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# Microfinance and HIV/AIDS NOTE #3
# Microinsurance for Markets Affected by HIV/AIDS

*Too many households worldwide are caught in a vicious cycle of poverty and HIV/AIDS. These households have to care for the sick, make up for lost productivity, cover funeral expenses and often take custody of orphan and vulnerable children. Poor households are especially vulnerable to the HIV/AIDS pandemic but have fewer resources at their disposal to protect against financial crises. Microinsurance can be an effective risk management strategy to protect poor households from these devastating losses.*

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Over 33 million people are living with HIV/AIDS worldwide, an overwhelming majority of whom are in developing countries.[1] Dealing with the HIV/AIDS crisis requires strategies and solutions that cut across health service delivery and financing, to livelihoods support and social protection of families. Too many households worldwide are caught in a vicious cycle of poverty and HIV/AIDS. These households have to care for the sick, make up for lost productivity, cover funeral expenses and often take custody of orphan and vulnerable children. Poor households are especially vulnerable to the HIV/AIDS pandemic but have fewer resources at their disposal to protect against financial crises. Exorbitant medical costs coupled with loss of productivity compel the poor to patch together limited resources at hand; they divert their basic income and modify consumption patterns, draw on limited savings, sell productive assets, or take out emergency loans to cope. Even where available, these resources may not provide sufficient protection, and may become less accessible and more expensive over time.

This MicroNOTE explores how microinsurance can be an effective risk management strategy to protect poor households from these devastating losses, how different insurers have responded to the pandemic with appropriate and affordable coverage, and the challenges and risks inherent in serving communities with a high prevalence of HIV/AIDS.



[1] UNAIDS/WHO, 2007

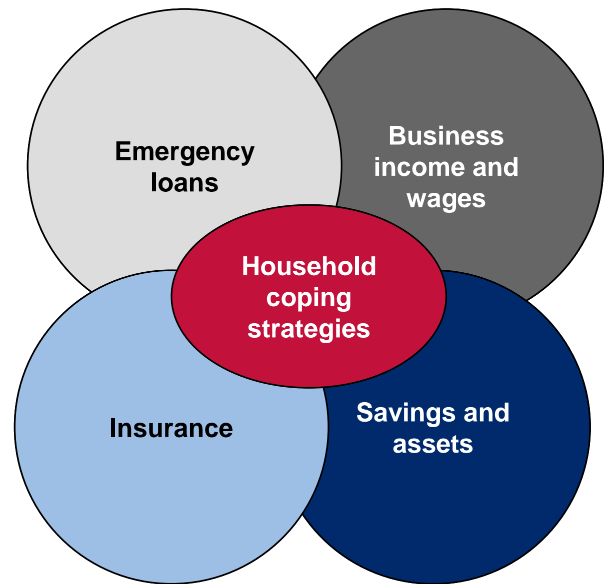
## FINANCIAL PROTECTION FOR THE POOR - MICROINSURANCE

Microinsurance is defined as the protection of the poor against specific risks in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved.[2] Microinsurance is distinct from insurance only in the market that it targets – the underserved. The pooling of financial risk is at the core of traditional insurance mechanisms and turns risk management from a reactive to a proactive process. In effect, through the collection and management of financial resources, large, unpredictable individual financial risks become predictable and are distributed among all members of the pool. Since part of the individual risk is borne by the entire group, the individual risk premiums can be relatively low in relation to the size of the potential loss. Insurance is thus especially critical in offering protection against large shocks, such as hospitalization or the death of a family member, that are commonly faced by households affected by HIV/AIDS. In short, microinsurance can and does serve as an important complement to ex post mechanisms that households utilize to cope with financial crises – such as drawing on savings, taking out emergency loans, or diverting their income from household consumption (see Figure 1).

A vast majority of the poor in developing countries work in informal or agricultural sectors and fall outside the purview of formal insurance.[3] They can neither afford commercial insurance nor access social protection benefits, such as health, disability or unemployment coverage, which are provided by employers and often co-financed by governments. Meanwhile, most developing country governments simply do not have adequate resources or institutional capacity to offer social protection for all. Microinsurance is emerging as a viable strategy to fill this gap and deliver insurance that is affordable, accessible and appropriate to the needs of the poor; it stimulates the private sector to reach underserved markets and builds on government efforts to provide social protection services for vulnerable populations.

