004 estimate (Asian Development outlook 2005)
Exchange Rate (current, LAK per USD1)[5]	10,652 (http://www.oanda.com/convert/classic 07.01.05)

[5] This exchange rate will be used in all calculations of current figures in this report.

Category	Value
PPP GDP per Capita (USD)	1,610 (2002) (World Development Report 2004)
Infant Mortality (per 1000 live births)	Total: 85.22 deaths/1,000 live births Female: 75.04 deaths/1,000 live births Male: 95.01 deaths/1,000 live births (USA Central Intelligence Agency, 2005 estimate)
Under Five Mortality (per thousand)	100 (2002) (World Development Report 2004)
Maternal Mortality (per 100,000 live births)	650 (1995) (World Development Report 2004)
Access to an improved water source (% of population)	37% (2002) (World Development Report 2004) note this source is not necessary safe, simply "improved"
Health Expenditure as % of GDP (public / private / total)	1.3% / 3.1% / 4.4% (2000, World Development Report 2004)
Health Expenditure per capita (USD)	USD11 (2000) (World Development Report 2004)
Doctors per 100,000 people	0.2 (1995-2000 estimate, World Development Report 2004)
Literacy rate	66.4% a 2002 estimate (USA Central Intelligence Agency)

According to the UNDP Human Development report (2001), 92% of the communities are rural. Two thirds of the population is engaged in subsistence agriculture outside the market economy. 38.6% of the population of Lao PDR is poor[6], showing a wide disparity ranging from 12.2% in Vientiane Municipality up to 74.6% in the Northern Region (Huaphanh District)[7]. Financial markets in Lao PDR are segmented into a non-monetized rural subsistence economy, an under-monetized micro-economy of mostly informal micro-enterprises, and a small formal sector of government agencies and larger enterprises.

B. Basic structure of the Lao PDR insurance industry

Lao PDR passed an insurance law based on the French model in 1990. The next year the government opened the parastatal insurer Assurance General du Laos (AGL). They were given an official three-year monopoly that has effectively continued through at least July 2005. Recently, Allianz purchased a minority share (49%) of the company and has taken over management. Currently Lao PDR has only one regulated insurance company -- AGL/Allianz Manola.

Two staff from the Ministry of Finance (MoF) supervise AGL/Allianz. Premiums and returns are controlled by the government, which only allows investment in local time deposits. In 1998, premiums were about USD 2.5 million with 90% in non-life, of which 40% was life business.

a Insurance providers

The only regulated insurer in Lao PDR is AGL, and although they have interest in the results of this report, they have yet to enter the low-income market. The research team was denied admittance to speak with anyone at AGL other than the senior executive who was away during the visit. The inability to visit any of the staff or management of the one insurer in Lao PDR hindered the ability of the team to obtain a better understanding of their interest and capacity to adequately manage such products.

[6] The PM Instruction No. 010 of June 25th 2001, defines poverty as: "the lack of essential needs of daily lives such as the lack of foods (possession of foods that are less than 2100 calories/head/day; less than LAK 85,000 (USD 8) per member of the household per month - 2001 prices), the lack of clothing, the non-possession of permanent accommodations, unaffordable fees of medical treatments in case of illness, unaffordable payments for self education as well as that of members of the family and unavailable conditions for convenient communications".

[7] National Human Development Report Lao PDR 2001 – Advancing Rural Development

b Insurance with special emphasis on SME

There is no special insurance being provided to SME businesses.

C. Basic status of insurance and/or microinsurance legislation

The insurance business in Lao PDR appears limited given the low population, limited banking structures, strong government control, and only one insurer. Legislation is old for insurance and could use updating to allow for a freer approach to a more profitable business.

No microinsurance legislation was identified, and there seems no interest in doing such at this time, as it is a very low priority for the Government of Laos (GoL). It is interesting to note that the World Bank's Economic Monitor for Lao PDR[8] does not even mention insurance. It is clear that the focus is on banking first.

The insurance legislation of 1990 remains in effect. However, the Asian Development Bank (ADB) has been working with the GoL on a draft law to regulate microfinance. Additionally, they are developing a capacity building plan to help microfinance providers (MFP) reach for best practice organizations.

A foundation of microfinance providers and activities is important to the provision and acceptance of microinsurance, because it creates structures around which financial transactions occur within the low-income market. In Lao PDR, as will be shown, the MFP sector is rather weak and in need of significant capacity building and growth. The ADB is well aware of this and has been working in the development of projects to improve the capacity of MFPs. As part of this effort, the Bank of Lao, with assistance from the ADB, has been working to develop a microfinance legislative framework. Such legislation can create problems for microinsurance in that it might restrict MFPs from performing necessary microinsurance activities. The draft microinsurance law has considered the issues related to microinsurance, and favourably provides appropriate flexibility to MFPs in such activities.

The "Final Draft of the Microfinance Regulation for the Lao PDR"[9] notes the following about insurance in relation to microfinance providers:

Article 4: Scope of Activities of Microfinance Institutions

> Microfinance Institutions shall be entitled to:
>
> (vii) provide financial services, including sale of insurance as an insurance agent, payment services and money transfer services;
>
> Deposit-Taking Microfinance Institutions and Registered Microfinance Institutions shall not:
>
> (v) provide insurance services as a broker;

[8] World Bank Office in Vientiane. Lao PDR Economic Monitor. November 2004 (covering May through November 2004).
[9] Copy received from Brett Coleman, Microfinance Specialist, Asian Development Bank on 20.6.2005.

Schedule A
The criteria for determining whether a person is fit and proper to become a member of the board of directors, a manager, a director or a shareholder (holding more than 10% of the capital or voting rights) of a Deposit-Taking Microfinance Institution.

> A person or entity shall be disqualified from holding the position of board of director's membership, manager, director or substantial shareholder if such person/entity:
>
> (ii) has contravened the provisions of any laws or regulations designed for the protection of members of the public against financial loss due to dishonesty or incompetence of, or malpractices by, persons engaged in the provision of banking, insurance, investment or other financial services;

The ability to have MFPs that can legally act as insurance agents will be important in building large networks of potential microinsurance policyholders. Brett Coleman of the ADB suggests, "after issuance of the regulations, a pilot microinsurance project would be welcome."[10]

Market Analysis

A. Microinsurance "industry" description, scope and trends

Currently there is no microinsurance "industry". Even the microfinance "industry" is extremely limited in Lao PDR. In discussions, it was clear that microinsurance was far from people's minds because of the more basic infrastructure that they were working to develop, especially re microfinance. Microfinance typically evolves before microinsurance because microfinance products are tangible and therefore easier for the market to understand. Once people become more familiar with microfinance and can trust the delivery channels, then there is potential for microinsurance. At this point, it appears that microinsurance might be in a trend to become interesting in the medium term.

i. Available knowledge sources and networks

The legal foundations of the present banking structure are laid down in the banking law of June 1990, which separated central and commercial banking functions. Financial institutions, comprising of the Bank of Lao (BoL), commercial banks including private banks and foreign bank branches, non-bank financial institutions, and credit cooperatives, were regulated by decree in January 1992. The mandate for rural and micro-finance de facto rests with the state commercial banks as they alone have rural branches.

After the Government adopted its New Economic Mechanism (NEM) in 1986, policymakers faced two major challenges: one is effective administration and decentralization; the other is balancing policymaking at the top with bottom-up participation. The political system in the villages is built more on consensus than on majority rule.

1. Banks accessible to low-income groups

[10] Email correspondence between Mr. Coleman and the author dated 20 June 2005.

Six government-owned banks dominate the rural banking sector. However, only the Agriculture Promotion Bank (APB) is relevant for this study as APB alone is authorized to collect rural savings. APB was established in 1993 as the prime agricultural lender with a nationwide operation and five regional banks, which grew out of departments of the former State Bank in 1990 and 1991. The delivery structure of APB comprises 16 branches and 90 sub-branches reaching a total of 18 provinces and 133 districts. The five regional banks add another twelve branches.

2. Agricultural Promotion Bank (APB)

APB is the largest provider of microfinance, though their main customers are farmers that are more well-off. They do not reach the small and poor farmers. The interest rate structure of the APB remains inverted, with average deposit rates *exceeding* its lending rates, yielding a *negative* return. Under such conditions, banks refrain from mobilizing savings and restrict their lending. Instead, they continue to depend on government and donor funds. For deregulation to be fully effective, the volume of subsidized credit programs needs to be drastically curtailed.

In a meeting with the APB, they acknowledged that the government imposed interest rates offered a negative yield on their portfolio. Their interest rates were noted as the following:

Loan Term	Interest rate	Typical use
>3 year term	5% – 7%	Buffalo
Mid-term	8%	Clearing land
Short-term	12%	Production
Commercial Loans	17% – 24%	
Overdraft	24%	

Savings Product	Interest rate
Savings	5%
3 months	6%
6 months	7%
12 months	8%
>12 months	12%

3. Microfinance

After the collapse of the former state cooperatives in the 1980s, no new network of credit cooperatives emerged. There is no other legislation that would permit the establishment of small local financial institutions owned by shareholders, communities, or corporate bodies. Nor is there any form of official recognition for self-help groups or informal financial institutions. A draft of a law to address these deficiencies was tabled before the cabinet; however, no decision has been taken so far.

Laotians tend to be risk-averse and savings-oriented. Historically, women are in charge of the family purse and of savings. According to the UNDP/UNCDF rural microfinance survey of 1996[11], 91% of households hold financial savings, mostly in cash, averaging USD 87. 91% also hold non-financial savings amounting to USD 565: 82% held in livestock and 18% in gold and silver.

[11] J. Garson, Microfinance and Anti-Poverty Strategies: A Donor Perspective, New York: UNDP/UNCDF, 1996

This microenterprise survey revealed that credit is not an important source of micro-enterprise finance. 30% had loans outstanding, averaging LAK 200,000, more than half of this from family members. Only about 5% had a loan from formal or informal institutional sources. Almost 75% reported finance as a major start-up problem. Among the problems of established enterprises, marketing ranked first.

Fonds Cooperatifs and CCSPs

The members of Fonds Cooperatifs (FC) CCSPs (CCSPs are a type of credit union) come from the 30% of rural households that produce a surplus, which can be marketed, and the 60% of urban households that are involved in family based or microenterprises. (70% of rural households are subsistence farmers who are not integrated into the market.)[12] Together these rural and urban target groups account for 35% of the population or 1.9 million people. At this time, the CCSPs that make up Fonds Cooperatifs are reaching 1,500 members. To the best of our knowledge, this is the largest private (i.e., non-government) microfinance program in Lao PDR. It may well be the only best practice program in the country. Currently, FC has 12 CCSPs throughout Lao PDR with the Louangphrabang CCSP being the most northern cooperative.[13]

3.1 Semiformal systems: Lao Village Credit Associations (LVCAs)

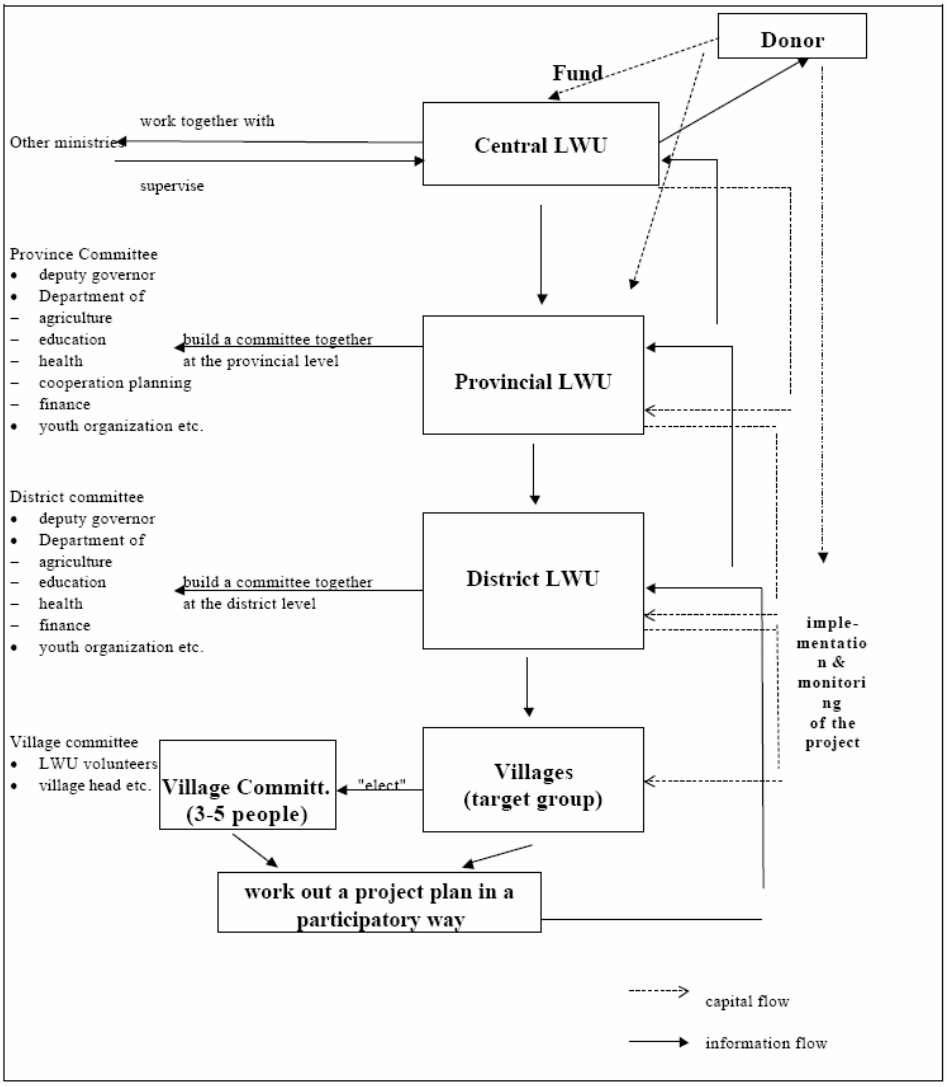
The semiformal financial sector comprises those institutions, programs, and projects that are officially recognized but do not fall under the banking law. These range from (earlier) credit cooperatives to revolving funds. In Lao PDR, semiformal finance is still below the stage of actual institution building. It largely rests on the cooperation of two types of partners: 1) international donor agencies, which may be multilateral, bilateral, or non-governmental, and 2) the Lao PDR Women's Union, LWU, with its local women's groups.

