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Microinsurance: A Case Study Of An Example Of The Full Service Model Of Microinsurance Provision

Self-Employed Women's Association
(SEWA)

Michael J. McCord, *MicroSave*
Jennifer Isern, CGAP
Syed Hashemi, CGAP

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Introduction:
At one time or another in their lives, most people experience financial stresses that are potentially disastrous. This is especially true for the poor in developing countries. Much microfinance activity, including that which incorporates savings programs, has been implemented in an effort to relieve some of these stresses and help people to secure, and even improve, the financial status of their families. As a result, many poor people in developing countries have experienced improved household incomes. They also see the benefits of saving money, as well as maintaining a healthy credit relationship, to protect against future crises.

It has become clear that savings, though critical, address only relatively simple life cycle events and minor emergencies. The issues of health care financing, deaths, and property loss, for example, often require a greater level of support so that the involved family does not slide back down the slippery slope of poverty.

For this reason, there has been much discussion about the provision of insurance products to the poor in order to address the needs arising from such events. Indeed, several organizations have created programs to provide insurance products, utilizing any of four general models of insurance provision. These models include:

1. The Partner-Agent Model
2. The Full-service Model
3. The Mutual Model
4. The Provider Model

This series of case studies is designed to review some of the products of the more prominent organizations offering insurance products to the poor and to review their product development and implementation of these models.

The Self-Employed Women's Association (SEWA) case study provides an example of the Full Service Model of insurance provision. As will be seen, SEWA offers a broad range of insurance coverage (life, disability, health, and property) under one premium with life coverage provided as an agent and the others provided under a full service model.[1]

Objectives: Although SEWA presents a mixed agent/full service example; this case study attempts to review its activities primarily within its role as a full service insurer. The case study aims to provide an understanding of the mechanisms and practicalities of the Full Service model, as well as an indication of the level of satisfaction of their market. Benefits and problems are identified, thus aiding in the identification of further potential applications. Additionally, this paper reviews the process by which the product was developed, tested, and implemented to provide information on the process itself and to identify issues in the product cycle.

Methodology: The assessment of SEWA was conducted through a field visit during the period 17 through 26 July 2000. The authors conducted interviews, document reviews, and field visits, as well as discussions with clients, former clients, and non-clients. Claims records, as well as accounting and other documentation where available, were examined.

A review of findings and suggestions was provided to management of SEWA and discussed during the visit.

[1] The authors wish to thank the management and staff of SEWA and its subsidiary organizations who were extremely helpful and open in discussing their operations and lessons learned. Most of the information reported in this paper derives from discussions with them as well as SEWA clients, and internal and public documents, which they kindly shared with the authors.

I. CONTEXT:

I.A: Macroeconomic & Legal Environment

Table 1.A.1: India Country Basics[2] **(**1998 unless noted and US$ where relevant):

GNP (US$ Billions)	427.4
Population (millions)	980
Surface Area ('000 Km^2)	3,288
GNP/Capita (US$)	440
GNP Growth Rate (1997-8)	4.3
GNP per Capita Rank (of 206)	161
Population per Km^2	330
Inflation (1999 est.)[3]	6.7
Exchange Rate (per US$1)[4]	44
PPP GNP per Capita	2,060
PPP GNP per Capita Rank (of 206 countries)	151
Infant Mortality (per 1000 live births) 1970/1998	137/70
Under Five Mortality (per thousand) 1970/1998	206/83
Maternal Mortality (per 100,000 live births) 1990-1998	410
Access to safe water (% of population) (1996)	81
Health Expenditure as % of GNP (public/private/total)	0.6/4.1/5.2

I.B: Institutional Summary

Table I.B.1: SEWA – Basic Institutional Information

Institution	**SEWA**
Institutional Type	Trade Union for Women workers of the informal sector
Registration	Trade Union
Institutional objective/mission	Organize women workers for full employment and self reliance
Main Activities	Banking, primary health care, training, insurance, representation
Year commenced	1972
Total Institution Members (6/00)	270,000

SEWA is both an institution and a movement have worked with among the poorest of the poor in India for more than a quarter century. They have built an ever growing, ever improving, system of comprehensive services. These services have assisted their members in innumerable ways to both improve household security (work, income, food, and social security), and become more autonomous and self-reliant. Their impact has been great and many of their members consider SEWA as their "mother".

Table I.B.2: General Information on the Insurance Program

	SEWA Insurance
Type	Non-Profit Insurer
Model employed	Full-Service (for health and property insurance) and partner-agent (for life insurance)
Year scheme formally started	1992
Target market	SEWA members (women self-employed workers) and their

[2] 2000 World Development Indicators, World Bank, Washington, D.C. 2000. pp. 12, 16 and 92.
[3] The World Factbook 2000. www.odci.gov/cia/publications/factbook/geos/in.html p. 1.
[4] Ibid. This exchange rate will be used in all calculations of current figures in this paper.

	husbands
Total number insured as of December 31, 2000	29,140
Majority of clients urban / rural	Urban and peri-urban
Geographical coverage of program	Mostly Gujarat State
Reserves	Fixed grant amount (currently approximately $450,000, originally approximately $386,000)

Unlike many start-up insurers in the microfinance arena, SEWA maintains significant reserves (provided by GTZ and carrying a principal-plus-inflation maintenance requirement). These reserves provide an important source of revenue through interest earnings that subsidize the program and its premiums. Although they carry a requirement to maintain their value against inflation, SEWA has, on a Rupees basis, grown the fund by an average of about 9% per year.

Their geographical market area has huge potential for them especially as they move their program further outside the City of Ahmedabad.

A timeline of significant events in the creation and implementation of the SEWA insurance program is presented in the table below.

Table I.B.3: Chronology of Significant Events

Year:	Event:
1972	Commencement of Self Employed Women's Association (SEWA)
1977	SEWA survey indicates the detrimental effect of death to SEWA's credit program
Early 1980's	Initial basic life insurance offered from LIC to SEWA members
1986	First health trainings provided for intended SEWA health care workers
1986/7	SEWA opens 5 health centres in urban slums of Ahmedabad
1987	First SEWA drug counters opened
1989	Government of India convinced to provide a 1 billion Rupee subsidy (about $2.4 million in 1989) to the Life Insurance Company to cover SEWA members
1990	First SEWA health cooperatives formed by SEWA health workers
1991	LIC formalizes life insurance scheme with SEWA acting as agent for life insurance
1992	SEWA convinces United India Insurance Company to add health, property and accidental death coverage for clients, and accidental death cover on husband's life
1992	SEWA receives endowment of Rs 10 million (approximately US$386,000[5]) from GTZ as a fixed reserve fund.
1993	Insurance package made voluntary for SEWA members (previously had been mandatory)
1994	SEWA took over the underwriting, management and servicing of the health insurance business
1996	Strong push to move insurance cover into rural areas commences
1997	SEWA took over the underwriting, management, and servicing of the property insurance business.
1999	Through a GTZ project SEWA acquired a part time insurance professional as an

[5] Exchange rate in 1992 was 25.92 Rs to 1 US$ per the Reserve Bank of India.

Year:	Event:
	advisor
2000	Government of India opens insurance industry to private ownership (this industry had been state owned throughout the period of SEWA interest in insurance provision). SEWA begins serious discussion about creating a formal insurance subsidiary.
2000	SEWA adds hospitalization care for husbands

From the table above it is clear that SEWA has been constantly trying to improve their product by expanding it and even absorbing some of the business under the belief that they can provide those services better than the formal insurers to their market.

I.C: Product Description

The components of the product are noted below.