Partners involved in delivering microinsurance cut across a variety of organizational types and sectors. At its core, the microinsurance supply chain is comprised of "risk-carriers" and "delivery channels." Risk carriers are specialized insurers that are finally liable for risk. These include commercial insurance companies, cooperative or mutual insurers, community based schemes, NGOs and informal groups and associations. Risk carriers often partner with delivery channels to reduce transaction costs and market their products to poor

**Figure 1: Household Risk Management**




**Box 1: What is Microinsurance?**

- Insurance allows those insured to share the risk of a financial loss.
- Microinsurance is a subset of insurance that provides financial protection to the poor for certain risks in a way that reflects their cash constraints and coverage requirements.
- Microinsurance is a risk management system involving low-income groups in which individuals, businesses, or other organizations pay a certain sum of money (a premium) in exchange for guaranteed compensation for losses resulting from certain perils under specified conditions.

(Source: MicroInsurance Centre)

[2] Churchill, Craig. "What is Insurance for the Poor?" in Protecting the Poor, a Microinsurance Compendium. 2008.

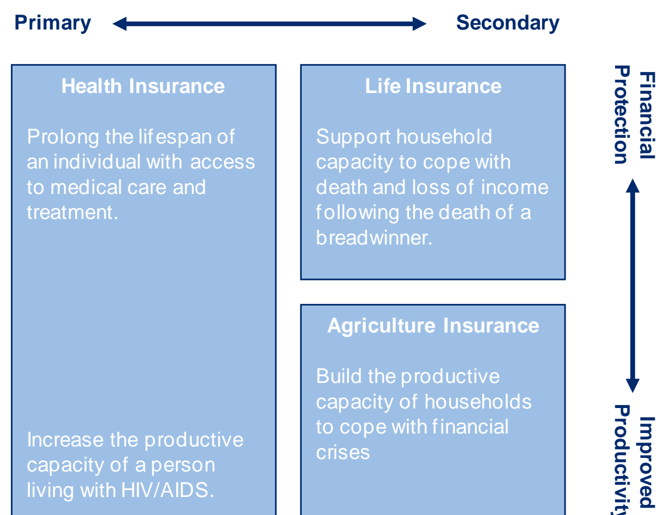
[3] According to the ILO (2001) no more than 20 percent of the active population in many developing countries is included in regular social security systems. In Africa, and South Asia, only 5 to 10 percent of the working population is covered by statutory insurance.

consumers. Microfinance institutions, trade associations, NGOs, retail networks and post offices are examples of delivery channels that service regular transactions and typically enjoy the trust of large segments of the poor. Other stakeholders involved in the delivery of microinsurance include health service providers, public ministries, non-governmental organizations and specialized AIDS service organizations (ASOs). In light of the HIV/AIDS pandemic and its impact on poor communities, some of these partners are adapting their products and business practices to accommodate markets affected by HIV/AIDS.

## INSURANCE FOR MARKETS AFFECTED BY HIV/AIDS

It is increasingly recognized that HIV/AIDS is part of a vicious cycle of poverty and not solely a public health issue. Families that are affected by HIV/AIDS face numerous hardships and require immediate access to health services as well as financial protections to cope with the economic impact of the crises. The intensity, frequency and long-term nature of shocks associated with HIV/AIDS can be devastating to households and call for multi-pronged responses. Moreover, the covariant nature of risks associated with an infectious pandemic such as HIV/AIDS can severely constrain broader support mechanisms in a given community.[4] For example, when whole communities are affected, undue pressures are placed on traditional safety nets, such as burial societies or rotating savings and credit associations (ROSCAs), further undermining the ability of households to cope.

**Figure 2: Insurance Products for HIV/AIDS Markets**




A bundle of insurance products can be used to relieve families from the primary or immediate medical expenses related to HIV/AIDS care as well as to help them cope with the economic repercussions or secondary effects of the pandemic (see Figure 2). This includes ***health insurance*** to increase access to health care and avoid high, often catastrophic, out-of-pocket payments for medical expenditures; ***life insurance*** policies, including *term life and endowment* insurance to offer compensation and financial stability following the death of a family member, *funeral coverage* to meet the immediate and often costly requirements of dealing with the bereaved, and *credit life* to cover the outstanding balance on a loan. Other types of coverage, such as index linked ***agriculture (crop or livestock)*** insurance can secure the productive capacity of families to manage the impact of HIV/AIDS and prevent them from falling into poverty in the first place.[5]

Studies on the demand for insurance among the poor consistently reveal that the loss of a household income earner and sickness of a family member are their greatest concerns. In countries with high HIV/AIDS prevalence, as in Malawi where over 15% of the population is HIV-positive, fear of death as a result of HIV/AIDS complications was cited as the highest-priority risk among poor

[4] Risks can be *idiosyncratic* (uncorrelated) or *covariate* (correlated). Covariate risks may impact on the regional or national level (such as natural disasters, epidemics or war) while idiosyncratic risks (such as old age or injury) are independent and affect only the individual or household.