3.1.1 Lao Women's Union (LWU)

The LWU is an official mass organization of the Party focused on women and with 650,000 members. LWU is considered the best-organized development organization in Lao PDR with the widest delivery network reaching out to virtually all provinces and districts. LWU has a unique delivery structure, extending from national, provincial, and district levels, with thousands of staff members and volunteers in the villages.

All donor-funded women's projects are handled by LWU, which closely cooperates with the various line ministries. Since 1989, it has addressed the needs of poor women implementing activities in the areas of education and training, health, and childcare, legal rights information, income-generating activities, and more recently improved access to credit. The process is shown below.

[12] Statistics provided by Fonds Cooperatifs May 2005.
[13] Further information on FC and the CCSPs can be found in Appendix 1.



Source: H. D. Seibel, C.R. Kunkel, Microfinance in Laos: A Case for Women's Banking? University of Cologne – Development Research Centre, 1999

In close cooperation with donors, government agencies, and international non-governmental organizations (NGOs), LWU has been instrumental in establishing most of the 1,650 existing Lao Village Credit Associations, LVCA[14]. They are set up in target villages selected by local government at provincial and district levels in cooperation with the donor. Joint ownership of the LVCAs lies with the village, the government, and the donor. They are managed by a village committee and supervised by local government committees together with the donor agency. In most cases, the microfinance activities are in the form of a revolving fund attached to some other, overriding concern, such as health, education and training, or raising livestock. Each program falls under the supervision of the respective ministry in charge.

Women organized in the LWU, who comprise more than half the adult female population, dominate the semiformal financial sector in Lao PDR. So far, the LVCAs have served as revolving funds channels for a variety of program purposes; they have not functioned as

[14] H. D. Seibel, C.R. Kunkel, Microfinance in Laos: A Case for Women's Banking? University of Cologne – Development Research Centre, 1999

financial intermediaries. LWU has helped to deliver credit. It has not helped women to mobilize savings or build viable financial institutions at the local level.

However, LWU seems to be the only organization that has the potential of spreading a network of autonomous local financial institutions all over Lao PDR, but LWU is not anything like a financial institution. It lacks the required technical competence and financial management skills. While supporting projects, they utilize the expertise available in the line ministries at the provincial and district level. A massive capacity-building input would be required to enable LWU to effectively approach this task.

3.1.2 Informal systems

Except for the LVCAs, local MFPs are in their infancy stage unlike the MFP "Industries" in other Southeast Asian countries. The place of MFPs is largely taken either by the LVCAs or by small local networks of reciprocal relationships and mutual obligations among relatives, friends and neighbours.

- **Piggy bank: A microfinance-in-kind institution**
  Most microfinance institutions promoted by NGOs are revolving funds; and most of the loans are in kind. One of the NGOs, the Quaker Service Laos (QSL), has been working in Lao PDR since 1973. From 1993 onwards it has focused on small-scale irrigation and community development projects. QSL has provided revolving funds for rice mills, rice banks, buffalo banks, pig banks, and chicken banks. The villagers start by setting up a group of some twenty participants. Every member receives a loan valued at LAK 66,000 (USD 6.20) for a pig. The loan period is two years, including a grace period of one year. The interest rate is 8% per annum (p.a.). Repayment during the second year is in quarterly instalments. Relying on peer pressure, a new loan is contingent upon full repayment of the old loan. If a member encounters a repayment problem, s/he brings it before the group that tries to find an acceptable solution: usually by granting an extension.
- **Rotating and non-rotating savings and credit associations**
  Local versions of ROSCAs are known as *Houia*. The rotation is daily, weekly, or monthly, with membership varying depending often on the frequency of the payments. Recipients are compensated for allocations that come late in the cycle through interest payments of the earlier beneficiaries.
- **Micro-businesswomen's informal self-help banks**
  In the urban micro-economy women have been the financial innovators in recent years, setting up rotating and non-rotating savings and credit associations that could be called micro-businesswoman's informal self-help banks.
- Most **currency exchange shops**, which until 1994 belonged to the non-formal financial sector, are owned and run by women. As an additional business, they lend to women entrepreneurs at real market rates of interest, ranging from 5-20% per month.

3.2 Donor Projects

The microfinance projects supported by multi- and bi-lateral donors[15] and international NGOs are most relevant. More than thirteen projects of international NGOs operate through LVCAs.

[15] It is estimated that about 80% of this amount was provided by the World Food Program to establish rice banks (source: H. D. Seibel, C.R. Kunkel, Cologne 1999)

Multi- and bi-lateral donors provide the funds to the Government that subsequently releases them through local governments to the villages.

Earlier the emphasis was on credit, rarely on savings. This, however, has changed recently. General loan terms and target beneficiaries – individuals, groups, or communities - are determined through an assessment by the donor agency and local government staff. The village committee makes the final decision on loan terms and appraisal requirements of the expectant borrowers. Most loans are in the range of approximately USD 10 to USD 100 and are often used for the purchase of livestock or looms. Most interest rates range from zero to 30% per annum with an average of around 10%, roughly equivalent to the preferential rates of the state commercial banks.

Experiences are mixed[16] and although the situation is improving, there is still little awareness of sound microfinance principles such as mobilizing own resources, covering of costs from the margin, ensuring timely repayment, and building a viable institution. The two training institutions - the training college of the Central Bank of Lao and the University - do not cater to this market. Due to the lack of effective training facilities, international NGOs and donor agencies carry out their own capacity building. However, experience reveals that a number of microfinance activities came to a halt after the completion of the donor support. Indeed, it is important to recognize that there is no independent NGO structure in Lao PDR, and that the government has tight control over such organizations.

4. Microinsurance

As mentioned in the Microfinance Study,[17] in the subsistence economy, insurance needs are covered by reciprocal exchange relations and mutual obligations. Based on experience elsewhere, the demand for microinsurance may evolve through several stages:

1. Small resources may be first mobilized through ad-hoc contributions in the neighbourhood and allocated based on reciprocity
2. Regular contributions are made and allocated in fixed amounts with self-help groups and informal institutions. These respond to social obligations and emergencies in a limited way
3. Informal and formal local microfinance institutions providing access to savings and credits as need arises.
4. Regular contributions through formal institutions.
5. These are usually followed by the demand for loan protection through life, health and livestock insurance as part of credit risk management.

Institutions also may gradually progress from informal and semiformal to formal and would eventually offer all three services: microsavings, microcredit, and microinsurance, with linkages between them.

If further consolidated, formal institutions such as MFPs could partner with a regulated insurance provider[18]. However, in 2005 the institutional preconditions are far from being conducive to start microinsurance programs.

[16] UNDP terminated a microfinance project and the IFAD project is challenged with low disbursement rates through the Laos Women's Union and about 50% defaulted loans.
[17] H. D. Seibel, C.R. Kunkel, 1999
[18] The Assurance Général du Laos (AGL), part of Allianz Group, is the only private insurance provider in Lao PDR. They have not yet attempted to expand their business to low-income groups or even the poor – though exploring opportunities through the present study). In the area of social protection, they offer a health insurance product for the same target group as the one operated by the SSO for the formal economy.

3.1 Community Based Health Insurance

Only in the area of healthcare, has the situation improved when the Ministry of Health in collaboration with WHO set up a community based health insurance scheme (CBHI). Linked to the CBHI, the Swiss Red Cross initiated a system of health cards for covering the poor (see section B, Government Policies and Safety Net Mechanisms - Social Security Systems in Laos).

The CBHI Management Committee consists of 15 representatives from insured families, village leaders, delegates from the District Governor's Office, and delegates from the health sector. They take over all tasks related to representation of the insured members, including management of registration, the collection of contributions, arrangement of contracts with providers, and monitoring of the provision of healthcare in remote areas. Furthermore, the Management Committee has the duty to provide the Ministry of Health (MoH) and World Health Organization (WHO) project team with the required statistics and information regarding the CBHI scheme.

Because they function as the insurer, though linked to the MoH and supported by WHO, they gain the capacity for potentially operating microinsurance business independently at a later stage. Currently they still have to cope with the extension of the CBHI and several challenges as mentioned in Section B on Government Policies.

3.2 Others systems

- Mutual Assistance Fund (MAF) of the Lao Federation of Trade Unions (LFTU): In 1993, the LFTU established the MAF to supplement the public sector social security scheme on a voluntary basis. The benefits cover sickness, maternity, employment injury, death, and marriage. In addition, the Fund offers features such as other financial and social support for sick members or in the event of emergencies. These are paid from the reserves of the fund. This compensated for the disadvantage that no interest was added to the savings. The Fund has become increasingly popular with approximate 33,000 members of about 77,000 trade union members[19].
- Welfare Fund for Teachers: In 1992, a voluntary welfare fund was established in the Hai Xai Phong District of Vientiane Municipality covering the costs for hospitalization (for details please see section B "Government policies and safety mechanisms – social security systems"). Members have access to loans at low interest rates and payments to families in the event of the members´ death.
- Emergency Funds are established at the workplace to assist employees confronted with a crisis such as the death of a family member, or payments for customary celebrations such as marriage or childbirth.

4. Conclusions

The institutional knowledge base for microinsurance is very limited. This is on the one hand due to an almost complete lack of experience with microinsurance (except CBHI). On the other hand, Lao PDR is lacking the environment for a diversity of civil society organizations. The only broad-based membership institution with significant outreach is the Lao's Women Union – which

[19] E. Adam, M. von Hauff, M. John (ed.), Social Protection on Southeast & East Asia, Friedrich Ebert Stiftung, Singapore 2002

is a mass organization of the Communist Party. They are in a position to mobilize villagers and organize projects. They are, however, not an expert organization – nor are they meant to be one, as they implement projects in close collaboration with Government Ministries.

Capacity building remains a problem, as no appropriate institutional facilities exist. The Central Bank of Lao has established a division for microfinance that operates through commercial banks and the Agriculture Promotion Bank. This, again, is not suitable as the banking sector does not penetrate the rural areas – they neither exist in villages nor in the districts but only at the provincial level. Even if a non-registered village bank intends to get their business audited, they have to request the Bank of Laos to undertake the audit for a price of USD 5,000 – which no village bank can afford. This, of course, does not contribute to enhance the professionalism of local village banks. The APB is not reaching the small farmers in the villages and the training college of the Central Bank of Lao and the University caters to the need of commercial banking rather than of microfinance.

Even a developed commercial insurance industry is lacking. The only private insurance provider is the Assurance Général du Laos (AGL), part of the Allianz Group and they are not yet involved in microinsurance. Thus, its expertise remains with the "traditional" insurance business.

B. The government and social protection

ii. Safety net mechanisms – social security systems

The Lao social security system - introduced in 1986 by the government for public employees, including, civil servants, the military, the police, and their relatives – has developed significantly since the middle of the last decade.

In articles 20 and 26 of the new Constitution of 1991, the governmental responsibility for the provision of medical services is stipulated. The same legislation granted social protection to war invalids, as well as the families of those who died in the service of the country, and civil servants. These groups were entitled the right to work as well as medical care and assistance in the case of incapacity for work, invalidity, old age, and several other cases, which are determined by law.

The **Public Sector Social Security Scheme**, covering around 875,000 people in 2003[20], is funded by a 6% contribution of employees based on their basic salaries and a government subsidy to pay the non-covered expenditures. The scheme offers cover for pensions, widow / widowerhood, maternity, and disability as well as medical care in the case of sickness or work injury. The contributory amount is currently mainly used for the payment of pensions, while reimbursement for health care expenditure depends on the fund's net balance. A reimbursement scheme, based on a fee-for-service system with a threshold for reimbursement, covers health insurance. The employee contribution of 6% of earnings is used to meet the short-term costs of the medical scheme. It is not based on actuarial calculations and thus is not sustainable.

Currently major reforms are on the way to enable broader protection for healthcare. These developments take the experiences of the social security schemes of the formal sector and partly by community-based health insurance (CBHI) into consideration.

20 The beneficiaries are composed of about 91,000 civil servants, around 100,000 arm forces and police officers, 4,500 contracted employees, and roughly 680,000 dependents. Source: Tangcharoensathein, Viroj et. al. (2004a)

A new Labour Law (1994) constituted the social protection for the private sector as well as the state owned enterprises (SOE), which before were covered under the public sector scheme. Furthermore, the civil service and the armed forces were covered by the legislation. Labour Law Articles 50 to 53 stipulated the employers' responsibility for the social welfare of the workers, including healthcare. Enforcement of the law was a problem as it depended largely on the employers' willingness, preparedness, and ability to fund the workers social security benefits.

According to the 1995 Census, the labour force numbered approximately 2.2 million persons. Of that, public and private sector employment was about 333,000, of which approximately 70,000 were engaged in the public sector, 80,000 in the military/police, and 183,000 in the private sector. Due to lack of data, the 1995 Census states only figures for the urban population (54.5% formal sector, 41.9% informal sector and 3.7% small farmers/fishermen)[21]. Thus, based on these figures, it can be estimated that only about 15% of the labour force is covered by the statutory social security schemes mentioned above.[22] This assumes limited formal employment in the rural areas.

Due to this situation the mandatory system was developed in 1999, laid down by Decree No. 207/PM[23] (based on articles 48 and 52 - 54 of the labour law), which came into effect in July 2000. The Social Security Organization (SSO) responsible for it's implementation became operational in 2001. Despite all these progresses, social security by now only reached 30% of the defined target population[24] of the formal economy.

This has lead to the development of the Community Based Health Insurance (CBHI) as a third approach to health insurance in 2000. In three pilot regions, the north (Louangphrabang Province), the centre (Vientiane Province), and the south (Champassak Province) it is being explored to see if this could be an appropriate system for workers in the informal economy – and subsequently expanding the scheme to fifteen districts.

Social security scheme for the formal economy

The Decree No. 207/PM provides for the main International Labour Organization (ILO) designated social security risks and entrusts the SSO with responsibility to operate the scheme (since 2001). The Board is legally and financially independent from the government and consist of representatives from the government, the employers, and employees. The focus of the scheme are the employees of private companies and their dependents,[25] including SOE, with equal to or more than ten workers including their branches with fewer than ten staff members. In addition, the Decree permits for voluntary subscription of small enterprises. Once the voluntary membership is accepted it becomes compulsory and permanent. Furthermore, individuals can also join the scheme, while paying the employer's and employee's contribution.