Table I.C.1: The Insurance Products Offered

The Product:	**SEWA Insurance**
Coverage	✓ Natural Death – $680 ✓ Accidental Death – $68 ✓ Widowhood – $68 ✓ Property and business assets lost in flood, riot, cyclone or fire ✓ In-patient health care with related medications and tests, plus cataracts, dentures, and hearing aids ✓ Grant for Maternity
Exclusions	✓ Pre-existing and illnesses
Limitations	✓ Covers only expenses related to illness or accident that requires at least 24 hours hospitalization ($27.27 annually). ✓ Maternity ($6.82 grant), cataracts ($27.27), dentures ($13.64), and hearing aids ($22.72) only covered for "lifetime insurees". ✓ Certain procedures only after one year. ✓ Ages 18-58.
Eligibility Requirements (and renewal terms):	✓ Must be a member of SEWA
Pricing (Premiums)	✓ $1.65 per year for member only (Husband's natural death – add $0.51, husbands health – add $0.45)
Pricing (co-payments)	✓ None (but coverage is far from offsetting all costs)
Method of disbursement	✓ Reimbursement to insured for health costs

II. MARKET RESEARCH

II.A: Market Definition/Segmentation

SEWA was set up in 1972 as a means of organizing poor women in the informal economy. These women constitute 94% of the female labor force but have none of the legal benefits provided to those in the formal economy. SEWA's purpose is to mobilize these women to help them gain economic (employment and income) and social (access to housing and health care) security, as well as providing them tools to become more autonomous and self-reliant both economically and in terms of their decision-making ability. SEWA's focus on insurance stems from this mission of protecting poor women from the vulnerabilities of every day life.

A survey conducted by SEWA in 1977 helped them to recognize the detrimental impact of client and family death to their loan portfolio. This helped them to see an unmet need in an area where no one offered any formal insurance to this market. SEWA developed as a movement, in a sense an amalgamation of the labor, women's, and cooperative movements. This gave them a broad mandate, almost a responsibility to take the lead and provide a wide range of integrated products and services that assisted the poor in achieving their goals. Among these, SEWA management recognized the critical nature of insurance to help the poor better sustain life shocks. Thus, insurance became a component of their strategy.

The nature of the ultimate product as a component of an integrated structure helps to define why particular coverage is offered, and why there are certain other restrictions. The health insurance, for example, fits into an array of services that include: mobile primary health care, preventive education, and discount drugs, as well as credit and savings facilities.

Over the last three decades, SEWA has succeeded in mobilizing a quarter of a million women as members, the large majority in the state of Gujarat. It now seeks to expand rapidly, moving to a membership of a half a million over the next few years. Gujarat currently has a population of about 10 million households. At least half of these households have women who are engaged in the informal sector. SEWA estimates therefore that roughly five million households in Gujarat alone are potential SEWA members. This constitutes the market for SEWA insurance. SEWA feels that they would be able to target 10 percent of this market, or half a million households, in the next five years. Since a far larger population are poor and vulnerable, without access to any public or private insurance facility, the potential market for microinsurance services is much greater.

II.B. Market Research Process

While SEWA rarely conducts formal business-school-type market research, there is a continuous informal process of interaction and feedback. This provides a basis for understanding client needs, their level of satisfaction, the perceived product quality and indicators of general success in the market. The development of, and alterations to, their insurance products, has been based on a long and continuous learning experience using these informal methods.

From its very inception, SEWA realized the need for forms of social security to protect women from the endemic crises in their lives. Informal women workers face serious occupational hazards (bidii rollers from the tobacco they rolled, vendors from sitting out in the sun all day, salt mine workers from constant contact with brine) in addition to the ill health pervasive amongst the poor. They face crises in the form of loss of property (from floods and communal violence), death of income earners, and loss of earnings and productive assets due to health issues. SEWA Bank (the SEWA microfinance institution) realized early on that such crises were the major reasons for loan defaults. A 1977 survey of loan defaults revealed that of the 500 women who were not making their repayments, 20 had died (15 at childbirth); most of the others reported they or a family member were ill causing financial hardship. SEWA clients consistently brought up the need for social protection in different formal meetings and informal conversations with SEWA staff.

These issues were addressed in meetings, and solutions discussed. These discussions formed the analysis activities and the conclusions propelled management to search for solutions. At this point SEWA was not interested in managing its own insurance business. Their objective was to provide insurance as an agent of a state run insurance company.

II.C: Competitive Analysis

There were virtually no competitors to SEWA insurance products as these were being discussed and designed. The very rationale behind SEWA's seeking to set up an insurance program was a result of

the near total absence of any formal security (health, life, property, pension) provisions for women in the informal economy. Conventional insurance companies saw that retailing to this market would result in extremely high transaction costs. The state provided very limited assistance to these women. Even the health care services in state hospitals which are supposed to be provided at minimal costs, offered extremely limited access to their services, with significant "hidden" costs.

III. PRODUCT DESIGN

III.A. Prototype Development and Testing:

In the early 1980's, SEWA had integrated a health education module in their literacy classes. This was a first step in helping members to improve their health, but was restricted to providing information on basic hygiene, nutrition, and identification and prevention of common diseases. In the mid-1980's, SEWA started acting on the need to provide access to health care services and trained their first batch of basic health-care providers. In 1986-87, they opened five health centers in urban slums in and around Ahmedabad. The health care providers provided members with basic health advice, accompanied them to hospitals and to doctors, and provide them with simple medicine.

SEWA also realized that poor women paid exorbitant prices for medicine. They therefore set up medicine shops with attending pharmacists who could sell prescription drugs to both members and the public at far lower prices. SEWA would purchase medicine in bulk and pass on the savings to clients.

As the health program developed and provided much needed services, SEWA realized that the only way to facilitate curative services to the large population of self-employed workers would be through some market mechanism of insurance coverage. Arising from member concerns, in the early 1980s SEWA conducted a member survey on frequency, causes, costs, and options when members faced sickness, accidents, and/or deaths in their families. Convinced that members faced serious difficulties, SEWA began researching options for insurance services. SEWA's early research focused on three areas:

- The capacity for members to pay premiums;
- Members' needs for insurance coverage;
- Typical packages of insurance products available on the market.

SEWA then initiated a dialogue with insurance companies to provide coverage to their members. Initially, insurance companies were skeptical that SEWA members would be able to pay premiums, maintain their accounts, and diffuse risk, especially since they perceived SEWA members as an especially vulnerable group. After extensive lobbying, SEWA negotiated with Life Insurance Corporation of India (LIC), one of the nationalized insurance companies, to provide limited natural death insurance to members in the mid 1980s.

SEWA management then tried to convince the government to provide social security for women in the informal sector. While workers in the informal sector did receive certain benefits, both from employers and the government, people in the informal sector, especially poorer women, were denied such support.

In 1989, two members of SEWA management sat on a government committee to address the concept of public insurance to low income families. On this committee, they convinced the government to provide a subsidy of about US$2.4 million to the public sector Life Insurance Corporation to subsidize coverage of SEWA members.[6] This subsidy influenced LIC to extend its coverage to

[6] Katharina Hauck. The Social Security Program of the Self-Employed Women's Association (SEWA). Presented in Kampala, Uganda at the National Workshop on Mutual Health Protection for Business Associations and Producer groups through Micro Finance Institutions, 1-2 December 1999, p. 7.

include natural death benefit, accidental death, and permanent disability insurance to SEWA members in July 1991. SEWA members therefore paid half of the actual premium; the other half came from the government subsidy.