[5] Index based insurance is a strategy for dealing with high-loss covariate risks, such as crop failure, by ensuring against the source of risk (such drought or flooding) rather than the economic losses themselves. Payments are made based upon an objective and independent index and do not require the calculation of actual losses for each individual.

**Box 2: The Complexity and Cost of Delivering Health Insurance**

- **Moral hazard, adverse selection and fraud are particularly problematic.** The subjective nature of sickness may not always be verifiable and can result in high enrollment of sick or at-risk families into schemes (adverse selection) or over utilization of services by the insured (moral hazard).
- **Health insurance is intrinsically linked to a third party, usually a healthcare provider.** This requires first that clients have access to quality health services. It also requires streamlined payment and reimbursement policies to efficiently exchange information, provide services, control costs and monitor fraud.
- **Client involvement and buy-in is indispensable for a health insurance scheme to succeed.** To ensure against adverse selection, health insurance generally only works with pre- existing groups such as informal savings collectives or associations. Moreover, clients are extremely sensitive to the product features (benefits and exclusions) which is more likely to influence adoption as compared with life or property insurance.

households.[6] While HIV/AIDS no doubt increases household vulnerability, the type of insurance that a community or family values and chooses to purchase is specific to context and dependent on cultural norms, access to social protection systems or community-based alternatives for managing risk. For example, in Nepal and Indonesia, there is limited demand for life and funeral insurance as funeral expenses are kept at a level that a family can afford. By contrast, life and funeral insurance are very much in demand in Uganda and South Africa where there are high levels of expenditure around the rites associated with funerals.[7]

The main types of insurance that can protect households affected by HIV/AIDS will be discussed below in relation to how they are delivered – either by regulated commercial insurers, community based schemes or informal societies.

## PRODUCTS AVAILABLE IN MARKETS AFFECTED BY HIV/AIDS

Conventionally, insurers limit their exposure to high "uninsurable" risks by instituting exclusions for HIV/AIDS or pricing products beyond the reach of vulnerable groups. In countries with high HIV/AIDS prevalence, microinsurance schemes are finding it difficult to exclude HIV/AIDS from their coverage for ethical, legal and practical reasons. Others find that HIV/AIDS prevention efforts in fact support their own risk-reduction strategies. The extent to which microinsurers extend coverage for people living with HIV/AIDS depends largely on the product (health, life or crop) and the market. Ultimately, microinsurance providers try to strike a balance between broad inclusion, appropriate benefits, low premium rates and sustainability.

### *Health Insurance*

The need and demand for protection from sickness, chronic illness and accident is paramount among the poor. With few options for risk-pooling available in developing countries, poor families face enormous financial barriers to accessing quality health services.[8] Out-of- pocket spending for health is the norm and can quickly impoverish families when medical expenses are frequent and high. Health insurance can lower the financial barriers that delay or impede access to essential services, and thus protect and improve the health status of individuals and communities. However, the delivery of health insurance is complex and costly to deliver (see Box 2). By and large, to keep premiums at an affordable level, microinsurers restrict health coverage to high-cost, unpredictable events such as hospitalization.[9] Few examples of programs with comprehensive outpatient coverage exist but these face challenges in balancing benefit levels with affordability.

By and large, comprehensive coverage of HIV/AIDS care is

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[6] Cohen, Monique and Jennifer Sebstad. "The demand for microinsurance" in the Microinsurance Compendium.2006.

[7] McCord, Michael. Microinsurance Note 7: Life Insurance for the Low Income Market. USAID. April 2007.

[8] According to 2005 estimates by the World Bank, IMF and WHO, out-of-pocket spending accounts for 93 percent of private spending, and more than 60 percent of total health spending in low-income countries. In South Asia and Sub-Saharan Africa, roughly half of all health spending is out-of-pocket. Gottret and Scheiber, World Bank, 2006.