Despite the stipulation of a mandatory membership, the compliance of employers subscribing their employees to SSO is still very low.[26] Presently, employees of 181 enterprises are enrolled

[21] E. Adam, M. von Hauff, M. John (ed.), Social Protection on Southeast & East Asia, Friedrich Ebert Stiftung, Singapore 2002
[22] Those employed divided by the total labour force. (333k/2,200k = 15%).
23 On 23 December 1999 the Prime Minister's Office signed Decree 207/PM on Social Security System for Enterprise Employees. The social security scheme was declared a compulsory and state-guaranteed insurance. Its purpose was described as 'to ensure welfare rights and benefits for employees, with the objective of improving living conditions and contributing to the socio-economic development of the country'.
[24] J. Hohmann, unpublished paper on the linkages of social security schemes in Lao P.D.R., Vientiane 2005
25 Spouses and children up to 18 years are covered as family members without any additional contribution.
26 The private insurance company Assurance Général du Laos (AGL), part of Allianz Group, is offering a comparable health insurance product for the same target group and a real competitor to the mandatory scheme.

and there are about 23,000 paying members and 48,000 beneficiaries.[27] According to a recently presented actuarial review of SSO, this represents only 31.4% of the legally covered population by the scheme.[28] All insured are located in Vientiane area. It is planned to extend the regional scope to other provinces of Lao PDR within the coming year.

Apart from health insurance, the SSO social security scheme is a broad scheme covering several short-term and long-term benefits. The short-term covers include

1. Sickness,
2. Income compensation in case of temporary loss of working capacity,
3. Work related injury or illness
4. Maternity
5. Funeral grants.

Long-term benefits cover:

1. Retirement pension
2. Survivors' benefits to protect dependents of deceased employees
3. Invalidity benefits in case of permanent loss of working capacity.

Benefits of medical care are currently offered at four public hospitals within Vientiane. They are provided without additional user fees.[29] The health care package is rather comprehensive, with only very few treatments excluded.[30] The hospitals are presently paid on a capitation basis (in 2004 – LAK 60,000 (USD 5.63))[31].

By Decree No. 207/PM, the total contribution is 9.5% of a person's wages with employees contributing 4.5%, and employers are obliged to pay 5%. An assessable income ceiling limiting access has been set at LAK 1,000,000 (USD93.88). This ceiling has not yet been adjusted to changes in the national income level.[32]

Community-based Health Insurance Scheme (CBHI)

According to the Director of the Social Security Organization, more than 80% of the population (including workers from the informal economy) is currently *excluded* from the two social security schemes mentioned above. Therefore, the Ministry of Health (MoH), in collaboration with the WHO developed a non-profit voluntary community based health insurance and launched three pilot schemes.

The community manages the CBHI. For that purpose a CBHI Management Committee[33] has to be created for each scheme. The CBHI Management Committee functions as the insurer taking over all tasks such as collecting contributions, calculating and paying the capitation lump sum to

27 Cited in J. Hohmann (2005): Female members represent around 66% of all primary members. In consequence, the coverage in employment sectors with high female workforce, such as the garment industry, is comparably higher than in typically male dominated employment industries (construction, transport). Figures provided by Mr. Davone, Computer Division, SSO

28 Actuarial Review of the Social Security Fund of the Lao PDR, ILO, Vientiane 2005 (unpublished)

29 Through Decree 52, the government introduced in 1995 for specific services in government health care institutions. User fees are levied for patient registration and ancillary services but not for consultations by professional health workers. By decree, monks, students, and indigents have been exempted from paying user-fees. However, the rules have been crudely implemented, especially for the poor.

30 Excluded are in-patient services beyond sixty days of hospitalization within one year, chemotherapy, open heart surgery, organ transplant, artificial insemination, sex interchange, haemodialysis, aesthetical surgery, (non-work related) motor vehicle accidents, and diseases covered by the government.

31 The amount has constantly changed in the past, due to the changed numbers of dependants and because the hospitals claimed that the per capita amounts were not covering their treatment costs.

32 Currently, 20% of male members and 6% of female members earn above the ceiling. See ILO (2005).

33 The Committee consists of 15 representatives from insured families, village leaders, delegates from the District Governor Office, and delegates from the health sector.

the provider (main and referral hospital), and monitoring the quality and quantity of health care provision. The capitation sum covers outpatient consultations and all fees to hospitals or physicians including physical rehabilitation and pre- and post-natal services on the basis of mutually agreed contracts that are approved by the Ministry of Public Health[34]. The whole family is the unit of insured persons.

The CBHI pilot models have made use of an insurance design, management mechanisms, and evaluation tools, which have already successfully been implemented for the SSO private sector social security system as mentioned below[35]

Location and number of members	Premiums and benefits	Remarks
• Sisathanak District, Vientiane Municipality (Centre) – 2,928 beneficiaries • Nambak District, Louangphrabang Province (North) – 3,880 beneficiaries since June 2003 • Champassak District in Champassak Province (South) – 1,569 beneficiaries since February 2004	Contribution according to family size: • LAK 10,000 (USD 0.94) per month for single members • LAK 17,000 (USD 1.60) per month for 2-4 persons per household • LAK 21,000 (USD 1.97) per month for 5-8 person • up to LAK 23,000 (USD 2.16) per month for more than 8 family members Provider payment is based on capitation and differs among the districts: LAK 35,000 –58,000 (USD 3.29 – 5.45) per person per year. No co-payments are applied Benefits as SSO health benefits: all normal expenses on health care, including medical consultations and exams, diagnostic procedures, cost of treatment and drugs, cost of nursing, administrative costs and room charges. In case of emergency, insured family members may use the medical services of nearby and appropriate hospitals	Challenges: • Limited membership • High drop-out rates (31% in Sisathanak) • Between 17% and 47% late payment of contributions • Tendency to over-use the benefits by members • Over-prescription of drugs to reduce counselling time by health workers • Larger average size families in the CBHI scheme (5.6) causing proportionally higher healthcare expenses per member in relation to the SSO formal sector scheme (2.1), as capitation is based on beneficiaries. • Cost of transport to the referral hospitals causes major financial problems

Although the experiences are promising, the very low-income population cannot enrol or maintain membership in the CBHI schemes. Therefore, it is proposed that collaboration between the MOH and the development partners enable use of planned Equity Funds to serve as the social assistance funds to purchase health insurance cards for the vulnerable populations that cannot regularly pay all or part of the regular contribution. This mechanism is pilot-tested in the CBHI Scheme in Nambak, where the Swiss Red Cross purchases the cards for very poor families.

[34] Exclusions such as traffic injury, organ transplantation, self-inflicted harm, complicated dental care (further details see Draft Regulations for the pilot projects CBHI, Ministry of Public Health (MoPH)/WHO, Vientiane, August 2002
[35] A. Ron, Draft Report: Review of CBHI pilot scheme Project, MoH – WHO, Vientiane, August 2004

The use of the Equity Funds would cover the poorest populations through the same prepayment mechanism as contributing families, and thereby facilitate equity in access to healthcare.

Equity Funds could be used in two ways, in conjunction with social health insurance[36]:

- **In communities where less than 25% of the population is below the poverty line**: Purchase of health insurance cards for the identified poorest families, at the same contribution level as other households enrolled in the CBHI scheme.
- **In communities where around 50% of the population is below the poverty line**: Subsidization of all households, without prior identification of the poorest, through a uniform subsidy, which will be reduced and replaced by household contributions over a period of five years. Thus, the contribution burden would be shared, with an increasing share for the households over time and as household income increases.

2. Voluntary systems operated by the government

The Ministry of Labour and Social Welfare (MOLSW) was established almost ten years ago and cover primarily disaster relief, reintegration of refugees, and assistance to orphans. Decree No.102/PM of 1993 states that in every classified village[37] the village chief is responsible for managing social organizations and assistance to the poor, disabled, the elderly, widows, and orphans. In the event of risks such as death, he may call together the village population to find solutions (usually through contributions) on how to assist the bereaved family. However, there are a few other subsidized services:

- Decree No. 52/PM (1995) exempts monks, students, veterans, and the poor[38] from paying user charges in hospitals. However, in practice only a few are classified as "poor".
- Drug revolving fund: without the provision of the fund, villages' access to medicine would be endangered. The poor are supposed to receive drugs for free, but according to WHO, de facto only 0.3 – 10% are exempted and thus gain access.
- Poverty Alleviation Fund: The government has defined 72 poor and 47 poorest districts providing USD 50,000 to each of the 47 poorest districts.
- The provision of basic medical treatment, pension (USD 10 per month), and income generating activities are granted to the poor, veterans, orphans, and the elderly.

3. Voluntary private systems

As mentioned above, more than 80% of the population is excluded from the statutory social security schemes -- and even those who are covered are often dissatisfied with the services. Building upon the solidarity mechanisms among family members, communities, and peer groups, a few voluntary systems have emerged[39]:

- **Mutual Assistance Fund (MAF) of LFTU**: In 1993, the Lao Federation of Trade Unions established the MAF to supplement the public sector social security scheme on a voluntary basis. The standard contribution is LAK 1,000 (USD 0.10) per month. However, district committees have flexibility to increase the premium up to LAK 6,000 (USD 0.56) per month. The benefits cover sickness and employment injury (up to LAK 80,000 (USD 7.50) for major surgery), maternity (LAK 20,000 (USD 1.90) per child upon birth), death (depending on the

[36] A. Ron, Draft Report: Review of CBHI pilot scheme Project, MoH – WHO, Vientiane, August 2004
[37] Definition by the Decree: Any geographical area comprising of over 20 houses, or with a population exceeding 100 persons.
[38] Definition of poor, which is certified by the village chief: < 16 kg rice/month and < 85.000 kip/month. In addition, if people do not have sufficient money for health, education, clothing, rice and cannot afford to live in a solid house they are considered to be below the poverty line.
[39] E. Adam, M. von Hauff, M. John (ed.), Social Protection on Southeast & East Asia, Friedrich Ebert Stiftung, Singapore 2002

membership LAK 200,000 (USD 18.78) for less than one year of membership, up to LAK 600,000 (USD 56.33) for more than three years of membership), marriage (LAK 20,000 (USD 1.88)), and disaster relief (up to LAK 100,000 (USD9.39)).

- **Welfare Fund for Teachers**: In 1992, a voluntary welfare fund was established in Hai Xai Phong District of Vientiane Municipality aiming at increasing the solidarity among teachers. Members contribute LAK 2,000 (USD 0.19) per annum and may receive LAK 1,000 (USD 0.09) per day if hospitalized up to a maximum of twenty days per case and two episodes of hospitalization per year. Members may have access to loans and payments to families in the event of the member's death. As the teachers are covered under the public social security scheme one advantage of this Fund is access to credit at low interest rates. Participation in this scheme also indicates member's dissatisfaction with the public services and their limited benefit package and reimbursement delays of six to twelve months.
- **Emergency Funds** are established at many workplaces to assist employees confronted with a crisis such as the death of a family member, or expenses for customary celebrations such as marriage, childbirth, and other village festivities. The existence of the funds is particularly evident in garment factories staffed with young women from rural areas. These women seek to maximize savings in preparation for the unemployed period after the end of their contracts. They also need this protection for lengthy illnesses for which user charges are taken at urban health care facilities. As the contributions are very low, it can be assumed that the protection is quite limited.

4. Conclusion

Although the government is fully supporting the current reforms and the extension of the schemes, the Social Security System is still rudimentary. Attempts to link up the three different schemes are currently limited to applying comparable procedures of membership administration and purchaser-provider relationships[40]. Furthermore, even users covered under the existing statutory schemes complain about the low reimbursement rate and the slow claim settlement. Moreover, only few people are fully aware about the benefits to which they are entitled. Often civil servants, who are granted a lower minimum salary than the private sector workers, are unable to pay for the provided medical services and hospitals have to absorb the medical costs. This indicates the insufficient contributions due to the low earnings – although the government aims at self-financing of both the schemes for the public sector and the private sector scheme.

In addition, due to substantial fiscal constraints, poor people are still not exempted from out-of-pocket payments, as laid down in Decree 52 from 1995. Neither do social security schemes of any significance exist for the informal economy, nor is any formal framework in place addressing overall policy issues of social protection for all sections of the population. Moreover, the rural population is largely unaware of the few protection measures and risk management methods available to them, other than relying on the family and village network that are not sufficient to cope with the major risks. The consideration to introduce the Health Equity Fund linked to the CBHI scheme, which is pilot-tested in a modified form in Nambak, could contribute to providing healthcare to poor people.

C. Banks and others

The Lao banking system is the financial sector. In 2000, it had total system assets of approximately US$400 million, which is less than 25% of Gross Domestic Product (GDP). In the first phase of reforms in the late 1990s, Lao moved away from its mono-bank system, separating central banking from commercial banking and permitting joint venture and foreign

[40] J. Hohmann, unpublished paper on the linkages of social security schemes in Lao P.D.R., Vientiane 2005

banks to operate in the country. In the mid-1990s, state-owned commercial banks (SCBs) had to be restructured and rehabilitated. The SCBs have accumulated significant non-performing loans since then. Thus restructuring those banks, improving regulation and supervision, supporting micro-rural finance and opening up the banking system have become the key focus of financial activity through the 2000's.[41]

The banking system comprises three state-owned banks, including the Agriculture Promotion Bank (APB), a policy bank, three joint-venture banks, six branches of foreign banks, and one representative office. There are no domestic private banks.[42]

Recently, some progress has been made in reforming the banking sector, with the cabinet approving a proposal to lower entry barriers and improve market access for foreign and private banks. An external audit and review for 2003 of the two dominant state-owned commercial banks - Banque Pour Le Commerce Extérieur Lao and Lao Development Bank--indicates that non-performing asset ratios remain at high levels. However, the quality of new lending has improved as a result of enhanced credit policy and capacity-building efforts by international banking advisors.[43]

D. Major customer profile

i. Characteristics of likely microinsurance customers:

In Lao PDR, potential microinsurance customers would most likely come from among the base of current microfinance clients. The microfinance industry in Lao PDR is relatively young and undeveloped. Fonds Cooperatifs, an umbrella network representing twelve CCSPs or credit cooperatives, presently has a total of 1,500 borrowers (referred to as members) throughout the country. This is perhaps the only private and legally registered microfinance institution in the country. Other microfinance programs are operating as part of multi-sector NGO programs. The numbers of borrowers reached by these other programs is unknown.