Thus, SEWA initially designed its insurance products in partnership with the collaborating insurance companies. These products were based on collective insurance products adapted according to SEWA's understanding of the insurance needs of its members. In this arrangement, which became operational in 1991, the primary objectives of each actor were as follows:

Table III.A.2: Primary Objectives of Stakeholders

Issue	Government of India	LIC	SEWA	Members/ Clients
Expand coverage of health services	Provide coverage to vulnerable groups, especially in the informal sector.		Meet member requests for insurance coverage. Reduce client/member vulnerability to shocks. Reduce delinquency in loan program. Link to SEWA's health services network.	Reduce shocks to their families from natural and accidental death, and those shocks related to their own health care costs, disability, loss of their business assets or home, and widowhood.
Test the model		Test the product with SEWA's large membership base, which could be an important target clientele.	Test the insurance market with formal insurance company.	
Cover costs		The government subsidy of approximately 50% of annual premiums reduced risk for LIC to test this market.	Secured government subsidy to reduce member costs during pilot testing phase.	

As discussed above, SEWA initially based prototype development and testing on member preferences and ability to pay premiums. Later, SEWA expanded services in response to positive experience and member feedback through the integrated network of SEWA service cooperatives. During 1992-94, SEWA negotiated with another insurance company, United India Insurance (UII) to expand coverage to widowhood (accidental death of husband), sickness and hospitalization, and loss of house and assets. In 1994, SEWA assumed responsibility for health insurance, and retained LIC for life insurance coverage of members and their husbands.

III.B. Delivery Channels and Partnerships:

One of the key hurdles of extending an important product like insurance to a new market is finding an efficient delivery channel. This is particularly true for products offered to the very poor, such as SEWA's members.

Over the years, MFIs have developed relatively efficient delivery channels to the very poor in order to offer effective credit and savings products. Many have come to recognize the potential benefits of

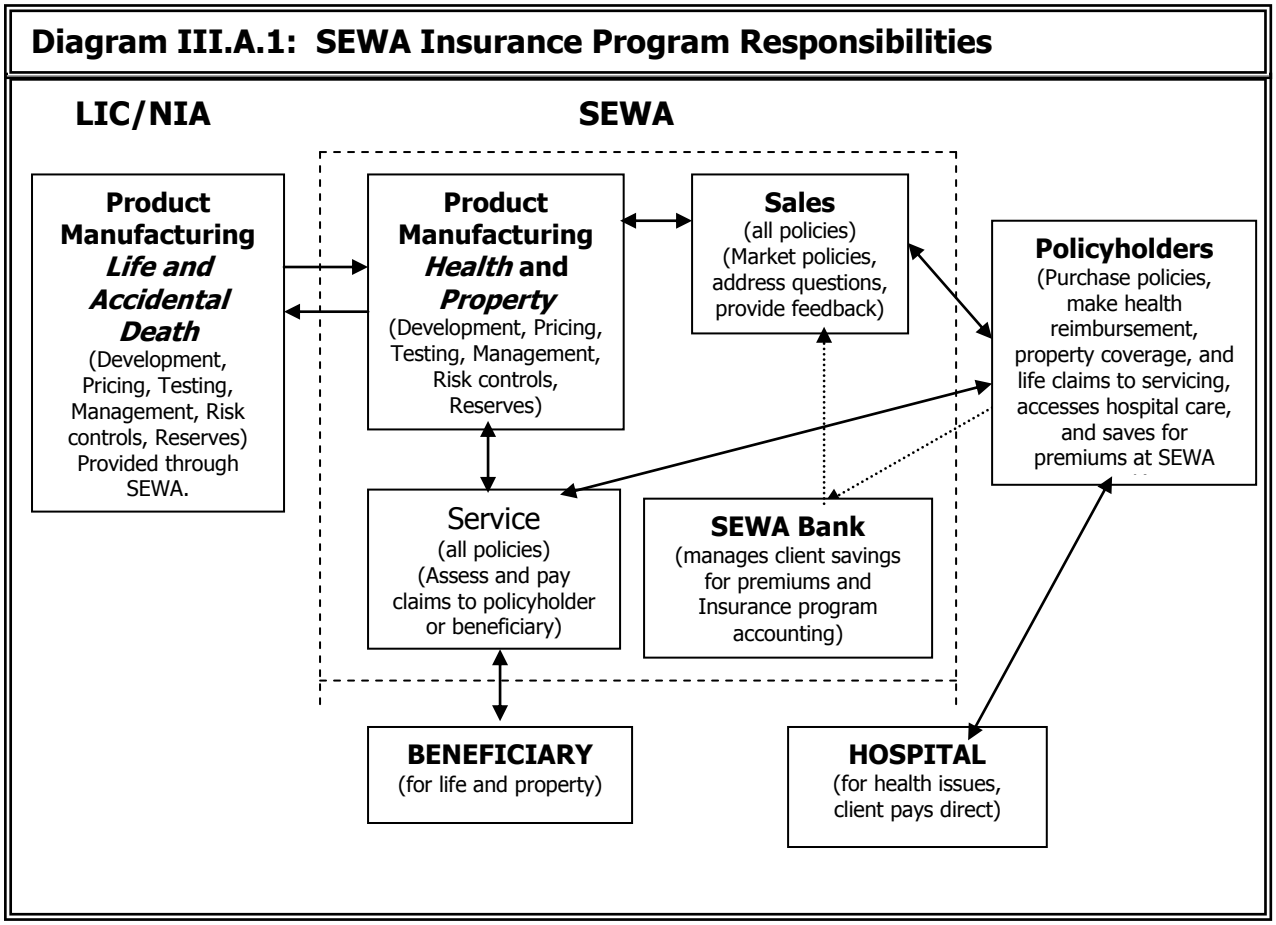
insurance products to their core operations and their clients. This has led to a search by several for quality insurance products to offer their clients. This has logically sent them looking to formal insurers who have the product, reserves and insurance management capacity, but do not have an efficient delivery channel to this target clientele.

SEWA's delivery channel is strengthened through its broad product and service offerings, including union representation and collective bargaining, banking, a health care services network, services enhancing housing and shelter, and occupation-based cooperatives. Building on this integrated approach of working with members, SEWA has cultivated a significant base of members, and experience in working with them.

As described above, SEWA initially chose to work exclusively as an agent for insurance companies who had product knowledge, systems, and reserves. SEWA's first partner was LIC, and this relationship continues for natural death benefits. Additional insurance company partners have included UII and New India Assurance (NIA). SEWA currently works with LIC for natural death coverage, and with NIA for accidental death and disability coverage of its members.

SEWA has gradually assumed a larger role in direct insurance, and SEWA's current package of insurance products includes a combination of SEWA direct services and SEWA working as an agent for parastatal insurance companies. The following diagram outlines the key activities and actors in SEWA's current insurance program.

Diagram III.A.1: SEWA Insurance Program Responsibilities



As seen in the diagram above, SEWA is now responsible for the core of insurance services to members, including product development, sales, reserves and liquidity management, financial management, member services and claims processing.

III.C Costing and Pricing

SEWA developed the price for its package of insurance services with the member's ability to pay as a leading influence. SEWA also used as a guide the formal insurer premiums on the products SEWA absorbed. Since SEWA initially started insurance services as an agent for a formal insurer, they negotiated prices for coverage on behalf of their members. The initial price was Rs15 for annual coverage of natural death of the member. LIC, SEWA's insurance partner for this service, set the price based on its other client profiles without conducting a specific risk assessment of SEWA's members.