[9] McCord and Noble, 2007. Microinsurance Note #6: Health Microinsurance. USAID. June 2007.

confined to the formal sector that receives direct and significant contributions from employers as well as subsidies from public social protection schemes. Comprehensive coverage for HIV/AIDS includes counseling services, the provision of anti retro viral therapies (ARTs), regular CD4 counts and viral load testing, ongoing treatment of opportunistic infections and hospitalization. Such treatment can dramatically extend the life-span of HIV positive individuals, keeping bread-winners economically active and allowing them to care for the young, sick and the elderly. Despite the high upfront cost of treatment, it is generally seen to be more cost-effective to provide coverage for HIV/AIDS – and to commence treatment at the early phases of infection – than to pay for the corresponding treatment of opportunistic infections and hospitalization as the disease progresses.[10]

In recent years, priority countries in Africa and the Caribbean have received sharp increases in funding for HIV/AIDS from global development assistance programs such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTAM) and the US President's Emergency Plan for AIDS Relief (PEPFAR)[11]. Among other resources, these efforts have significantly increased the availability of ARTs through the public sector and lead to partnerships with commercial and not-for-profit private health providers to scale-up access to treatment and care. Concurrent with this surge in donor funds, commercial prices for ARTs worldwide are also decreasing and offer potential for microinsurers to directly offer coverage for treatment in the future.

Few *commercial insurers* offer comprehensive health coverage for the low-income market, which covers diagnostic, inpatient and outpatient health services. **Microcare Health Limited** in Uganda is one example of a regulated insurer that targets both low-income and corporate clients and integrates prevention, testing and counseling services of HIV/AIDS within its comprehensive health package as a risk-reduction strategy. They have recently been able to include treatment of first-line anti-retroviral drugs in their community schemes by linking with the public delivery channels, a benefit that was only accessible to corporate clients in the past. In Nigeria, the largest Health Maintenance Organization (HMO) **Hygeia Nigeria Ltd,** is unique in offering its 200,000 corporate clients with voluntary counseling, testing, and treatment of HIV/AIDS. In early 2007, the HMO commenced a community health care scheme with support from the Dutch Health Insurance Fund in partnership with the PharmAccess foundation to extend coverage of the same services to 115,000 poor residents in Lagos and Kwara states, comprising market women and farmers.[12]

**Box 3: Inclusion of HIV/AIDS Coverage in Rwanda's Health Mutuals**

In Rwanda, community based health mutuals (mutuelles de la sante) have been rolled-out under a national solidarity funding structure whereby public subsidies (including donor funds) are channeled to the district level to supplement local funding pools of household contributions. Over 70 percent of the population including indigents and vulnerable groups receive coverage of primary and tertiary medical services, including care and treatment of ARTs. Preliminary assessments suggest that the inclusion of people living with AIDS within the scheme results in only limited incremental costs, as long as the ARTs continue to be paid for by donor funds. (Diop et al 2007)

*Community based health insurance schemes* play an important role in financing and managing health care for the informal sector. Community based schemes are especially prevalent in sub-Saharan Africa, but have also developed in Asia and in Latin America. These schemes generally entail pre-payment by individual members, risk-sharing across the group and strong involvement by the community in product design. Because they are based on group solidarity

[10] Radermacher, Ralf, Dror and Noble. "Challenges and Strategies to Extend Health Insurance to the Poor". In Protecting the Poor: A Microinsurance Compendium. 2006.

[11] Gottret, Pablo and George Scheiber. "External Assistance for Health", in Health Financing Revisted, a Practitioners Guide. 2006. The World Bank.

[12] See www.pharmaccess.org for more information.

**Box 4: Life Insurance in South Africa Cannot Exclude HIV/AIDS**

In South Africa, regulatory bodies have taken a proactive stance on the treatment of HIV/AIDS for life insurance policies. In 2005, the Life Offices Association that represents 95 percent of the insurance companies removed exclusion clauses for HIV/AIDS on new policies for long-term life insurance. This was subsequently extended to the "Zimele" line of insurance products launched in 2007 for the low-income market. (Bester et al 2007)

and inclusion, these schemes tend to emphasize education, awareness and prevention of HIV/AIDS, and often partner with NGOs and social service organizations to render these services.[13] However these schemes are generally limited in scale, resources and administrative capacity. Without access to re-insurance, whereby certain financial burdens against large losses are transferred to an external insurer, community based schemes may not be able to adequately deal with catastrophic shocks that affect a high portion of their members. Community based schemes that offer treatment and comprehensive care of HIV/AIDS generally maintain formal linkages with government health financing channels, such as in Rwanda (see Box 3).