Fonds Cooperatifs has targeted their program to the 30% of rural households that produce a marketable surplus, and the 60% of urban households that are involved in family based or microenterprises. (An estimated 70% of all rural households are headed by subsistence farmers who are not integrated into the market.)[44] Together these rural and urban target groups account for 35% of the country's population or 2.2 million people. Assuming six persons per household, this suggests that the potential market for microinsurance might be as high as 367,000 households in the short, or more likely medium term. However, the market for microinsurance would most likely be significantly less than these 367,000 households since some of the households in this category will have access to life and medical insurance through a family member who holds a government job, and because FC is unlikely to reach 100% of their market target. The existing member base of Fonds Cooperatifs is made up of wealthier rural households and entrepreneurial urban households, who are in the socio-economic centre. They are not rich but they are not living below the poverty line. The first target market for microinsurance would have similar characteristics. (See Annex 1 for statistics on persons interviewed for this research.)

[41] World Bank Office in Vientiane. Lao PDR Economic Monitor. November 2004 (covering May through November 2004).
[42] Ibid
[43] Asian Development Outlook 2005. http://www.adb.org/Documents/Books/ADO/2005/lao.asp 25 August 2005.
[44] Statistics provided by Fonds Cooperatifs May 2005.

ii. Assess the most important risks of low-income groups and analyse the current risk management strategies applied by them

The risks faced by low-income groups in Lao PDR can be categorized as life cycle, business, and environmental types of risks. In the life cycle category, respondents identified serious illness (i.e., illness requiring hospitalization), death of a family member, and children's education as events that require large sums of money. Business risks included weak business environment (or lack of demand), production risks, livestock disease, and loan repayment. Environmental risks included covariant shocks such as flooding as well as livestock loss due to disease.

The top five reported risks:

- Serious Illness
- Livestock Disease
- Poor Business
- Production Problems
- Death of Close Relative

SERIOUS ILLNESS

Illness was the most frequently mentioned risk facing families. Generally, outpatient visits to the doctor have only a moderate financial impact on a family. For the lower middle class focus group participants, doctor visits reportedly cost from USD 12 to USD 50. The fifty-dollar estimate includes transportation, the doctor's fee, and medication in the case of malaria. However, some outpatient conditions can have a very significant impact. For example, one family has a daughter who was recently diagnosed with goitre. Her medicine alone costs LAK 500,000 (USD 46.94) per month. This cost will quickly become a burden to this family. If the condition does not improve, the girl will need to have surgery.

Life cycle events such a giving birth can have widely varying impacts on a family's finances depending on where the birth takes place and the health of the mother. In one village, it was reported that giving birth costs LAK 100,000 (USD 9.39) when the doctor attends the mother in her home. A birth in a hospital can cost from LAK 300,000 up to LAK 2 million (USD 28 -188) depending on the length of stay.

Generally, hospitalization is considered to be the most expensive risk of all. One informant estimated the average cost of hospitalization for people in his village to be around LAK 5 million (USD 469). Examples of hospitalization costs include:

- Appendix operation with a five-day hospital stay, LAK 3 million (USD 282)
- Hospitalization for malaria, LAK 2 million (USD 188).

The worst possible risk that can happen is to have a family member suffer from a long-term illness that requires hospitalization but eventually results in death. The example below shows how long term illness can cause a family to lose all their assets.

LIVESTOCK DISEASE

This risk was mentioned frequently in the Louangphrabang region but not in the Vientiane area. This is a widespread risk. With one informant reporting that each family in his village probably loses at least one animal per year to disease, the negative impact of such a loss on household income cannot be underestimated. The cost of livestock losses varies depending on the number of animal deaths and the type of animal. Pigs cost USD 40 each, cows USD 200 each and water buffalo USD 100 for a small one up to USD 500 for a large one. Disease can also affect

poultry as well as the larger animals. One family reported losing USD 200 worth of animals in one year. The animals had been purchased with a microfinance loan so the impact was magnified because it put more stress on the family to find ways to repay the loan.

The impact of livestock disease in addition to appearing to be more important in the Louangphrabang area is also very significant in remote rural areas where families are more dependent on livestock for their livelihoods. The significance of this risk is heightened by the fact that livestock purchases are the principal and preferred means by which Lao families save for the future.

WEAK BUSINESS ENVIRONMENT

Participants mentioned two dimensions to this risk. The first relates to the seasonality of the tourism sector that affects those living close to Louangphrabang, a major tourist centre. During high season, business is good and everyone is earning a relatively high income. In the low season, incomes plummet. For example, owners of a small restaurant estimate that their sales are LAK 5 to 6 million (USD 469 to 563) per month in the high season and only LAK 1 million (USD94) in the low season. Another risk relates to crop seasonality. Farmers who grow vegetables as cash crops find that they can hardly cover their costs due to the low prices at harvest time when supply costs are high as is the cost of transportation to market. Neither of these risks lend themselves to protection with insurance.

PRODUCTION PROBLEMS

Another business risk relates to a range of activities associated with food processing or production. Two important sources of income for several respondents were Lao whiskey and rice noodles production. Respondents reported that if the quality of the rice used in production of either whiskey or noodles is not good, the final product is not good and cannot be sold at the best price. Whiskey production also requires the correct temperatures to ferment properly. Other production problems include machinery breakdowns. The impact of the risks posed by production problems includes decreased income, high repair costs, and losses due to down time. The risks related to whiskey production are less severe as the costs of production are low and the margins are usually high when the product is good. These risks are not insurable.

DEATH OF A CLOSE RELATIVE

Funeral costs are another significant life cycle risk. Like the costs associated with illness, funeral costs are significant in that they are generally unpredictable. Reported funeral costs ranged from LAK 2,100,000 (USD 197) for a small child to LAK 6,000,000 (USD 563) for an elderly woman. In one village, the minimum cost of a funeral is reported to be LAK 500,000 (USD 46.94) although some respondents state that funeral costs can be managed to a certain extent by shortening the number of days over which one takes place. On the other hand, the cost of a funeral somewhat understates the cost of a death in the family. Buddhist tradition calls for holding a memorial service on the anniversary of a death. As can be seen below, the cost of the memorial can be more than the funeral.

> About two years ago, Mrs. B. of Pale Vaed had to pay for two funerals only a few months apart. The total cost was over LAK 8 million (USD751). To pay for these funerals she used income from her business and from her husband's job. She sold some poultry and then sold two buffalo. One year later she spent LAK 10 million (USD 939) for the one-year memorial service for her mother.

Of the above risks, illness, particularly hospitalization, livestock, and funeral / death best lend themselves to microinsurance.

CURRENT RISK MANAGEMENT STRATEGIES APPLIED BY LOW INCOME GROUPS

In Lao PDR, people use a limited range of coping mechanisms. In large part, this reflects a less developed financial services sector. People primarily depend on both *ex ante and ex post* mechanisms of self-insurance to protect themselves against loss from shocks

RISK REDUCTION STRATEGIES (ex-anti strategies)

Saving

One of the ways in which people generally prepare for unexpected events or risks is through saving. However, we found only a few people who were saving money in a bank. This may reflect the fact that price inflation in Lao PDR has been high for a number of years, and thus maintaining savings in a non-monetized form may be a better alternative. It could also reflect that fact that opening a bank account is costly and it is not possible to receive all of one's money when one closes the account[45]. Those who had savings in a bank reported having only small amounts in the range of USD 10 to 100. Most respondents said that they could not save although they keep some cash at home for daily household and business expenses. These savings are also used to fund unexpected expenses. Generally, the amount of cash reported kept at home is greater than the amounts estimated to be in bank accounts.

The members of FC's CCSPs do save in a variety of ways. Livestock purchases, particularly cows and buffalos, are the preferred method for saving. Teak wood gardens in which teak trees are grown as a long-term investment strategy are popular in the Louangphrabang area. Teak trees can be harvested starting when they are fifteen years old. At that age, one tree is worth USD 15. The largest teak trees are worth USD100 each. Respondents also reported buying and selling gold jewellery depending on their financial situation.

ROSCAs ("Houia")

More than half of the people interviewed (nine of seventeen) reported participating in a Houia, or a local version of a ROSCA. A variety of Houia were reported including groups that have daily or monthly payments. The daily Houia tended to have larger groups with 150 to 170 members. The daily contributions were LAK 10,000 or 100,000 (USD 0.94 to 9.39) with the payments being collected by a collector. These Houia are organized within large markets. In both of the examples of daily Houia, interest charged on the payout is 20% and the decision about who's turn it is to take the payout is made by the leader of the group, based on who has the most need for the funds.

The monthly Houia are organized in various ways. Membership of the respondents' groups ranged from 34 to 70 members with an average of 42 members. The interest rates varied from 20% to 50%. Contributions varied from LAK 100,000 to 300,000 (USD9.39 – 28.16). The process for deciding whose turn it is to take the payout changed from group to group. Many groups use an auction system where the highest interest rate will win the pot. In other groups, individuals must declare why they want the money and the group agrees together who should get the payout.

[45] Reported by Fonds Cooperatifs.

Participants in a Houia make contributions each month or each day until it is their turn to receive the payment. After they receive the payout, they must contribute the original contribution amount plus the interest amount. For example, if the original amount is LAK 100,000 (USD 9.39) and the interest is 30%, and thus they contribute LAK 130,000 (USD 12.20) for each period after they receive the payout until the Houia is finished. For this reason, many people prefer to wait to take their turn at the end. For them, the Houia is like an interest bearing savings account. For those who take their turn at the beginning, the Houia is like taking a loan at interest.

Many people participate in Houia in order to save up for large purchases. Some interviewees reported that they would use their turn to pay off their loan to CCSP. Others reported that they would fix their house. Participation in a Houia is a risk reduction strategy because a household can receive the payout out of turn when they have an emergency, by paying extra interest.

Reduced Expenditures
Another risk reduction strategy is to cut down on household expenditures and reduce consumption in order to prepare for the costs of an upcoming event such as a birth in the family.

Income Diversification
One of the most widespread strategies for risk reduction is income diversification. The average number of economic activities per household was 2.8 not including salaried jobs held by household members. Households living in areas affected by the high tourism season switch to, or add, other activities during the low season in order to maintain an adequate income. Some focus on agriculture activities during the low season while others make and sell Lao whiskey.

PURCHASING INVENTORY
Some of the respondents who have production-related businesses had a clear preference for purchasing more inputs, such as rice, when they had surplus funds on hand. This is part of the pattern of preference for saving in hard assets rather than in cash. It makes sense in an environment of rapid price inflation and in an economy where agricultural prices vary from season to season. This strategy saves money and protects the purchaser from the risk of price inflation in the future. Other respondents who are not involved in food processing, also purchase rice when they have surplus funds. These respondents use rice purchases as an income smoothing strategy. They buy rice during the high season, when they have surplus funds and sell the rice when their business activities are low and they need extra cash.

Income Diversification as a Risk Management Tool

Income diversification is not only a risk reduction strategy used as a precautionary measure but also it can occur as a result of risks already experienced by the household. For example, Mrs. N. reported that almost one-third of the pigs that she purchased with her CCSP loan died of disease. In order to make up for this loss and earn income with which to repay her loan, she and her husband decided to start growing vegetables as cash crops on their rice field. In the process, they discovered that raising pigs and growing vegetables are complementary businesses. The vegetables that they are unable to sell in time can be fed to the pigs and the pig manure can be used to fertilize the vegetable garden. The unfortunate death of her pigs led to a valuable lesson learned for Mrs. N.

USE OF FORMAL INSURANCE

Government employees including schoolteachers, policemen, and soldiers, as well as office workers are covered by State provided life and medical insurance. Families in which at least

one spouse works for the government have some medical coverage. Six out of the seventeen families interviewed had this kind of formal insurance. As mentioned earlier, the client base of Fonds Cooperatifs' programs come from the middle class. Thus, these families are more likely to have a member who is employed by the government than lower income groups.

The government medical insurance covers the government employee 100% and covers other family members by between 50% and 100%. Generally, the interviewees report that this insurance covers hospitalization but not outpatient care. The cost of the premium for government insurance was reported variously as LAK 2000 or 4000 (USD 0.19 to 0.38) per month.

The benefit of medical insurance to families is very clear. Mrs. B. in Pale Vaed has a son who was hospitalized for three weeks with malaria. The hospital bill came to LAK 2 million (USD 188) and she was reimbursed 50%. However, at least one respondent commented that the government was slow to reimburse people.

The extensive coverage of government insurance offers insights into possible expectations that might have to be met by private insurers entering this market.

LOSS MANAGEMENT STRATEGIES (ex-post strategies)

DIVERISIFYING OR INCREASING INCOME
In cases of emergencies, households first use their existing income. If that is not sufficient, they will look for ways to increase their income. Households who have a business that declines in the low season will look to other activities to bolster their income at this time.

GIFTS
Households will receive gifts from family and from their community in the cases of specific risks. In the case of a death in the family, most villages will contribute something to the cost of the funeral. Typically, the village chief will request each household in the village to contribute LAK 5000 (USD 0.47 cents). This can amount to about LAK 1 million (USD 93.88) but will cover only a fraction of the actual funeral costs. This system varies depending on the village and the actions of the village head. Gifts from relatives may also be received in cases of funerals and possibly large medical expenses.

SELLING ASSETS
After using existing income, the second strategy that households most typically use is the sale of assets, particularly livestock and poultry. Livestock and poultry sales are common coping mechanisms. Many households sell animals just to make it through the low season. In situations of large emergencies, households will be forced to sell off larger animals such as buffalo which can bring as much as USD 500 each, although frequently these must be sold at a deep discount because of the urgent requirement for cash. A less common strategy is to sell gold jewellery. In extreme cases, people will sell land, such as rice fields or teak wood gardens.

BORROWING
Borrowing cash is not a common loss management strategy for the sample interviewed. Very few respondents reported borrowing to help pay for an unexpected event. However, the few cases of borrowing were to cover the highest risk event: hospitalization. The first source of borrowing is from family members, for which respondents reported not paying interest. One respondent stated that she paid the doctor in instalments to cover the high cost for hospitalization of one of her family members.

In just one case, we learned that a family might use their land title as collateral to borrow. The cost of this borrowing was 10% per month. The informant mentioned that this is not very uncommon and happens only once every four to five years in their village. In another case, we learned of a family that borrowed from the husband's office (the Army) at no interest. However, this does not appear to be a strategy that is accessible to other families. Borrowing appears to be the last resort for the interviewed families.