Over a period of nine years, SEWA and their insurance partners gradually increased the premium to cover new additional services. Member ability to pay premiums remains a key factor in SEWA's pricing strategy and overall design of the service package. The current annual premium of Rs72.5 (US$1.65) for members, and an additional optional Rs22.5 (US$0.51) and Rs20 (US$0.45) for their husbands is detailed below:

Diagram III.C.1: SEWA Insurance Annual Premium Details

SEWA Insurance Annual Premiums Plan Year 2000/1				
	Rupies		US$	
Type	Women	Husbands	Women	Husbands
Natural Death	22.5	22.5	0.51	0.51
Accidental Death (Memb)	3.5	-	0.08	-
Widowhood	3.5	-	0.08	-
Health	30.0	20.0	0.68	0.45
Property	8.0	-	0.18	-
Service Fee	5.0	-		
TOTAL	72.5	42.5	1.65	0.97

In order to get into the program, members must pay Rs72.5. If they want their husbands covered, they can add on life insurance (with a total cost of Rs95), or health insurance (Rs92.5), or both (Rs115). Another way to pay premiums is for members to establish a fixed deposit, where the annual interest on the deposit covers the insurance premiums. Members who pay their premiums from interest earned on their fixed deposit also receive a maternity grant and coverage for cataracts, dentures, and hearing aids, at no additional cost. SEWA requires no co-payments, though insured must pay for health care service in advance and claim for reimbursement.

SEWA reports that this price is effectively subsidized by 1) interest from the GTZ endowment which SEWA manages, and 2) a Government fund allocated to LIC (in 1989) to cover half of the premium for life insurance of SEWA insured members and husbands (thus, the real premium for natural death insurance is Rs45, of which members pay 22.5). SEWA estimates that members pay approximately 50% of the costs of their insurance coverage, while 25% is subsidized by the Government fund, and 25% is covered by the endowment interest.

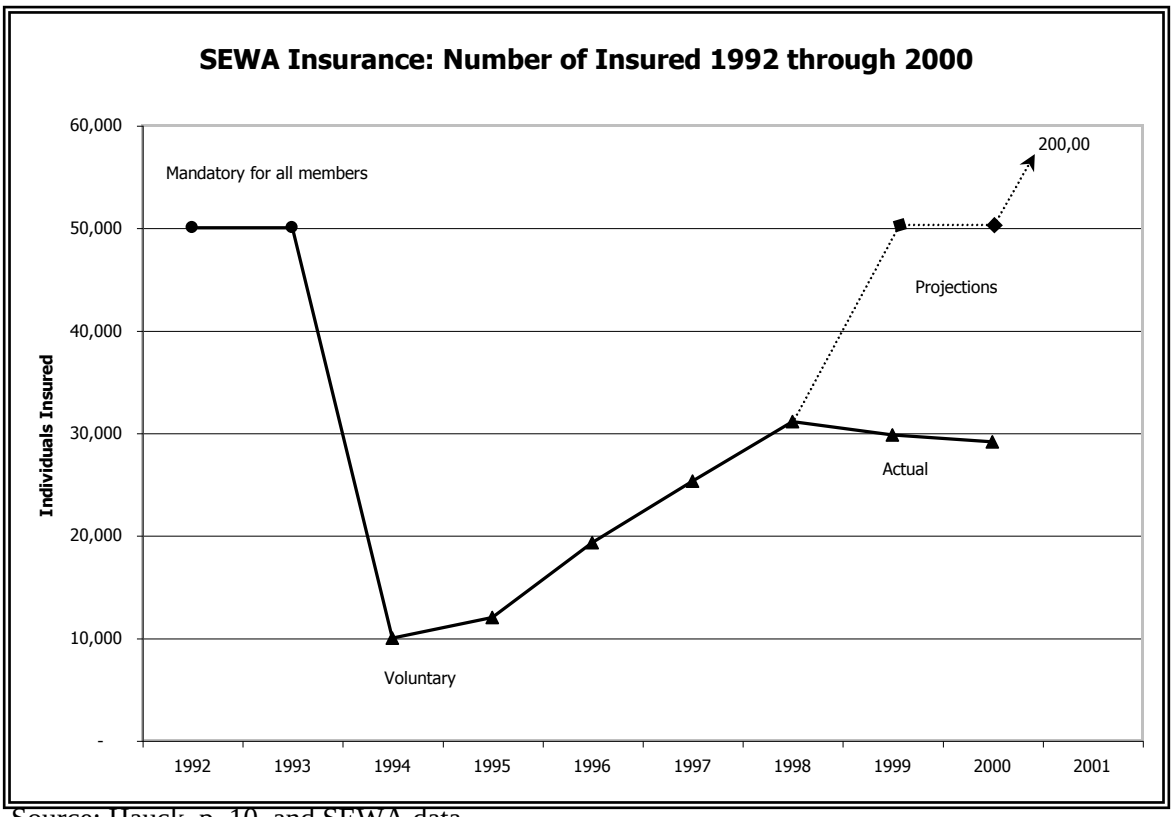
IV. PILOT TESTING

As with most other MFIs introducing a new insurance program within any of the models, SEWA did not have a formal structured pilot test. They knew what they wanted in insurance products for their

members and worked year after year to accumulate the full range of products they have now. When they anecdotally saw problems, they worked to correct them. SEWA management has undertaken very little analysis, or formal assessment during the life of this business activity.

As can be seen from Table IV.1: SEWA Number of Insured, below, SEWA started out ensuring all members at that time. This was an initial requirement from the LIC in an effort to cover the maximum risk pool and provide LIC with some protection from adverse selection. No testing was done, and SEWA simply rolled out the product to all clients.

Table IV.1: SEWA Number of Insured



Source: Hauck, p. 10, and SEWA data.

Partly because SEWA is so large, they have a relatively weak communication mechanism with all of their clients. Getting information to members has proven difficult over the years. Nevertheless, SEWA decided, for efficiency, that the first premiums would be paid from member deposit accounts at SEWA. Thus, when the premiums were due, they simply debited the accounts of the all the members and all members were thereby insured. They quickly realized that this was a mistake when uninformed clients suddenly found their accounts depleted for a product they knew nothing about.

Although the mechanism is effective and efficient, clearly the communications had been weak. This reflects one of the problems with a mandatory product, especially at the startup of a new product or business. Because everyone is forced to purchase the product, institutions tend to be much less effective at marketing the business or product. This frequently results in a negative surprise to clients (as was the case with SEWA) or they simply end up paying a premium for the service they do want and know about, ignoring the new product.

Especially with a new product or business, it is important to test first on a sample of clients who have a choice about their participation. Even in rollout, the product should be voluntary, at least initially, to

force staff to adequately market the product to clients and determine their interest based on whether or not they pay. The most effective sign of real demand for a product (its terms, price, composition) is how many people buy it.

SEWA quickly recognized the mandatory nature of the product and their automatic debiting as a mistake and after the second yearly cycle reverted to a voluntary system. Insured population dropped by 80% from 50,000 to 10,000 in the first year it was made voluntary and still has not risen to the initial levels of mandatory participation even with 500% growth in total SEWA members since that time. Table IV.1 above shows the population growth experienced by SEWA.

As will be noted in the next section on Rollout, many of the lessons learned on a large scale at SEWA could have been addressed on a pilot level, and with better analysis of the product (which should have been done during, and after, the pilot phase).

V. ROLL-OUT / IMPLEMENTATION

SEWA has implemented its insurance program since the 1980s in an evolution of partnerships and service combinations.

The experience of the first years of life insurance revealed to SEWA the inadequacies of the program. While it offered some protection to member families through life insurance, it offered nothing to the women themselves. Often after death, the member's husband would use the insurance money simply to re-marry. This was really of little benefit to the member and solved none of the problems SEWA sought to address.