## *Life Insurance*

Life insurance, including funeral cover and credit life, are by far the most common types of insurance products available for the low-income market. They are especially relevant for communities affected by HIV/AIDS, who require funds to stabilize their income after the death of a bread-winner, cover the cost of funerals, or require coverage on an outstanding loan balance. Term life products with a savings component can be especially effective in providing longer term financial payouts to children or designated family members of a deceased client. Such products are commonly - and profitably - provided by regulated commercial insurers that work through various delivery channels such as microfinance institutions or informal associations.

Insurers are increasingly changing their practices with respect to HIV/AIDS as they find that excluding HIV/AIDS as a possible cause of death in their life, funeral and credit policies is more costly than including it. For example, two large insurers that serve the low-income market, **AIG Uganda and Madison Insurance Ltd.** in Zambia, amended their exclusion clauses around HIV/AIDS because of negative publicity from consumers, and a resulting drop in their sale of policies. Moreover, the difficulty in isolating AIDS as a cause of death proved that inclusion was a more effective strategy. Such changes on the treatment of HIV/AIDS are also occurring at the regulatory level and carry significant impact (see Box 4).

Although **credit life** products are seen first as a mechanism to protect the portfolio of a financial institution, they can be valuable for consumers in countries with a high rate of HIV/AIDS. In the absence of adequate coverage, institutions working in communities with high HIV/AIDS prevalence may be forced to write off large portions of their portfolio due to death, and eventually discontinue their operations. Moreover, the absence of credit life can result in HIV positive clients being excluded from group lending programs where members are afraid to assume a loan should the infected individual die. Credit life can also assist group members from shouldering the full cost of a deceased member's loan.

**Funeral cover** is a common form of insurance that is provided by regulated commercial and informal schemes. In countries where funeral rites are traditionally expensive, such as in South Africa, both types of providers have offered competitive burial policies to the low income market for many years. FinMark Trust estimates that there are between 80,000 and 100,000 burial societies in South Africa that serve over 8 million people. These societies offer a combination of cash and in-kind funeral benefits for their members, and do not exclude HIV/AIDS as a cause of death. However, the extent to which these societies are able to manage risk and maintain solvency given the growing

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[13] Community based schemes can generally be classified into *community pre-payment or mutual health organizations*, *provider-based health insurance schemes* that are centered around a particular hospital, and schemes that are attached to *government or social health insurance*. (World Bank 2006).

mortality due to HIV/AIDS is questionable.

### *Agriculture Insurance*

Besides tackling the primary medical risks associated with the onset of HIV/AIDS, affected families require support to protect and build their asset base. Efforts to support livelihoods, such as through savings and loan programs, conditional grants or vocational training initiatives, can be effectively bolstered with insurance. Index based insurance for weather related risk is emerging as an effective strategy to protect rural livelihoods. For example, farmers can be compensated for losses caused by extreme rainfall or drought when weather conditions exceed a specified index. Since agricultural activities dominate the livelihoods of rural poor, insurance against crop failure or loss of livestock – that tends to strike whole communities at once – are important forms of protection.

The **Micro Insurance Agency (MIA)** is an insurance brokerage network that offers a range of products including credit life, term life, livestock, property and health insurance (limited to hospitalization) to low-income groups. MIA does not exclude HIV/AIDS on any product, since the cost of monitoring and screening generally outweigh the benefits. In Malawi, MIA has launched an index based crop insurance product to enable groundnut farmers to access financing so they are able to purchase certified and more productive groundnut seed. In effect, the insurance company pays off the farmers' loan in the event of a drought, and has allowed farmers to invest in a higher-yield, higher-return activity. In a country where prevalence of HIV/AIDS has only recently stabilized to 15% from nearly 30% in the early 1990s, such efforts are important to provide economic and food security for HIV/AIDS impacted communities.

## INSTITUTIONAL CHALLENGES AND STRATEGIES TO MITIGATE RISK

Insurers take different approaches to mitigate the impact of HIV/AIDS on their clients – in line with their institutional and regulatory incentives, objective to serve vulnerable groups or ability to partner with the public sector. Despite their different approaches, all insurers operating in communities with high prevalence of HIV/AIDS face common challenges that are made more difficult in serving the poor. The practical and ethical difficulties in screening for HIV/AIDS mean that insurers may not be able to accurately assess the risk in their pools, in the first place. Given increasing mortality and morbidity rates for people living with AIDS, new insurers are less likely to enter markets that are perceived to be high-risk, or they adjust for this risk and price products out of reach for poor consumers. Based on data from South Africa, premiums for some group schemes that target the poor are estimated to be four times higher than would have been the case without HIV/AIDS.[14] While the cost of coverage may increase on certain products, in the absence of accurate mortality information, insurers are likely to considerably inflate their prices as a buffer. Insurers are also affected by their clients' ability to pay for services; as the disposable income of clients affected by HIV/AIDS falls, they are less likely to make regular payments on their premiums or consider purchasing new coverage.