DEMAND FOR MICROINSURANCE

The idiosyncratic risks for which people in Lao PDR most need assistance are those that bring with them the highest costs. They include:

- The risks of serious or long-term illness and hospitalization,
- Livestock disease
- Death of a breadwinner

Serious illness and loss of livestock have both short- and long-term impacts on a household's economic stability. Livestock disease is a significant risk because livestock purchases are themselves a risk-reducing coping mechanism which families use to save for future emergencies. Therefore, death of livestock increases household vulnerability in the short and long term.

This research found that death of a family member was a manageable risk in that costs can be managed depending on the economic status of the family. However, we did not come across examples of families where a breadwinner had died. In the case of the death of a breadwinner, the impact will be much greater than the examples we have presented. Most households we interviewed grow some if not all their own rice. The death of a male household head would mean the loss of significant labour power for the family and would impact their food security.

The coping mechanisms used in Lao PDR are notable due to the limited use of the kind of high-stress strategies that undermine household coping capacity for the future. That is to say, most of the respondents in this study have their own land. We found little evidence of land being sold to cover emergency expenditures. We found no direct evidence of pawning of land although we heard that people could borrow against their land title. Pawning of land is not a popular mechanism for raising cash in Lao PDR, in contrast to Indonesia. This suggests that since households are coping with emergencies without doing long-term damage to their asset base, they may not perceive the need for microinsurance.

At the same time, we found that households have very low levels of cash savings. This is due to a combination of factors including a reported difficulty in saving and the preference for saving in hard assets. Many households rely on participation in a Houia in order to save and to have access to large sums of cash in case of emergencies.

If households could obtain life and medical insurance at the same cost as government employees, they could easily afford the premiums of LAK 2000 to 4000 (USD 0.19 to 0.38) per month. Many households are spending LAK 100,000 to 300,000 (USD 9.39 – 28.16) per month on Houia, albeit with the knowledge that they will receive a certain payout in the future.

Given the low level of access to microfinance in Lao PDR and the fact that current microfinance efforts seem to be reaching the middle class, some of whom have access to formal insurance through a family member with government employment, it appears to be premature to introduce microinsurance products. There is not enough demand to make microinsurance commercially

viable at this time. Furthermore, the demand centres are not all in one place but are both rural and urban based and spread throughout the country without effective intermediaries that could distribute the insurance products to them. In the short term, efforts should be made to expand the outreach of microfinance and to include poorer, more vulnerable groups in that outreach. In order to do this, solidarity group lending or other methodologies that do not require collateral should be introduced on a large scale. (FC's programs require collateral and guarantors.) Expansion of microfinance will assist in producing the future market for microinsurance.

E. Problems, Obstacles and Opportunities

i. Identify cultural, social barriers that hinder widespread adoption and use of microinsurance and risk reduction measures

The low-income financial products market in Lao PDR is at a nascent stage of development. In order for commercial microinsurance to work, people should already have access to monetized savings and credit so that they understand the basic formal financial products. This makes the introduction of microinsurance more acceptable.

Many people are already receiving government insurance, and others participate in Houia that might be a form of insurance. Additionally, the Government's community-based health insurance has shown that most people at least are not averse to microinsurance.

In making microinsurance efficient it is best if it can be sold to groups of policyholders. This dramatically reduces the costs of delivery. It was reported that Lao people do not like to be in large groups. Additionally, there are few organizations with effective outreach to large numbers of people, except the Lao Women's Union.

ii. Identify institutional barriers to integration of microinsurance and risk management

In Lao PDR, the financial sector is still very new with many efforts to improve the banking industry. This industry is very small and is dominated by SOEs that are still digging out from serious non-performing asset problems. This is not the time to burden them with a new product line.

The Lao Women's Union is the key mass organization for getting new ideas into the whole market around Lao PDR. This organization is working with several donors and others to implement various products and projects. Their capacity for promoting and selling microinsurance appeared limited, and thus they would need significant capacity building to be able to implement such a program. However, there may be a philosophy difference between the Union and a commercial insurer that would make this relationship difficult. It is not likely that the Union would be an appropriate partner for commercial microinsurance.

The insurance market remains very small also, with one regulated insurance company enjoying monopoly status. Although this company has provided an alternative package to employers, their market remains among the wealthier members of Lao society. They have noted interest in moving down market to develop products for low-income people. In order for insurance companies to reach the low-income market effectively and efficiently, it is likely necessary to do so through one or more intermediaries. These intermediaries would already be managing financial transactions with a large membership so that their cost of delivery would be minimal and both they and their clients will be used to the mechanisms of financial transactions. At present, there is not an appropriate intermediary to deliver commercial microinsurance.

The lack of MFPs to work with in marketing microinsurance is an important constraint, not only because of the lack of intermediaries, but also because MFPs are important in helping to develop monetized savings as well as maintaining financial networks. Such entities represent an important step towards complete microfinance provision, which will include microinsurance.

There are two potential training facilities, the Banking College and the University. Neither of which has the capacity (nor the will) to develop and implement microinsurance courses. It is likely that AGL would need to train its own staff as well as those from any potential intermediary that might be developed through the ongoing work of the ADB and others.

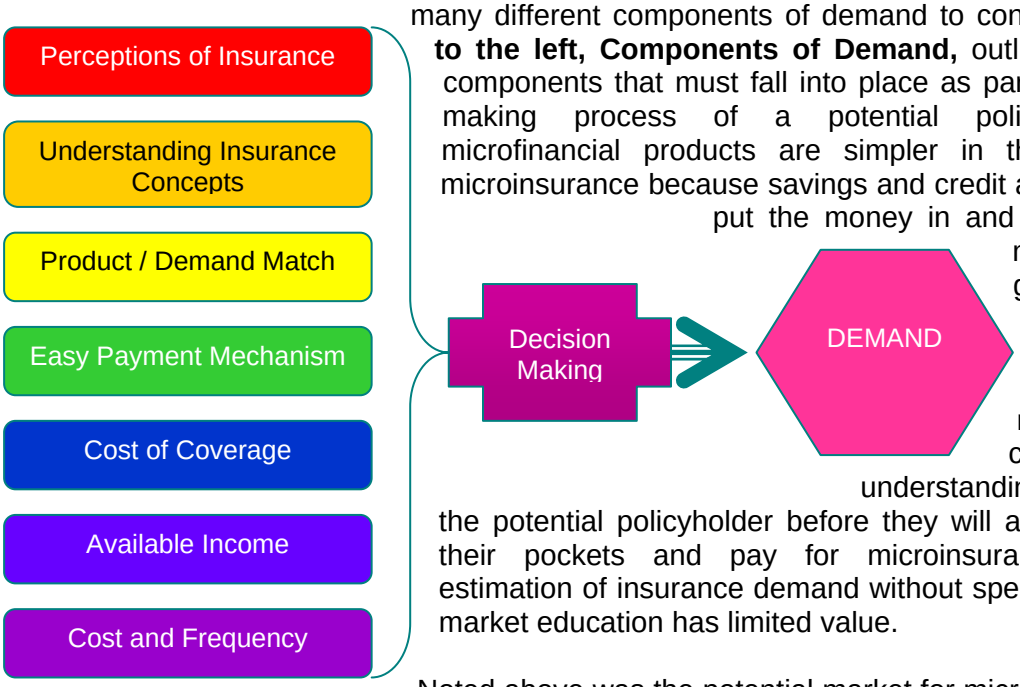
iii. Identify potential partners who share common vision and appetite to learn and implement the new product segment of microinsurance

Several potential partners were identified and met that share a common vision required for successful implementation of microinsurance[46] - GTZ, ILO, Concern Worldwide, World Concern, Belgian Technical Cooperation, the APB, and the AFD.[47] All indicated in one way or another that it is too early for microinsurance in Lao PDR given the very basic financial structures in terms of physical infrastructure, regulation and supervision, and most importantly, human capacity of both potential implementers and the market.

Market Strategy

A. Qualitatively estimate potential demand and market potential for microinsurance

An estimate of the total market potential for microinsurance is difficult because there are so many different components of demand to consider. The f**igure to the left, Components of Demand,** outlines many of the components that must fall into place as part of the decision-making process of a potential policyholder. Other microfinancial products are simpler in this respect than microinsurance because savings and credit are tangible – you put the money in and you can get the money out, or you get money and repay it. An intangible product requires much more consideration and understanding on the part of the potential policyholder before they will actually reach into their pockets and pay for microinsurance. Thus, any estimation of insurance demand without specific products and market education has limited value.



Noted above was the potential market for microfinance as about 367,000. Many fewer than these will actually be potential microinsurance policyholders (of any product beyond credit life). It may be that best practice microfinance can reach about 25% of

[46] Though their current projects are supporting non-insurance microfinance and other projects the could be a direction for the future.
[47] AFD is subsequently planning to support the health sector, and this may include health microinsurance.

this amount over the next five years – about 92,000 clients. Of those maybe one in four would purchase a policy, but not until they are comfortable with the MFP and have generated some surplus income that allows them to pay for microinsurance. The Houia will not be replaced by microinsurance as these are often primarily social organizations, and so the amount contributed by them will not likely be diverted to microinsurance. The potential market lies among those who are making more money because of some economic improvement.

Because of the state of microfinance and the general financial sector, it is unlikely that these conditions will be met to an extent that makes product development and implementation worthwhile for another two years. Thus, the demand for microinsurance at this time in Lao PDR is effectively nil.

B. Distribution systems

Distribution through existing entities is not likely to be effective at this time given that the potential distributors either think it is too early for microinsurance, or do not have the capacity to sell commercial microinsurance. It might be reasonable to begin discussions with potential distributors so that they know of the potential for microinsurance once the market is ready, and because potential distributors will have a better understanding of when the market is ready. Of the organizations visited, it would be wise to meet with Concern Worldwide and Belgian Technical Assistance who appear to have the best objective knowledge of microfinance and the low-income market in Lao PDR. Also important would be to follow the activities of the ADB who are working on a major project for enhancement of microfinance.

It is possible for an insurer to create a distribution system on their own, as did Delta Life in Bangladesh. This model has proven profitable, though the delivery channel is about ten to twelve percent of premiums more expensive than other insurers using a partnership model with intermediaries. Unless low-income people are used for distribution, it is very difficult for an insurer to have effective agents in these markets. Two key reasons for this: (1) low-income and especially rural people do not trust outsiders and this makes sales especially difficult for an intangible product. (2) Agents have very little incentive to work with the low-income market especially if they are not in large groups because the commission on microinsurance premiums is much less attractive than those on larger clients.

AIG / Tata in India is testing a mechanism of training village women as sales agents for their village. The success of this model is yet to be seen, and India has a dramatically different financial landscape than Lao PDR.

C. Marketing considerations

Marketing microinsurance in Lao PDR will require trusted media, and significant education of both the sales force and the market itself. It is important to recognize this as "educating" and not just "informing". Educating will ensure that people who purchase the insurance actually understand what they are buying and how it helps them. This creates a better policyholder, and will significantly increase the potential for renewals.

Common mistakes in marketing centre on misunderstandings of the low-income market - posters that are filled with complex text; television advertising when most of the market does not have a television. It is critical that any marketing efforts be vetted by focus groups of likely policyholders. This will save much money, time, and confusion. It will be necessary to develop picture based posters and brochures. The brochures are important because people need

something tangible that reflects the product. People will not get individual policies (too expensive to produce and distribute) so they need something tangible to satisfy the physical evidence aspect of the "8 Ps" of marketing.[48] There should also be something small that people have that tells them what to do to make a claim, and what is covered. This needs to be simple, and in other countries can be done on the front and back of a business card sized document.

The simplicity of the information provided, reflects the policy components that also must be very simple. There should be few exceptions or limitations, and the cover should be very clear. This is necessary in marketing to the low-income market, and will be especially important in Lao PDR.

Product and/or Services – Specific

A. Prototype

Given that any commercial microinsurance product would be premature at this point, it is difficult to detail a product. However, the most important insurance risks that people noted in the demand study were:

- The risks of serious illness including long-term illness and hospitalization,
- Livestock disease and
- Death of a breadwinner

Health insurance is extremely difficult to manage profitably and thus insurers usually start with an easier product to introduce to the market so that the market, the intermediary, and the insurer staff and management can become comfortable with the product, the market, and the transactional logistics. From this base, insurers move to products that are more difficult.

The demand research showed much interest in hospitalization cover. This is commonly where people have the most financial difficulty and risk. To make this product successful will require much focus on controls, and good relationships with providers. Some prerequisites include:

- In-patient facilities that will:
  - Offer good quality care
  - Work with low-income people
  - Treat policyholders without charge (reimbursement schemes defeat the purposes of insurance in that the policyholder still has to find the money before receiving care.)
  - Prepare monthly invoices for the insurer
  - Accept payment directly from the insurer on a monthly basis, or hold a deposit from the insurer which is depleted on mutual agreement to cover care costs
  - Allow confirmation of admittance and treatments by insurer staff
  - Provide updated fee schedules
  - Allow the purchase of medication from an unrelated source
- Policyholders that:
  - Are part of some large group

[48] The "8 Ps" are: Product (design) - specific features, terms etc.; Price - interest rates, transaction cost etc.; Place - distribution, accessibility etc; Promotion - advertising, PR, etc; Positioning - in target customer's mind; Physical Evidence - the physical appearance of the product/service; People - the human interactions as the product/service is delivered; and, Process - how the product /service is delivered: the steps.

  - Are somehow vetted for general heath by the large group (it is too expensive to do a medical exam on every insured, and too much volume to review applications)
  - Exhibit appropriate diversification
- Systems that:
  - Provide an easy and efficient mechanism for paying premiums (this will need to be developed by the insurer or an intermediary)
  - An efficient and inexpensive way to vet admissions that is not expensive for the policyholder
  - Possibly cover basic transportation costs

A product like this, given satisfaction of the above prerequisites, should cover:

- Transport to the hospital
- Any in-patient care up to a limit in terms of cost and in terms of longevity of hospitalization. Maybe the equivalent of USD500 and 14 days.
- A non-private room
- Medications, diagnostic tests, treatments, and surgery (it might be best to source the medications separately since this is usually the most expensive part of treatment and the hospital has the ability to over-prescribe).

Pricing of the health product requires serious actuarial work. The risk structure of the lives of low-income households is usually significantly different that that for the middle and upper classes, for which there is often some data.

Covering the life of a breadwinner is often the "easiest" insurance to offer when starting, but the demand appears limited, and there seems no appropriate distribution channel available yet. When the time comes to start, maybe after twenty-four to thirty-six months, a simple life product tied to a ten-year savings might be appropriate. It will be helpful for people to see some accumulation of savings to help offset the intangible nature of insurance, but needs to be very simple.