SEWA realized that what was more important than simply covering the member's death, was insuring their husbands lives so that the members would receive some money if their husbands died. Additionally, members needed health and property insurance. In 1992, SEWA managed to convince United India Insurance Company (another large parastatal) to provide an integrated insurance package that included health and property insurance for members, and accidental death insurance covering their husbands**.** Since insurance companies would not provide for maternity benefits SEWA later decide to go alone on this and initiated a separate product – a grant to members in the event of a pregnancy.

SEWA realized the need to develop a mechanism to assist members in savings for the premiums. Thus, in addition to paying premiums on an annual basis, SEWA developed an option for members to purchase "lifelong insurance" with the deposit of a lump sum. This would be kept as a fixed deposit at SEWA bank and annual deposit interest earnings would be used to pay the annual insurance premium. Members were able to fund the fixed deposit at the start of an insurance year and receive insurance without additional cost. This also meant that SEWA would not have to market to these members to convince them of the benefits of paying the premiums. Theoretically, once they had funded the fixed deposit, they would have insurance for life (as the title suggests). In addition, participation in this payment scheme also provides additional insurance benefits for members - cataracts, hearing aids, dentures, and the maternity grant.

SEWA then realized that many members who would have preferred to pay a lump sum for lifelong insurance could not access the amount required to fund the fixed deposit. SEWA then provided an alternate method whereby these women would save in installments with SEWA Bank over two years to generate enough money for the lump sum payment. With this alternate method, SEWA provided the incremental savers with full insurance coverage starting after the first installment was deposited.

SEWA quickly deemed that conventional insurance companies were not equipped to meet the real needs of poorer women. There was considerable dissatisfaction by clients. The insurance claims

policy was often too strict. Insurance staff would not immediately visit clients to check on claims. The paperwork for filing claims was too involved. There would be long delays in payment. There were conditions that were not culturally sensitive. In the event of accidental deaths, for example, the insurance company insists on an autopsy to assess cause of death, while autopsies are culturally unacceptable. Often transportation of the body to a morgue far way is unavailable; corpses are not carried because they would defile the transport vehicle.

Other insurer decisions were senseless. For example, Katharina Hauck in "The Social Security Program of the Self Employed Women's Association" provides an interesting example of a scorpion that stung a field worker. As a reflex, she sucked her finger. She died from ingesting the poison, but the insurance company would not accept this as an accidental death. The argument was that death occurred because of sucking the finger, a deliberate action, and not because of the accidental sting.

General client dissatisfaction led SEWA, in 1995-96, to take over the health insurance scheme. The SEWA health program (a separate unit from the insurance operations), works closely to promote insurance and to integrate their services with the insurance program. SEWA health care workers therefore will provide advice on preventive care, referrals to doctors and hospitals, and assistance in the processing of claims.

Based on this experience, SEWA now offers three options for insurance coverage to clients from 18-58 years, as described in the table below:

Table V.1: Current Benefits and Premiums

	Basic coverage	Basic coverage plus husband	Extended coverage
Premiums (amounts in Rupees):	Annual premium of Rs. 72.5	Annual premium of Rs. 95 plus life insurance for member's husband	Becoming a lifetime insurance member (to age 58), by depositing Rs. 700 or 900 (if husband is included).
Benefits (amounts in Rupees):	Natural death: 3,000 Accidental death: 40,000 Maximum annual hospitalization expense: 1,200 Maximum annual damages to house and assets due to flood, fire, riots, cyclone: 5,000 Husband's accidental death: 15,000	Natural death: 3,000 Accidental death: 40,000 Maximum annual hospitalization expense: 1,200 Maximum annual damages to house and assets due to flood, fire, riots, cyclone: 5,000 Husband's accidental death: 40,000	Maternity benefit: 300 Cataract operation: 1,200 Hearing aid: 1,000 Denture: 600

Although the marketing would make one believe that once they maintain the initial required balance, they would have insurance coverage for life. In fact, this is not case. The initial balance requirement was Rs500 (US$11.35) and Rs700 (US$15.90) for members and consolidated member/husband insurance, respectively.

For the insurance year 2000/1, LIC increased its premium rates from Rs15 (US$0.34) to Rs 22.5 (US$0.51) per year. SEWA held all other insurance component prices constant but still had to acquire the additional premium from the fixed deposit "lifetime" members. They did this by increasing the required fixed deposit amounts to Rs700 (US$15.90) and Rs900 (US$20.45).

Since the final premium negotiations with NIC were concluded in the middle of the annual premium payment period, it was very difficult for SEWA to notify the fixed deposit members of the change, and explain to them why their "lifetime" insurance fund needed additional funding. As of July 2000, less than half of the fixed deposit members had conformed to the new requirement. SEWA appears to be allowing those members that have insufficient fixed deposit balances to continue and possibly bring their balances into compliance during the year. Although the fixed deposit concept addresses several problems with the collection of premiums, and certainly minimizes drop out, it is a system in which adjustments (caused by changes in interest rates or premiums) are very difficult to implement (to say nothing of the adjustment to a "lifetime" account).

It is also clear that SEWA pays interest on the fixed deposit accounts in advance to cover premiums. The interest rate paid on the accounts now is about 10% (down from 13% prior to the premium adjustment). Because the interest is paid in advance, the interest rate is effectively 11.6%. This has a significant negative impact on the SEWA Bank operations, and can be quite detrimental when the Bank's interest rates fluctuate.

SEWA has more than 250,000 members as of July 2000. From this membership base, SEWA has an excellent potential client group for the insurance program. Participation in SEWA's insurance program has grown steadily since it was made voluntary in 1994, though their recent annually re-projected targets have been deficient by over 40% each year, as seen in Table IV.1, above. SEWA's newly developed business plan, the product of an extensive planning process, calls for growth of almost 600% from 29,140 insured in 2000/1 to 200,000 insured in 2001/2, after declines in the prior two years.

In 1999, GTZ developed a second project with SEWA and the Women's World Banking office in India to strengthen SEWA's management capacity, and share their experiences with other MFIs in India. Part of this grant includes the (65%) employment of an insurance professional, and consulting time of a chartered actuary. The input of these executives should help SEWA to professionalize their operations and work towards controlled growth.

The Government of India introduced sweeping changes in the insurance sector legislation in July 2000 by allowing new entrants such as private insurers and foreign companies. Although there are opportunities to reintegrate their insurance program back to a professional insurer (several have requested such of SEWA management[7]), SEWA has decided to continue along a path towards launching an insurance cooperative which would be a subsidiary of the SEWA system. Discussions are now underway with the Insurance Regulatory Development Agency.

Some of the issues that arose during the first six months, and corrective actions instituted to address them are outlined below:

[7] The new regulations require that new entrants to the insurance market maintain a certain percentage of the premiums from rural areas. This creates a perfect opportunity for SEWA to link back up with a private insurance company that is incentivised to work with SEWA's members.