Of the different institutional models, community-based or informal schemes are likely to experience the largest shock from working in HIV/AIDS affected markets. The premium under these schemes are typically set by members of the group rather than on actuarial data, and are based on what people are able to pay rather than the cost structure of benefits received. Such schemes generally do not have the actuarial input and oversight to adjust their prices based on risk, and thus may not be able to adequately protect policyholders from covariant shock.

Microinsurers working in HIV/AIDS impacted markets can

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[14] Bester, Hennie, Doubell Chamberlain, Ryan Hawthorne, Stephen Malherbe and Richard Walker, "Making Insurance Markets Work for the Poor in South Africa: A Scoping Study". February 2004.

alleviate risk in several ways, including:

- Expand the size of their pool to include different risk groups and ensure a sufficient spread of risk;
- Utilize accurate and up-to-date mortality and morbidity data to price products, and design appropriate benefit packages and level of coverage based on willingness to pay;
- Require that all members within a certain group purchase coverage, to prevent adverse selection by the sick, old or other high-risk groups.
- Ensure that members are able to contribute a premium on a regular basis.

## RECOMMENDATIONS

Following are recommendations for different stakeholders considering providing or scaling-up insurance services for the poor in HIV/AIDS affected markets. This broad audience includes insurance risk carriers and delivery channels, AIDS support organizations, health care providers, public ministries, and donors. The first set of recommendations are offered to improve access to microinsurance services for communities affected by HIV/AIDS, followed by suggestions to strengthen the broader response to HIV/AIDS among health and other development practitioners.

**Institutions that carry insurance risk and deliver insurance products should do so according to their core competencies.** Given the specialized nature of insurance, only institutions that have technical competency in risk assessment should directly manage insurance services. To protect policyholders and the solvency of institutions, insurers need to draw on actuarial input and maintain sound financing and investment policies around their core insurance business. Organizations that deliver insurance to the poor, such as MFIs or NGOs, should generally not take on insurance risk. As the interface between clients and licensed insurers, these partners have an important role in making sure that insurance products are in line with their client's needs, that clients are able to make informed choices and that they have adequate protection measures.

**Insurers should promote non-exclusive insurance products tailored for specific contexts. Insurers should avoid exclusions around HIV/AIDS to reduce the cost of screening and keep their products simple.** Non-exclusionary policies will also help insurers to increase their sale of policies and achieve scale. The extent to which insurers are able - or required - to remove exclusions will depend on the specific type of product (health, life or agriculture) and the benefits involved, consumer ability to pay for coverage, and the regulatory environment.

**Health microinsurers and ASOs should strengthen linkages with public health systems to increase access to coverage for HIV/AIDS treatment and prevention.** In countries where ARTs are available free of cost in the public sector, microinsurance schemes can help to increase uptake by the poor by administering treatment and care within their accredited health facilities, or referring clients to public health centers. Microinsurers should consider offering coverage for health care expenses that clients incur when adhering to ARTs, such as for nutritional supplements or transport, as well as promote HIV/AIDS prevention programs among their clientele. Donors can play a strategic part in facilitating linkages between microinsurance schemes, ASOs and public health systems.

**Donors should carefully target subsidies, where required, with clear and time-bound exit strategies.** Targeted subsidies to cover the cost of HIV/AIDS related medical care and treatment may be required for vulnerable groups. Donors should carefully design such subsidies with sustainability objectives and clear exit strategies. In general, donors should channel these subsidies through intermediary organizations rather than directly administer premiums on behalf of clients. In all cases, donors should facilitate linkages with the public sector and

leverage funding commitments from district or national level ministries to meet the needs of vulnerable groups over the long term.

**Donors, public health ministries and ASOs should integrate the care and treatment of HIV/AIDS within the broader framework of general primary health care.** HIV/AIDS is closely interlinked with other health burdens and should not be addressed in a vacuum. Donors and public health ministries should aim towards building inclusive health systems and address HIV/AIDS with related infections including TB, reproductive and women's health and malaria. Education and prevention of HIV/AIDS can also be best addressed within comprehensive systems.

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