Livestock insurance is also complicated and usually not done profitably. A product like this requires much attention to controls. Success would require at least:

- Offering the cover to groups of farmers (at least ten people) who understand that in case of fraud among any members all cover will be terminated.
- Cover no more than 75% of the livestock replacement value.
- Have a veterinarian check all new covered livestock
- Have a veterinarian determine a cause of death
- If marketable, sell the livestock in front of all group members
- Confirm appropriate vaccinations

Clearly, this product will be labour intensive and somewhat expensive identifying and developing the farmers group, the veterinarian visits, and still there is potential for moral hazard and fraud looms large. Profitability is likely to be elusive.

B. Life Cycle

Any insurance products will start especially slowly in Lao PDR, and will take time to catch on after people see the results. Because of the difficulty in managing the health and livestock policies, it is likely best to offer the life insurance product linked to an endowment first, even though this was not the first preference of the market.

An insurer in Laos would be best to start in this market with cover for the breadwinner(s) in the low-income households. This will help the insurer to better understand this market, and to start to collect some actual mortality and maybe morbidity data that will help in more adequately computing premiums. This should be considered as a pilot test where the market is tested for their actual appetite for insurance, the distribution channel is tested for efficiencies and capacity, and the systems, preferably computerized systems, are tested. Once the (1) volume of policyholders reaches a sizable risk pool, maybe 20,000 in Lao PDR, (2) the three areas of market, people, and systems are all stable, and (3) the capacity and quality of hospitals is assessed, then a health scheme could be tested, followed by the livestock policy, after the health and life products are stable.

Operations

A. Capacity needs

When considering operational capacity one must understand the model to be followed in order to understand the capacity needs. Thus, we look at three potential models.

In the community-based health insurance programs, the risk pool is severely limited by the population of the community or group, as well as the capacity of a local person to manage the insurance transactions. They generally have limited reserves, and no access to reinsurance. Unless there is going to be significant coordination of these groups, risk pooling among all the groups, and "reinsurance" from the government or a donor agency, these will prove difficult to sustain. If there were a coordinating body for the CBHIs, and premiums were combined to create a larger pool, this may prove an appropriate entry point for a commercial insurer. The insurer could then absorb the premiums and shift the risk from the community to a regulated insurer. This would link people into a broader and (presumably) more stable system offering access to additional products. This would likely be an improvement for the local groups.

To make this happen there would need to be:

- A mechanism to consolidate the premiums and track the policyholders. Such systems would have to be developed by the insurer in close contact with the coordinating body and could include mobile electronic options.
- Health care facilities within relatively easy access of policyholders, and these facilities would need to be willing to compile activity and invoice the insurer on a monthly basis.
- Controls developed to manage the provider – policyholder transactions. This is commonly a place where there is significant moral hazard and outright fraud.

A second model for Lao PDR might be that of the Mutual Benefit Association (MBA). In this case, a large group of people, maybe the consolidated CBHIs, could generate the initial capital from their member to start a member owned insurance provider. In many ways, this model is hardly different from starting a greenfield insurance company, except that people with little knowledge of insurance would populate the board. This structure would require:

- A legal structure for this type of insurer
- At least two professional insurers to manage the MBA
- Training on all levels, including the board
- Implementation of computerized systems
- Facilities

- All that was required of the CBHI consolidation model above.

The third option would be the partnership model that has been presented throughout this paper. This model has a regulated insurer working with intermediaries so that the risk is borne by the insurer, and the marketing is done by organizations that work directly with the low-income market. The capacity of the current insurer is unknown because our team was denied appointments to meet with relevant people during the visit. The intermediaries need significant capacity building in terms of offering best practice microfinancial products. There is some progress being made in intermediary capacity building but this will take time before insurance can be introduced. Additionally, the market is not ready for microinsurance.

B. Other resources required

There will be a large and continuing need for the development and stability of potential microinsurance intermediaries. Plus, capacity building of these future intermediaries will require a sustainable training and capacity building infrastructure. As we have seen in many other countries, getting microfinance to a stable stage is a long and arduous task, requiring much technical assistance.

In general, people with insurance expertise will need to be developed in terms of the micro-market. However, because there is only one insurer in Lao PDR, it is likely that these professionals would have to be poached from that insurer.

C. Legal Structure

If an MBA is to be developed there is a need for:

- Specialized legislation that allows for such a membership body outside the control of government or the party. A good example can be found in the Philippines.
- The development of a supervisory body and guidelines for supervision to provide the legal oversight in its mission to protect the consumers. This would more likely be additional training for the two people in the Ministry of Finance who supervise the current insurance company.

To implement the insurer – intermediary model is mostly covered by the current insurance legislation. It will be important to have a provision for institutional agents, so that every intermediary's field staff to not need to be licensed as agents.

There is also new microfinance legislation being worked on with the ADB. It will be important that MFPs that are covered by this legislation are legally able to act as agents and accept some form of remuneration.

D. Financial

Identify the donor community and their interest in microinsurance

Apart from the WHO, the ILO and the Belgian Technical Cooperation (BTC) none of the international agencies support microinsurance – and even those organizations promote only one pilot scheme, the Community Based Health Insurance (CBHI) in collaboration with the Ministry of Health and Social Welfare. The Swiss Red Cross linked a small project component to

the CBHI, providing health cards to enable poor to have access to the scheme. Discussions took place with the World Bank and the ADB, however, it did not materialized into a direct implementation of such insurance schemes. Unanimously, all organizations considered the environmental preconditions as premature for starting microinsurance.

However, a number of organizations support health projects and microfinance activities. In general, both could offer potential linkages to microinsurance, if the agencies intend to support long-term investments and institutional strengthening at a later stage.

The following table lists those projects of multi- and bilateral donor agencies and international NGOs, which in general, offer the potential of integrating microinsurance into their portfolio.

Name of organization	Project
ILO	**"Development of Social Security"** in collaboration with the Ministry of Labour and Social Welfare (MoLSW). The comprehensive support covers the following activities, among others: Set up of a tripartite steering committee attached to ILO/UNDP project; Support to the community based health insurance scheme jointly with the WHO. Project "**Capacity Building for Labour Law Implementation**"
UNDP	To reach the poorest people in Lao PDR, UNDP has been focusing its rural development activities in several poor districts, including Sekong, Huaphanh, and Xiengkhoang. Projects cover a wide range of sectors, such as income generating activities, and the provision of health: "**Macroeconomics of Poverty Reduction**," initiated by UNDP's Bureau for Asia and the Pacific. The regional programme has several objectives: Discussions on integrating poverty reduction objectives into national economic policy-making and general socio-economic development strategies; Policy options and institutional means to foster more pro-poor stabilization, economic restructuring, and growth. In order to achieve these objectives, the programme supports activities such as access to assets, productive inputs, technology and employment, and the ability of low-income households to save and invest as well as access to health and decent standard of living.
WHO	WHO supports projects in health financing, health system organisation, and regulation. In this context WHO jointly with the Ministry of Health implements the "**Development of Social Safety Net through Community Based Health Insurance**" projects in Lao PDR and Viet Nam: The CBHI is piloted in three districts in Lao as a trial of an innovative scheme of health care financing.
ADB	ADB has taken a leading role in improving the landscape for microfinance. This has included: Promotion of the Agriculture Promotion Bank Support to CBHI Assistance in developing the microfinance legal structure

Name of organization	Project
World Bank	Several poverty reduction projects such as the "**Poverty reduction Fund"** and the "**First Poverty Reduction Support Credit"** are provided with strong emphasis on macro-economic development. The "**Financial Management Capacity Building Credit Project"** aims to provide a comprehensive framework for the capacity building activities to improve the financial management in Lao PDR and to provide a credit for specific technical assistance and training activities within such framework Designing and implementing individual restructuring plans for state owned commercial banks; Assessing, developing, and supporting the legal and institutional framework for resolving non-performing loans; Strengthening the capacity of the Bank of Lao PDR (BoL) to supervise SCBs and the capacity of the government to monitor and support Bank restructuring plans; Developing rural and micro finance.
EU	In the area of rural poverty reduction, the European Union (EU) has targeted especially the north of the country with significant minority populations. NGOs play an important role and collaborate closely with the Commission, carrying out projects in health, humanitarian assistance and food security. Other main areas of support: Reinforcement of the healthcare system through the provision of basic equipment and drugs; Capacity building through training of local staff in technical issues as well as the management of the health system; Increased access to healthcare by improving physical structures in remote areas and the provision of mobile medical teams; Strengthening of the public healthcare system's capacity to provide access to effective and affordable Sexually Transmitted Diseases (STD) services Establishment of support mechanisms for the planning and monitoring of a National Care and Prevention Programme.
International Fund for Agriculture Development (IFAD)	The Xieng Khouang Agricultural Development Project Phase II aims at Increasing the household food and income security, improving nutrition for the poor, and increasing the availability of alternatives to opium poppy cultivation. These objectives will be achieved by, e.g.: Encouraging agricultural development, including irrigation, crop and livestock production; Providing income-diversification opportunities through savings and credit; Community-based savings and credit groups. The **Oudomxai Community Initiatives Support Project** aims at: Improving the capability of the poor and their organizations to make efficient use of their natural resources and the services available for their own social and economic development; Providing rural financial services to support investment in on- and off-farm income-generating activities; Support the implementation of the National Poverty Reduction Programme, including the support for the Lao Women's Union to mainstream gender issues in all project activities.

Name of organization	Project
EC/UNFPA	The European Commission (EC) funds the United Nations Population Fund (UNFPA), which launched the EC/UNFPA **Reproductive Health Initiative** in collaborations with NGOs. The project aims to create sustainable mechanisms through which reproductive health demands of vulnerable groups and deprived populations could be met.
Belgian Technical Cooperation (BTC)	The following projects are directly linked to health insurance: Development of Social Security; Financial & managerial strengthening of the social security organization including social health insurance; Support to the health sector reform in the provinces in Vientiane and Savannakhet with the focus on reforming the health system and controlling malaria; Education, agriculture, infrastructure, and healthcare are covered in a project for integrated rural development in the province of Savannakhet.
JICA	The following projects could have a relevance for health microinsurance: **"Propagation of public health"**: efficient management system of medicine and health care; Improvement of medical technology: improvement of medical services of core hospitals, as well as educating medical personnel; **"Local Development Program**": Community development, programs for the Elderly, disabled, and child care, etc.; Improvement of health and hygiene with the Ministry of Health. Conference ASIA-PACIFIC Elderly, International Cooperation towards Aging People in Lao PDR, ASEAN – Japan High Level Meeting, Yokohama, Japan 30.08. -02.09-2004 Help-Age International - Concerning Ageing Health and Welfare.
GTZ	The "**Integrated Rural Development Programme"** in Luang Namtha: The variety of components include: Improvement of agricultural production and increased access to financial services (e.g. set up of village banks); Strengthening of the basic health network, including preventive and curative care.
International NGOs Swiss Red Cross	The Swiss Red Cross focus on **mother and child health care** in rural areas through preventive care and awareness building, immunization, family planning, and development of village pharmacies. Moreover, they provide health cards for poor in order to have access to the community based health insurance scheme (**CBHI)** of the Ministry of Labour and Social Welfare.
Save the Children Norway (SCN)	**Child Labour** in the Provinces Borikhamsxay and Pakkading: Awareness on issues related to children and work for reducing the incidence of economic exploitation of children.
CARE International/Lao	**HIV/AIDS and STD Prevention** and Project Management (HASPM): The HASPM project aims at reducing HIV/AIDS and STD incidence in Louangphrabang, and the vulnerability to HIV and STDs. Health care and social development are components of Care's support.
Action Contra la Faim (ACF), CONCERN World-wide, German Agro Action (DWHH/ GAA), Quaker Service (QSL)	Microfinance and economic development

Name of organization	Project
Australian Red Cross (ARL), Comité de Coopération avec le Laos (CCL), Chritian Reformed World Relief Committee (CRWRC), Handicap International (Belgium & Action Nord Sud), World Vision (WVL)	Health Care

Conclusions

The Lao PDR is a country with 6.2 million people, and a continued relatively strong central authority. The macro financial activities are in a nascent stage, as are the microfinancial. There are efforts underway to improve these structures, their supervision, legislation, and capacity. The insurance "industry" is comprised of one insurance company and two supervisors sitting in the Ministry of Finance. The major banks and a majority share of the insurance company are owned by the State.

Demand research among potential microinsurance clients showed a need for hospitalization, and livestock cover, as well as that for the death of a breadwinner. The demand was weak to moderate.

The infrastructure for microinsurance is extremely weak in the Lao PDR. Potential intermediaries are extremely limited in both number and capacity, and in most cases where there are such intermediaries; they are still working with the low—income market using non-best practice methodologies.

For a commercial insurer to enter this market it will almost certainly need an infrastructure of intermediaries to reach this market. That infrastructure is not nearly present. Coupling that with weak to moderate demand, it is clear that it is too early for profitable commercial microinsurance in the Lao PDR. It may be appropriate to begin developing the microinsurance products and processes with subsidies from government (as a support for social security), or from donors to support initial research and development and first and second year operational deficits.

Donors and development organizations should observe the experience with the CBHI and the development of the microfinance market in particular with respect to the organisational structure, capacity, and best practice operations, as well as the successful implementation of the MFP legislation. Success in these areas will provide evidence of the preparedness for microinsurance, and should reignite the effort to develop microinsurance products. This is likely to take at least the next two years to develop the potential for profitable professional microinsurance.

During the intervening time, it is appropriate for the government and / or donors to work with the insurance "industry" to prepare legislation facilitating microinsurance as well as working with those involved in capacity building of MFPs and the market to develop a more receptive market, and marketing and servicing capacity. Any potential microinsurer should consider also inputs to the current process of developing legislation for microfinance.

The Government should be seriously considering mechanisms to assist in the provision of social security to the low-income masses. This effort should include interactions with the insurance "sector" to consider the distribution of activities in terms of social security. This should lead to a more efficient implementation of private / social insurance that would serve best the citizens of the Lao PDR.