Table V.2: Significant Issues and Corrective Actions Taken

Issues:	Corrective Actions:
SEWA had great difficulty getting LIC to offer an adequate life product to their members	SEWA management, through membership on a government committee called to address the issues of insurance for the poor, were able to convince the Government to allocate a fund to LIC to subsidize the cost of life insurance to SEWA members.
Mandatory member participation	Poor communication about the product and the automatic savings withdrawal led to problems with members. After the first two years, they converted the insurance from mandatory to voluntary. Resulted in a loss of 80% of the insured from year 2 to year 3.
Automatic withdrawals for premium payments	Withdrawals were made from savings accounts of all members to cover the mandatory premium. All members had not been notified, or did not agree, and after the funds were withdrawn, they were surprised. Moved to voluntary direct payments in year three.
Insurers were unwilling to cover maternity	Maternity was not considered an insurable event (since the insured has control over event occurrence) and thus insurers would not cover this. SEWA provided, at no cost to members, a grant of Rs 300 (about US$6.80 today) to each insured childbearing member. Now this is provided to fixed deposit "lifetime" members.
Parastatal insurers were inflexible in dealing with the poor	Likely due to their status as parastatals, the insurance companies made little effort to effectively satisfy the needs of SEWA and its members. SEWA thus took over the business of insuring their clients for non-life products.
Members needed more than just life insurance	After initially covering members for their own death, SEWA recognized a need to broaden the coverage to widowhood, health, and property. They were able to get UIIC to offer a more comprehensive package to satisfy these needs, and later entered the insurance business by offering the non-life products themselves.
Members needed a better way to pay annual premiums than the single payment method.	Because members found it difficult to make a single annual premium payment, SEWA offered a fixed deposit account with required balances. If the member maintained those balances, their premiums would be paid from the interest earned on the account. SEWA marketed this as a "lifetime" membership in the insurance program.
Members did not comply with agreements on progressive fixed deposit savings	To facilitate poorer members to save up for the required fixed deposit balance, SEWA offered them a progressive savings program. After the first deposit, members were insured. Most members never made another deposit and had access to insurance. This program was eliminated.
Older members were slighted by maternity grant	Older members complained that the childbearing members were getting a benefit to which they had no access. SEWA added coverage for cataracts, hearing aids, and dentures, also at no additional cost to the insured, and also available only to "lifetime" members
The "lifetime" insurance was not enough to cover rate adjustments	Although marketing materials made it appear that by funding the special fixed deposit account, members would have insurance for life (or at least to age 58). When the premium increased, SEWA was forced to go back to members to increase the balances by 40% for the member's policies. This resulted in lost goodwill among SEWA's members.

VI. INSTITUTIONAL IMPACT:

VI.A Human Resources

SEWA has developed a small team to manage the insurance program. The SEWA insurance board sets policy, decides on service packages and premiums, and supervises the insurance management

unit. At present, overall responsibility for the insurance program rests with SEWA's health services program, and SEWA Bank assures financial management.

The insurance management unit currently consists of two full-time people who manage administration and operations. In addition, SEWA benefits from the part-time support of a GTZ technical advisor, formerly an insurance specialist with United Indian Insurance Company (UIIC), and an early collaborator with SEWA's insurance program.

The insurance program relies on direct contact with members through an integrated team of field workers. Six field staff work full-time with SEWA's insurance program. In addition, SEWA's banking cooperative and health workers work part-time with the insurance program at peak periods such as high claim periods (e.g., after floods) or during campaigns to register new members. In this way, an additional 25 to 50 workers can be mobilized quickly to work with the insurance program which is a definite benefit of working within the integrated structure of SEWA.

SEWA's small management and field staff currently work with over 29,000 insurance clients, and this is a very lean operation. In the business plan under development, SEWA would strengthen this small team by adding financial managers, a professional actuary, claims processors, marketing and service specialist, and many more field staff to manage a rapid growth to 250,000 insured members initially, growing to a half million people in five years.

Initially, the LIC insurance company provided training for SEWA staff in insurance concepts and marketing techniques for the new products. The insurance program now organizes orientations for field workers to explain the benefits, pricing, claims procedures, and other aspects of operations. Such orientation is vital to ensuring a uniform service delivery, and it is specially important for field workers from the health services network and banking cooperative who do not work full time throughout the year on the insurance program.

VI.B Operations and Systems

As SEWA has gradually assumed more responsibility for its insurance business, they have developed basic systems and procedures. Many of these were weak, and some non-existent, being addressed only once a need was identified. Institutionalization of the insurance program has been especially intense since 1999 when the part-time GTZ technical advisor joined the SEWA team.

Information is tracked manually. Records, especially for financial management, are shared between the insurance program and the bank cooperative. Financial and outreach projections have been developed in recent years, though actual operations have fallen far short of projections. Projections are being refined as part of the new five-year business plan currently under development.

Procedures for claims, premium payments, and other services have recently been formalized into a procedures manual. As the program has evolved, SEWA has built systems according to needs. For example, following the floods of mid-2000 and the shock of not having adequate procedures to address such a crisis, SEWA finalized a new claims procedure for property insurance, trained field workers in the new system, and immediately implemented the changes. SEWA has proven very agile in responding to such situations. Looking to the future, SEWA will build on the current systems and procedures to further strengthen management and administration, in a proactive manner, which is needed to handle the increased outreach proposed in the new business plan. Significant efforts will be made to build SEWA's capacity to manage such client volume and management challenges.

VI.C Feedback Mechanisms

Feedback on insurance products and indeed on every aspect of SEWA activity comes from various formal and informal mechanisms. Clients directly interact with SEWA field staff regularly, whether it be SEWA Bank staff or health workers or workers with the Housing Trust. Most SEWA members are also organized into cooperatives (dairy, artisan, vending, etc) that meet frequently. About five hundred elected representatives of these cooperatives (out of 714) meet every month at different locations. SEWA head office staff make frequent field visits and receive information. In addition, women have free access to the head office and it is common to see women squatting outside the founder's office waiting to meet with her. In a situation of proactive effort to reduce hierarchy and the distance between head office and membership, feedback is continuous.

The informal feedback mechanisms are enhanced by the broad network of SEWA activities and staff, between bank staff, health and housing staff, cooperative representatives the informal feedback is superior. However, the analysis of the feedback is weak. There appears little formal consolidation of the information gathered, and in the insurance program, there is little formal financial or operational analysis. This is detrimental to the effective operations of the insurance business.

VI.D Marketing

Marketing has been an ongoing challenge for SEWA to explain the concept of insurance to clients (and initially, to staff). Clear messages about prices, benefits, and claims procedures, and are critical to a good program. In their efforts to educate their clients, they have developed pictoral posters showing the different types of risks they cover and their prices. "Demonstration-effect" marketing and peer-to-peer client marketing occur frequently through members to other members. However, SEWA's active marketing season is April through June (to coincide with its annual insurance year which begins 1 July). Prior to this period, SEWA Insurance staff retrain staff of the Bank, Health (provision), and Housing to market the insurance package to their clients. This greatly broadens the marketing capacity of the relatively small insurance staff.

The annual premium period does minimize the administrative burden for SEWA insurance staff but is not convenient to members, and likely significantly restricts membership. The current system offers two options for premium (as discussed in detail above) the "lifetime insurance" and the single annual payment method. This suggests an inadvertent exclusion of the very poor who are unlikely to have Rs700 to start a "lifetime" account. These accounts are held by over two-thirds of the insured members. Additionally, even the ability to pay the annual premium of Rs75 can be very difficult for July 1 each year.

The time of year for the annual insurance renewal may also be detrimental. The declines in membership over the last two years (see Table V.2) have been attributed by SEWA management as resulting from cyclone (in 1999) and flooding (2000), both of which tend to be seasonal. Meteorological cycles need to be recognized in setting the premium collection periods. Although they should save, without a formal mechanism to help people save regularly for large expenditures, few do save. Thus, annual premiums dampen the income smoothing effect that insurance is designed to enhance. The fixed deposit product surely aids in this for the relatively more wealthy.

Personal and household income cycles also need to be considered in identifying the appropriate periods for insurance premium payments. Because of their close affiliation with the SEWA Bank, it would be relatively easy for SEWA insurance to offer rolling admissions and premium collection. Current systems would need to be strengthened before this is possible, however. The result might be a more effective marketing response.

Marketing includes customer service issues which are discussed below in terms of claims process and client satisfaction.