APPENDIX 1: The Terms of Reference

Microinsurance: Demand & Market Prospects
India, Indonesia, and Lao PDR

1. Introduction

Allianz[49] has expressed interest to partner with UNDP and GTZ in carrying out market research to estimate demand for microinsurance interventions in two to three major Asian markets (India, Indonesia, and Lao PDR). This represents a mutually beneficial opportunity for UNDP and Allianz. For UNDP, it creates access to microinsurance to meet the unmet demand for reducing vulnerability of over 3 billion people and it has the potential to assist in meeting the MDGs. For Allianz, it provides a leadership niche in this growing industry. Microinsurance also constitutes a new market opportunity for Allianz. In partnership with UNDP, Allianz can make an important contribution to the development of the nascent microinsurance markets. A consumer base of practically half of the global population presents a significant market with a lucrative potential for the insurance industry. Given the added threat of human induced climate change, the insurance industry can proactively assist in reducing the vulnerability of the poor people in developing countries to weather-related natural disasters.

The underlying hypothesis of this proposed partnership is that the delivery of microinsurance will benefit poor and low-income groups, establish local entrepreneurs, and strengthen livelihoods. This will be driven by the creation of safety mechanisms for managing risks, and shocks and stresses including natural hazards. It is hypothesized that access to insurance by entrepreneurs in the developing countries will draw private sector investments and promote national development priorities.

2. Background

Currently over 1 billion people – two thirds of them women – live in extreme poverty on less than $1 a day without access to most of the social services basic to a decent quality of human life. This figure rises to nearly 3 billion, if a standard of US$2 is used.[50] The success of the strategy to reduce the proportion of people living in poverty is contingent upon generating income providing activities, augmenting access to resources necessary for livelihoods, building assets and assisting the poor and the disadvantaged population to manage risks.

Vulnerability to risks from stresses and shocks including illnesses, injuries, property loss, and untimely death are every day realities for the poor. Additionally, it is the poor people occupying marginal, dangerous and less desirable locations to live and eke out livelihoods, who are hardest hit by natural disasters. In 2000, leaders of 189 nations agreed on eight Millennium Development Goals including their commitment to reduce the proportion of people living in abject poverty by 50% by 2015. Simultaneously, in the face of economic globalization, it has become necessary to think innovatively to reduce the vulnerability of the poor people to shocks and stresses through provision of safety net mechanisms to manage risks.

[49] Allianz is one of the leading global services providers in insurance, banking, and asset management. Allianz is working in more than 70 countries and it is one of the five leading asset managers in the world. Allianz has demonstrated strong commitment to the broader goals of sustainable development.
[50] OECD. 2001. DAC guidelines on Poverty Reduction. Paris.

Micro and small enterprises employ a significant portion of the labour force in developing countries, albeit in "survivalist" employment and in the informal economy. The informal economy provides employment for majority of people, particularly the women, in the developing world. Besides providing low incomes, the informal economy does not provide any formal means to manage risk.

Many of the micro and small enterprises operate outside the legal system that *inter alia* contributes to their low productivity. These enterprises lack access to financing and long-term capital, which is the basis for providing sustainability to all entrepreneurial activities. Additionally the institutions that finance such enterprises are themselves prone to the risks of the borrowers, a fact that can constrain their going to scale. For instance, microfinance institutions (MFPs) allow low-income entrepreneurs to borrow money and are therefore vulnerable to the same risk as their clients. In the event of a risk event striking a borrower or their family member, their ability to repay the loan is in serious jeopardy. While MFPs use several options[51] to protect themselves from the risk of non-payment, none of them is perfect.

Micro and small enterprises can be engines of growth, if they are developed to generate income and wages for their clients and support their transition out of poverty[52]. In addition, since reducing vulnerability is about risk management, risk management should be an intrinsic component of sustainable livelihoods. Microinsurance[53], though relatively new, provides such an option to the "working" poor people. Microinsurance aims to provide protection to low income people against specific risks and hazards in exchange for premium payments proportionate to the likelihood and costs of risks involved.[54] At the same time, there is a need to explore safety net and insurance mechanisms that would, in particular allow the poor people to alleviate the economic impact of natural disasters.

Informal mechanisms such as savings and other traditional risk management structures[55] have proven to be of high costs and therefore unsustainable as long-term coping strategies[56]. While the private and formal sectors appear to be the most suitable to provide microinsurance products -- as they can design and offer sustainable and long-term risk reduction strategies that are also profitable -- this role is yet to explored comprehensively both as a business model and as an intervention for social protection. Equally important is to understand how microinsurance relates to government policies and the role of the government and the public sector in terms of creating an enabling environment, laying the foundation for its efficient implementation through developing capacity, strengthening institutions and infrastructure, and disseminating information for the development of microinsurance opportunities as safety net mechanisms.

Microinsurance to manage risks for population with low incomes and low insured values has limited precedent. Although MFPs have demonstrated interest in participating in the

[51] Expect the group to repay; Try to claim from the estate; Write off the loan as a bad debt; Self-insure; Collaborate with an insurance company.

[52] Sievers, Martin and Paul Vandenberg. 2004. Synergies through Linkages: Who Benefits from Linking Finance and Business Development Services? SEED Working Paper No. 64. ILO. Geneva.

[53] Access to insurance reduces the vulnerability of households and increases their ability to take advantage of opportunities. Moreover, by reducing the impact of household losses that could exacerbate their poverty situation, insurance enhances the stability and profitability of households.

[54] Cohen, Monique and Jennefer Sebstad. 2003. Reducing Vulnerability: The Demand for Microinsurance. MicroSave Nairobi.

[55] While targeted savings and consumption loans including Rotating Savings and Credit Societies and savings clubs can help the poor to cope with day to day events, but as risks increase in magnitude and uncertainty, the losses increase and simple savings and loan activities are unable to manage those losses. Brown, Warren. Why MFIs are providing insurance to low income people? 2000. Dhaka

[56] Kawas, Celina and Marla Gitterman. 2000. Roundtable on Microinsurance Services in the Informal Economy: The Role of Microfinance Institutions. The Ford Foundation. New York.

microinsurance industry[57] as in fact many of the existing products have been defined for the clients of an MFP, it is critical that the finances and management of the insurance business are separated from the MFP's savings and credit activities. Part of the reason lies in the fact that the microinsurance product could have high transaction costs and the difficulties in controlling moral hazard and adverse selection. While households understand microfinance very well, they have limited understanding of insurance that could lead to a bias against insurers. Microfinance providers may also be challenged by the need to achieve scale, and skills requirements for actuarial analysis, investment opportunities, and regulation.

MFPs have employed different strategies for providing insurance to their clients. For instance, institutions like SEWA or ASA in India,[58] in collaboration with national public insurance companies and private insurance providers such as the BajajAllianz and GTZ, have provided integrated insurance schemes covering sickness, death, widowhood, maternity, and loss of flood, fire, and riots to its clients. MFPs in Uganda, in partnership with American International Group (AIG) have offered a group personal accident and credit life and disability policy in Uganda since 1997. The premium is bundled with the cost of auxiliary financial services into the MFPs' interest rates, or as a separate fee. Gaining from their experience in Uganda, FINCA has, offered the same AIG product in Malawi, Tanzania, and Zambia. A private insurance company, Delta Life Insurance, provides a combination of life and endowment microinsurance products, viz., called Gono-Grameen Bima. CARD Bank in Philippines, through its Mutual Benefits Association (MBA) has been offering life insurance policies with long-term savings. Canadian Cooperative Association (CCA) China has recently started a small pilot health program consisting of an integrated health insurance approach for its clients. The program is being supported by funds from the Canadian government as well as client membership fees.

The lessons from the limited number of ongoing activities clearly emphasize that microinsurance is a highly technical operation, and that it is vital to better understand the market potential and efficient delivery of microinsurance services. Apparently none of the initial microinsurance ventures were preceded by any form of market potential study that looked at the demand and acceptability of the product, development costs, cost of premiums or their affordability based on a sustainable business model. Furthermore, none of the products launched until now were followed up, or included the education of clients, insurance service providers and other stakeholders or disseminated relevant information on a broader basis. This is part of the reason why the client turnover rate in some of these initiatives has been large and many of them have failed to show even a modicum of the potential profits microinsurance is potentially capable of. There is indeed a lot to understand prior to introducing microinsurance as a viable market initiative to help the poor people cope with income erosion to reduce their vulnerability while providing a new business opportunity to forward looking insurance companies.

Microinsurance is a nascent market. If microinsurance can be cost effectively delivered through MFPs and other organizations of civil society, the significant numbers of their clients who are in need of insurance services per se represent a profitable segment for the insurance industry. Previous attempts to launch microinsurance products have quickly revealed some key factors for implementation success:

The products should be launched after a careful market study including qualitative consumer surveys;

- The products should be designed in close consultation with the stakeholders;

[57] Response to demand from clients, reducing household risk, protecting the institution, and an additional business opportunity.
[58] India is leading insurance industry expansion in to emerging Asian markets. Both India and China are opening their enormous markets to overseas companies, which will create market expansion opportunities for the insurance sector.

- The information and knowledge of the products must be clearly communicated to and shared with the potential customers;
- The claims must be settled as quickly as possible;
- The transaction costs of delivery must be clearly understood, appropriately allocated, and minimized;
- The product provider must have a depth of knowledge and experience in the actuarial side of insurance provision;
- Products must be launched sequentially starting with simple products (life/funeral, catastrophe insurance) and then moving into more sophisticated products such as health;

Hence the need for initiating market potential studies in a limited number of countries. It is also recommended that the outcome of the studies be implemented through timely pilot "learning by doing" microinsurance initiatives that are based on sound business models and practices premised on well-defined market and comprehensive market analysis. It is hoped that the success of such smaller pilot initiatives would allow microinsurance initiatives to be taken to scale and achieve wider acceptance and validation. The pilot initiatives will also assist in delineating and creating an enabling environment, and putting it in place to ensure that the process is efficient and transparent with minimal transaction costs. In addition, the learning from the pilots will provide a valuable estimate of the extent and nature of capacity development at the human, institutional, and system-wide level that is required for local governments, civil society, and the private sector to make microinsurance a viable business.

The countries of interest would include India, Indonesia, and Lao PDR. While India, has a high number of existing microinsurance activities, Indonesia has an active microfinance and micro enterprise system and intends to expand social security systems to the informal economy. In Lao PDR, belonging to the Least Developing Countries, the demand is high and the government supports already social health insurance. Additionally in India, the government policy directs insurance industry to spend a certain amount of resources for improving the quality of life for the poor people.

3. Objectives of the Study

It is in the above context that the UNDP-Allianz-GTZ joint market research and exploration of microinsurance interventions in selected countries is being formulated. The first step is to review the existing experiences through a desk study and then undertake market-based studies in a limited number of countries to have a better knowledge and understanding of the potential for microinsurance and efficient delivery of demand based products. It is hoped that the study would provide an evidence-based theory of change to make microinsurance a sustainable alternative for providing safety net mechanism for the poor and the disadvantaged communities.

3.1 Overall Long-Term Objectives

- To substantiate linkages between microfinance, development of entrepreneurs and sustainable livelihoods through the availability and access to microinsurance by the workers in the informal sector;
- Explore the use of microinsurance as a safety net mechanism to reduce vulnerability of livelihoods of the poor including impacts of climate induced natural disasters;

Goals of this Activity

- To estimate the demand for microinsurance in three countries of Asia.
- To estimate the potential supply of microinsurance in terms of risk takers (regulated insurers, the governments, and others) and various delivery channels. This estimation will include a discussion of transaction costs for delivery of microinsurance services.
- To explore the option of undertaking pilot initiatives through the development of a basic process outline inclusive of estimated costs.
- To foster dialogue and cooperation between the insurance industry, governments, and civil society, and enhance north-south and south-south partnerships.

3.2 Benefits of UNDP - Allianz – GTZ Collaboration

A joint study on microinsurance will benefit from the unique capabilities of the three partners. By virtue of its extensive country offices, and projects that work closely with the developing countries' governments, private sector, and civil society UNDP and GTZ provide an in-depth understanding of national policies, institutions and capacities, an excellent ability to convene diverse stakeholders, and make available experiences from several microinsurance projects. Allianz, as a leader in the insurance market, brings the knowledge of insurance market structures and product design to the partnership. Its participation in the joint study will lend greater credibility to translating the ensuing demand into viable and affordable products for the world's most vulnerable populations.

4. Activities Needed to Generate Outputs

The market study will explore options for engaging the insurance industry in providing microinsurance as a safety net mechanism for the developing countries by assisting in risk management and strengthening the development of local entrepreneurs and other poor and low-income groups within the overall framework of sustainable livelihoods and Millennium Development Goals (MDGs.

A team of three international consultants will complete the activity (one of the consultants heading the team). These consultants, knowledgeable about microfinance and microinsurance initiatives globally, will receive country specific technical information from national insurance experts. This activity while being led by Allianz would also include discussions with other microinsurance providers like ICICI etc. in the country. These inputs will include desk activities such as briefings on the state of the market in the target country, as well as, acquisition and provision of secondary data relating to the insurance industry, including: Insurance laws and regulations; insurance commission annual reports; microinsurance activities; and available studies on the sector especially as relate to the low-income market. In-country experts will also provide access to any relevant documents and / or studies including those conducted by Allianz in the target countries, as well as assist in obtaining entry for interviews by the consultants as appropriate. The assistance of the insurer in the advisory capacity will be limited to ensure the objectivity of the results and recommendations and broader viability of the Market intelligence activities.
Further inputs are expected from UNDP, GTZ, and other organizations, if required. The studies will be conducted in teams of two with additional contribution by the national Allianz insurance experts to prepare a business plan for undertaking potential pilot projects in at least two

countries jointly selected by the organizations who will fund the future projects (details are elaborated under Para 5).

In particular, the experts will analyze the lessons learned from prominent past and ongoing microinsurance activities globally, and prepare a comprehensive report for each of the three selected countries covering the issues addressed in the terms of reference provided below. The experts will ensure that the paper is cohesive, clear, forward-looking and uses out of the box thinking to identify pathways for the implementation of policy and microinsurance incentives that promote cost-effective adoption of risk management strategies and has practical recommendations that can be implemented at the field level.

The paper will cover the following:

I. Landscape review

The research should glean critical lessons for enabling policy environment, barriers, and incentives for marketing microinsurance as a business product by engaging the insurance industry in partnership with the national governments, and capacity development demand for implementing microinsurance initiatives at the ground level. It should cover:

A. Literature review and analysis;
B. Relevant institutional and legislative frameworks;
Available knowledge sources and networks including current providers of microinsurance at the ground level as well as the insurance companies that underwrite the microinsurance;

- Assess the most important risks and the vulnerability of poor and low-income groups and analyse the current risk management strategies applied by them.
- Analyse the options of risk management strategies available in the selected countries and identify the gaps of risk management tools (incl. linkages of microinsurance with national social security programs).
- Identify successful microinsurance initiatives and evaluate the possibility for, and potential impediments to, their replicability;
- Identify market barriers to the adoption, use and sustainability of cost-effective microinsurance and risk reduction measures;
- Identify cultural, social barriers that hinder widespread adoption and use of microinsurance and risk reduction measures;
- Identify institutional barriers (regulatory, governmental, development banking, legislative) to integration of microinsurance and risk management and elaborate on relevant reforms supporting social security in the informal economy, if any;
- Identify demand centres of microinsurance as well as the areas for which microinsurance is most desired.
- Examine the role of microinsurance for reducing the vulnerability of low-income groups and on the development of local entrepreneurs.

II. Role of Governmental, Civil Society, Disaster Community:

A. Identify and evaluate government policies and strategies in place for providing an enabling environment for microinsurance at the state/community levels, and highlight important lessons; include funding sources, business prospects, etc.;

B. Identify community initiatives including microfinance led initiatives to provide microinsurance to local clients. Highlight important lessons; include funding sources.
C. Define capacity development needs (human, institutional and system-wide) for implementing successful microinsurance initiatives.

III. Insurance/reinsurance Industry: Market opportunities

A. Identify insurance industry market strategies (including products of interest) and ongoing initiatives to provide microinsurance and reducing vulnerability, and increasing physical and economic resilience (risk management, risk pooling, incentives, funds). Note vision, funding sources.
B. Assess the insurance products in the context of other risk management tools for poor and low-income groups (state supported programs and informal systems such as saving & credit products);
C. Identify partners (in the selected countries) who share common vision and appetite to learn and implement the new product segment of microinsurance;
D. Qualitatively estimate potential demand and market potential for microinsurance (in three countries) including clients' comprehension of the concept of insurance, understanding of risks, and willingness and ability to pay according to different social and economic groups.
E. Provide present viable business propositions and recommendations for design and delivery of microinsurance products; broadly estimate the transaction costs including consideration of the capacities and institutional capabilities of microfinance and local development banks to deliver insurance benefits;
F. Identify development banking and commercial banking initiatives to provide microfinance and/or safety net mechanisms for the governments or communities to increase physical and economic resilience.

IV. Bilateral, Multilateral, and other Donor Community

A. Identify donor community and their interest in microinsurance;
B. Identify risk pooling limitations and opportunities.

V. Action Plan: Undertaking Pilot Interventions

A. Synthesize critical lessons learned from previous initiatives undertaken to determine both the key factors for success, and the barriers, and operational and institutional impediments, to the implementation of microinsurance strategies for risk management, risk transfer and risk reduction.
B. Identify creative and innovative pathways for advancing the implementation of policy and insurance incentives that promote cost-effective adoption of risk management strategies.
C. Identify areas in which funding support may be necessary including linkage of microinsurance with development of local entrepreneurs.
D. Identify capacity development needs.

Planning meeting

In order to ensure that all parties are clear on the objectives, approach, and expected outputs, it is necessary to have all parties meet to plan this activity. Because of cost constraints, this

meeting should take place as a teleconference with parties from Allianz, GTZ, and UNDP, as well as the core consulting team, Michael J. McCord, Monique Cohen, and Gaby Ramm. This meeting should take place before the first field visit.

Output

An output in the general form of a business plan will be provided for each country, following the basic outline below:

Executive Summary
Includes a synopsis of the national strategic business plan that summarizes the highlights of the plan.

Vision/Mission
Provides a snapshot of the present stage of microinsurance in the country, plus a picture of where the industry is going given Allianz/UNDP/GTZ intervention as suggested in the plan. Included will be summary of the goals, objectives, and requirements on how to get there.

Microinsurance Overview
This section provides basic information about microinsurance in the country, including issues of: regulation, competition, social protection programs, other government, private, and civil society, and donor initiatives and plans that make up the structure of microinsurance and insurance in the country. This section will also include a discussion of key international lessons learned.

Demand Analysis
In this section we will define the microinsurance market in the country, the general characteristics of the target market, assessment of current risks impacting the market, how these are managed by the market currently, where there might be potential demand opportunities in terms of products and services. This section will also include consideration of the benefits of microinsurance over those of currently utilized risk management strategies. Finally, it will include a discussion of market risks to product introduction. Some specific information will include:

A. Existing risks experienced by low income populations,
B. How poor people prioritize risk,
C. The strategies they use to mitigate risks ahead of time and to cope with shocks after they occur,
D. Significant differences in coping behaviour by gender.

Annex 1 provides a detailed explanation of the methodology for conducting the demand analysis.

Product/Service Strategy

A detailed review of formal and informal sector microinsurance initiatives will identify:

A. Potential partnerships
B. Products
C. Interested MFPs, insurers, and others
D. Delivery channels
E. Transactional processes between the different organizations (agents and insurers)
F. General potential product opportunities with a product development strategy

G. Additional research required
H. Potential relationship structure issues between different institutional partners
I. Capacity development requirements
J. Output indicators
K. Risks to the product(s) including governmental, regulatory, legislative, supervisory, environmental, cultural, and others.

Marketing / Market Education Plan

This section will discuss the marketing requirements of insurers, the delivery channels, and the potential market. Some suggested areas of market education would be addressed based on lessons from the demand analysis. Delivery strategies will be addressed.

Financial Plan
This section will include:
A. A basic draft outline of the costs of testing and implementation.
B. A discussion of potential profitability
C. An estimate of additional donor / investor inputs required

Support Documents
This section includes a variety of additional documents to substantiate the plan.

6. Duration and Costs

Country	Final Product Due on or before:
India	30 April 2005
Indonesia	31 August 2005
Lao PDR	31 August 2005

7. Qualifications and Experience

The candidates should have an advanced degree in a field related to finance, insurance with an emphasis on microinsurance and microfinance and international development and 10-12 years of professional experience in implementing such initiatives at the field level. Experience in dealing with issues of insurance, safety net mechanism, or risk management at the level of government, civil society, communities, or the private sector is highly desirable.

S/he should have a good understanding and experience in the area of poverty alleviation, sustainable development, development of entrepreneurs and building partnerships between diverse stakeholders. The consultant should have a good knowledge base of MDGs and well experienced in the role of insurance in reducing vulnerability and strengthening sustainable livelihoods. Excellent writing skills in English are necessary. The candidate should be able to function effectively in an international, multi cultural environment. S/he must be fluent in both spoken and written English. Knowledge of other UN Official Language is an asset.

Annex 1: Methodologies to be applied in demand research

Methodology:
Microfinance Opportunities will use the qualitative research methods it has developed and used in other microinsurance market research studies. These include Focus Group Discussions (FGD), Participatory Rapid Appraisal (PRA), and Individual In-depth Interviews.

1. Focus Group Discussions and Participatory Rapid Appraisals

A variety of qualitative tools and techniques will be implemented including focus group discussions which address low income populations' risks and risk management strategies, PRA tools including the life cycle, time series of crisis, seasonality of income, expenditures, savings and credit, and seasonality of risks. These will be used to investigate:

A. Risk and Risk Management Strategies
Range of risks and the effectiveness of the coping strategies (indigenous/informal group insurance mechanisms, formal insurance and other instruments) used to address them.
Ranking of key risk in terms of the financial stress and lump sum cash needs to cope with them.

B. Client Satisfaction with Existing Insurance Schemes for Poor Households
FGDs will be held with members, ex-members, and non-members of existing insurance schemes for poor households in order to learn about the level of satisfaction with and understanding of these products.

Individual Interviews
In-depth interviews will be held with key informants who are members of indigenous, informal group based insurance schemes or who are policyholders with existing insurance schemes. Individual interviews will also be used to explore the demand side issues related to affordability. This will generate information for the purposes of learning more about:

Indigenous/Informal Insurance Schemes And The Importance And Use Of Savings And Loans To Manage Risk, Interviews will be held with key informants to ascertain the use of indigenous insurance schemes and the use of savings and loan products to manage risk.

Information Related To The Demand For Microinsurance Products. The AIMS/SEEP loan use tool will be used to investigate the use of savings and loans by microfinance clients to cope with key risks. These interviews will identify clients' pre-existing financial obligations in order to determine their willingness and ability to pay for microinsurance.

APPENDIX 2: METHODOLOGY AND RESPONDENT STATISTICS

Methodology

We carried out individual in-depth interviews with 18 respondents over the course of the week of May 31 to June 2, 2005. Two interview tools were used to explore: risks and coping strategies, and loan and savings use over time. Additionally, one key informant interview was conducted. The interviews took place with members of the Fonds Cooperatifs network of credit cooperatives (CCSPs). Fourteen interviews were conducted with members of the CCSP in Louangphrabang and four interviews were conducted with members or employees of the CCSP in Hong Ngua, in Naxaythong District. Seventy-two percent of households and 76% of villages in Louangphrabang province are considered poor. However, the districts within Louangphrabang in which we conducted our research are not categorized as poor. The Naxaythong district is adjacent to Vientiane and is also not a poor area.

Fonds Cooperatifs and CCSPs

The members of Fonds Cooperatifs CCSPs come from the 30% of rural households that produce a surplus, which can be marketed, and the 60% of urban households that are involved in family based or microenterprises. (70% of rural households are subsistence farmers who are not integrated into the market.)[59] Together these rural and urban target groups account for 35% of the population or 1.9 million people. At this time, the CCSPs that make up Fonds Cooperatifs are reaching 1,500 members. To the best of our knowledge, this is the largest private (i.e., non-government) microfinance program in Lao PDR. It may well be the only best practice program in the country. Currently, FC has 12 CCSPs throughout Lao PDR with the Louangphrabang CCSP being the most northern cooperative.

The CCSPs offer their members loans ranging from USD 100 to USD 1000 with loan terms up to 1 year. Repayment is usually interest only with balloon payments of principal at the end of the term. The interest rate is 36% per year. Sixty percent of the members are women.

Characteristics of Sample Group

Seven men and eleven women were interviewed, reflecting the gender distribution of members of the CCSPs. Nine interviews were conducted in Louangphrabang district and five in the Xieng Ngeun districts in the region of the Louangphrabang CCSP. Four interviews were conducted in the Naxaythong district about 35 km outside of Vientiane.

Household Composition	
	Average
Total Number of People in Household	6.2
No. Aged 17 and above	3.4
No. Aged 16 and less	2.2
No. of Children 6-16 in school	1.8
No. engaged in economic activities	2.7

Age of Respondents	
Average Age	41.5
Youngest Respondent	23
Oldest Respondent	60

[59] Statistics provided by Fonds Cooperatifs May 2005.

Education Level of Respondents	
	N=17
None	1
Some Elementary School	4
Completed Elementary School	1
Completed Junior High School	5
Completed High School	6

Gender and Marital Status of Respondents	
	N=17
Married	15
Single	1
Widowed	1
Male	6
Female	11

Gender of Primary Income Earner	
	N=16
Male	8
Female	1
Both (husband and wife work together)	7

Household Economic Status	
Average Annual Household Income	LAK 23.6 million (USD2200)
Average Number of Economic Activities per Household (not including salaried employment)	2.8
Number of households with at least one person in a salaried employment	9
Respondents owning own house	16

Access to Financial Services	
Average Amount of Current Loan from CCSP	4.8 million kip
No. of respondents with Savings Account in Bank	3
No. of respondents participating in Houia (ROSCA)	9
No. of respondents with access to formal Insurance	6

Economic Activities of Respondents

Cattle keeping for others
Cattle raising
Corn Growing
Fish trading
Handicrafts Selling
Handicrafts/Weaving production
Ice Making
Whiskey production
Noodle production
Pig Raising
Poultry Raising
Restaurant
Rice Growing
Small shop
Teak Wood growing
Vegetable Farming
Watch repair shop

Appendix 3: People Met During the Visit

Name	Position	Company	Email	Web Site	Phone
Woitellier, Etienne	Directeur	Agence Francaise de Développement	afdvientiane@groupe-afd.org	www.afd.fr	+856-21-243 295
Sayaphet, Phanthaboun	Deputy Director	Agricultural Promotion Bank	phansayaphet@yahoo.com		+856-21-212 024
Coleman, Brett	Microfinance Specialist	Asian Development Bank	bcoleman@adb.org	www.adb.org	+632-632-5561
Cyhn, Jin	Economist – Governance, Finance and Trade Division; Mekong Department	Asian Development Bank	jcyhn@adb.org	www.adb.org	+632-632-5441
Phomkong, Phongsavanh	Consultant	Assignments for World Bank etc.	pphong2000@yahoo.com		+856-21-413 240
Hohmann, Juergen	Health Economist, Social Security Specialist	Belgium Technical Cooperation	Juergen.hohmann@attglobal.net		+856-20-561-500-4
Bagchi, Palash	Assistant Country Director	Concern Worldwide	acdlaos@laotel.com		+856-21-213-578
Svengsuksa, Sisaliao, Dr.	President	Fonds Cooperatif	fcsisaliao@etlao.com		+856-21-261-825
Genrich, Rolf	Program Director	GTZ - Human Resource Development for Market	rolf.genrich@gtz.de	www.gtz.de	+856-21-217 554
Matzdorf, Manfred	Senior Advisor	GTZ – Private Sector Development and SME Promotion	manfred.matzdorf@gtz.de	www.gtz.de	+856-21- 217 554
Kallabinski, Jens	Program Coordinator	GTZ – Rural Development in Mountainous Areas of Northern Lao PDR	jens.kallabinski@gtz.de	www.gtz.de	+856-21-414 563

Name	Position	Company	Email	Web Site	Phone
Howell, Fiona	Chief Technical Advisor	ILO	ilossp@etllao.com		+856-21-242 074
Sophimmavong, Khamtanh	Head of International Relation Division	Lao Federation of Trade Unions	Khamtanh_s@hotmail.com		+856-21-212 754
Latmany, Chantheum	Executive Member Committee, Chief of Cabinet	Lao Women's Union			+856-21-911 438
Manivong, Khamphet		Ministry of Health			
Vorsaran, Somnuk	Director General	Social Security Organization	somnv02@yahoo.co.uk		+856-21-241 280
Shouia, Dean A.	Program Management Officer	WHO	sHouiad@lao.wpro.who.int		+856-21-413 413