VII. RESULTS

Table VII.1: SEWA Objectives

SEWA	Results Observed:
Meet member requests for insurance coverage.	Over the years SEWA has developed a comprehensive pool of insurance services covering part of the costs of the major traditional insurance needs of their members. They have done this both through formal insurers and when they were not satisfied that appropriate coverage was provided, they took on the insurance business themselves.
Reduce client/member vulnerability to shocks.	SEWA has clearly reduced the client vulnerability to shocks such as widowhood, property loss, and health. However, because of the reimbursement system for health, and the long delays for all insurance products, the level of reduction is in question. For example, the financial needs of an acute surgical requirement are immediate and impacted by a client's ability to pay immediately. This still requires utilization of traditional means of rapid cash accumulation (through depletion of savings, borrowing, or selling assets). On average, the 22% of the total expenses that are covered by SEWA do not arrive until almost three months after discharge.
Reduce delinquency in loan program.	A direct correlation between insurance provision and delinquency was not assessed.
Link to SEWA's health services network.	The SEWA insurance provides an important component to SEWA's comprehensive and integrated service provision to their clients with preventive and primary care covered by SEWA's health unit and the major medical covered by SEWA insurance. This linkage provides very significant benefits to SEWA members.
Test the insurance market with formal insurance company.	Although formal testing procedures were non-existent, SEWA was still able to determine that the relationship with UIIC was not what they wanted for their clients with regards to health and property insurance. Thus, they became insurers to the clients of this business.
Secured government subsidy to reduce member costs during pilot testing phase.	SEWA was successful in obtaining a subsidy to LIC to cover half of the premium for their insured members. This was a direct result of the respect SEWA commands within India.

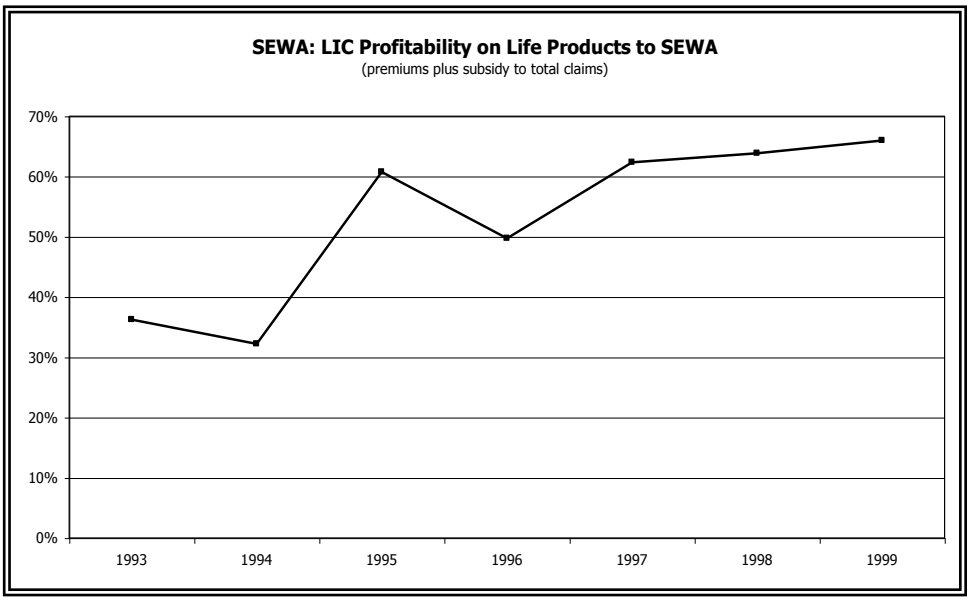
By taking on the risk themselves, SEWA has substantially met their objectives.

Table VII.2: LIC Objectives

LIC	Results:
Test the product with SEWA's large membership base, which could be an important target clientele.	This product has been tested over more than eight years with SEWA. They used no formal testing mechanism. Because of the pricing structure, LIC claims that this is not a viable market (see chart below). The parastatal's management states that they remain with SEWA for political reasons relating to the strength of SEWA within the government.
The government subsidy of approximately 50% of annual premiums reduced risk for LIC to test this market.	Through SEWA's efforts, the subsidy was granted which convinced LIC to work with SEWA on this program. The subsidy has been insufficient to cover even claims costs at current premium levels, though the premium was increased by 50% for the 2000/1 insurance year.

It is clear that LIC provides insurance coverage to SEWA clients because of political pressure. They only enhanced their relationship based on the 50% premium subsidy offered by the Government. They appear to remain in the program because of continued political pressure. LIC has suffered significant losses during each of the years the program has been offered (except the first which is an anomaly likely because of a late start in the program year and delayed claims payments). Table VII.3, below, shows the earnings trend for LIC from 1993 to 1999[8].

Table VII.3: LIC Profitability on Life Products



Recognizing they are operating in an industry of new regulations and expectations, LIC, after hard fought negotiations with SEWA management, increased the total subsidized premium from Rs30 per year to Rs 45, resulting in an increase to clients from Rs15 to Rs22.5. They project that this increase will at least allow them to cover claims costs.

Table VII.4: Government of India Objectives

Government of India	Results:
Provide coverage to vulnerable groups, especially in the informal sector.	With their grant to cover premium subsidies to LIC, they have been able, through SEWA, to improve the coverage of tens of thousands of vulnerable women over the eight years since the grant was provided.

The Government has met it objectives to a limited extent with SEWA. More importantly, the issue of insurance protection for the vulnerable has been brought to the forefront of discussion, in significant part because of the efforts of SEWA and its management. One tangible result of this is Government's requirement in the 1999 legislation that new insurers in India must maintain a certain percentage of their premiums from rural areas, which include the vulnerable.

[8] Data for this chart was provided by LIC, is inclusive of the 50% subsidy, and projects 1999 claims for the year based on five months actual data.

Table VII.5: SEWA Member Objectives

SEWA Members	Results:
Reduce shocks to their families from natural and accidental death, and those shocks related to their own health care costs, disability, loss of their business assets or home, and widowhood.	SEWA Insurance has clearly assisted its member clients in improving their ability to sustain such shocks. Clients report appreciating the benefits coupled with the low premiums.

More detailed discussion of client satisfaction is provided below.

VII.A Financial and Operating Results

Table VII.A.1 shows the underwriting results for SEWA during the period 1996-2000. These figures reflect operations before the subsidy interest received on the GTZ funds. Results have been relatively stagnant with premiums plus fees covering approximately 80% of claims and operations costs of the insurance unit. The interest earnings from the GTZ fund cover the additional 20%.

During the 2000 insurance year, claims increased dramatically for health and maternity, and property (resulting from the July 2000 floods) and as did operational costs, from personnel additions and costs related to a higher volume of claims. This reduced the total operating income to coverage of only 50% of total operational costs.

Table VII.A.2 shows the total income of SEWA Insurance (premiums, fees, and interest on the GTZ fund) against total expenses. The dramatic impact of the interest earned on about US$450,000 held as reserves by SEWA is evident in this chart. Over the five-year period, income has gone from about 2.15 times expenses to 1.15 times - a drop of almost 50%. However, during the mid years, expense coverage was relatively consistent at about 1.6 times earnings - a very healthy return.

Table VII.A.1: SEWA Financial Ratios (Underwriting Operations)

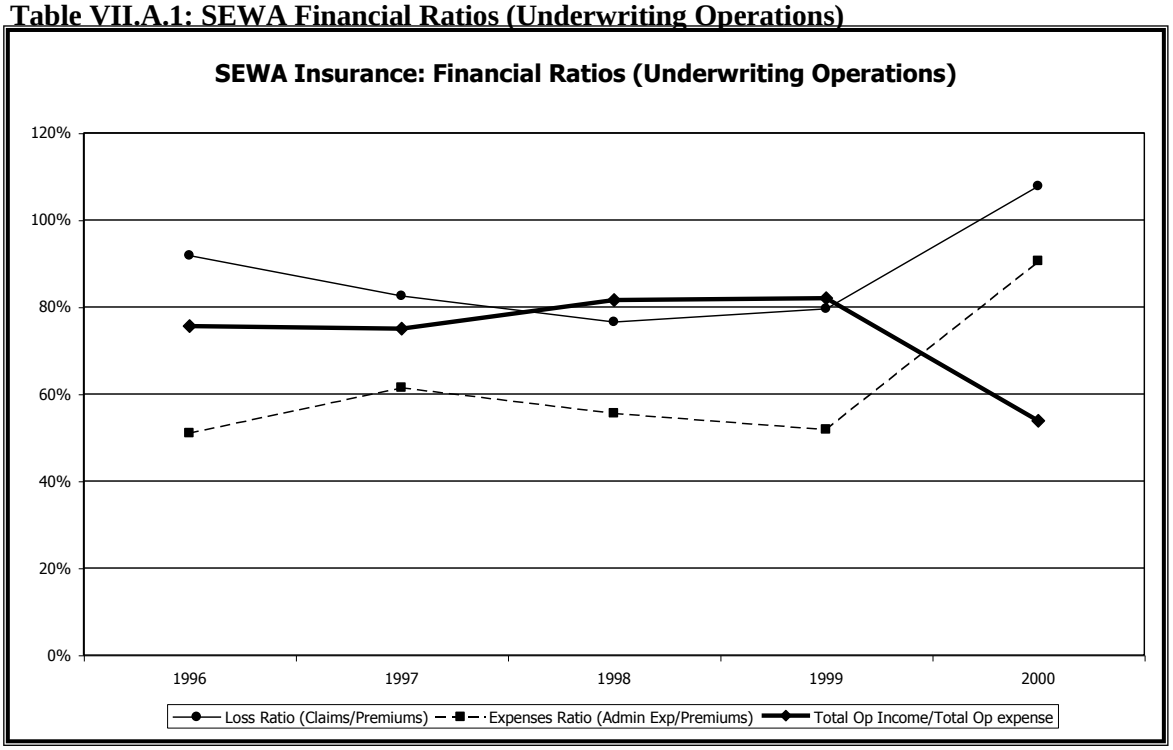
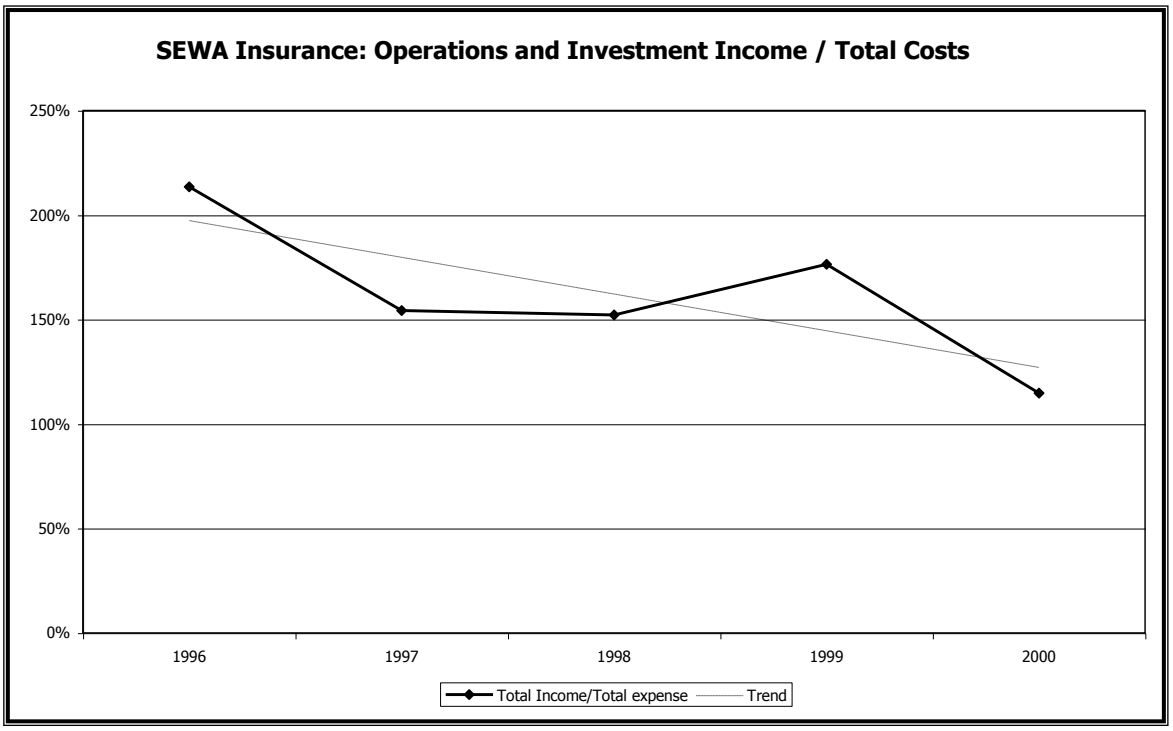


Table VII.A.2: SEWA Financial Ratios (Overall Program Cost Coverage)



Over the eight years since the GTZ grant was received, and after subsidizing its operations from the interest, the fund has still grown by an average 9% per year while inflation averaged just under 8% for that period.

The high level of sustainability even given the relatively low premiums is related to the limited nature of the coverage and the low percentage of benefits to actual costs provided by the SEWA insurance. Another important factor in SEWA's ability to offer this program with relatively low costs is the strong subsidy component provided by SEWA's health care program and the "barefoot doctors" service. Though not directly associated with the insurance program, these other services provide accessible primary health care, preventive care, and direct assistance to insurance clients to help them access insured services. This creates a more comprehensive package for clients in areas of parallel operations, and represents an important subsidy to the benefit of the client.

Attrition:
Another strong benefit to SEWA is in their apparently low level of attrition. Attrition is astonishingly high in many other insurance programs focused on the poor and vulnerable populations. Although SEWA does not track attrition from its program, it is clear that a high percentage of clients are being retained. Two-thirds of their clients are part of the "lifetime" membership program so these are retained without effort. The fixed deposit account has a very positive impact in retaining clients for SEWA. Of the annual payers, most are anecdotally reported to continue from year to year.

Though SEWA has not tracked attrition, it is clear that they are losing some clients to attrition since they have experienced an overall decline in the number of insured members by 6% over the years 1999/2000 and 2000/1. As mentioned above, there are several difficulties for the poor in paying premiums during the one premium period each year, and especially during the last two years.

Claims Processing Duration:
Operationally, SEWA claims processing time is faster than the processing by the formal insurers, though total time from event to payment of client is still very long as shown in Table VII.A.3. With

health claims, although SEWA processing only takes an average of 13 days, it take over 50 days for them to receive the claim, and then another 16 for the beneficiary to actually receive the money. Average total duration from hospital discharge to receipt of benefit is 81 days. People who are paying moneylender rates of up to 10% per week could find that their benefit does not even pay the interest by the time they receive it.

Table VII.A.3: SEWA - Average Duration of Claims Processing, by Component (days)[9]
Data collected and compiled by the author from SEWA claims documents.

Insurable Event	Accidental Death	Natural Death	Health	Property
Insurer	NIA	LIC	SEWA	SEWA
Event to Claim Receipt	99	128	52	N/A
Claim Receipt to Payment Available	149	66	13	42
Payment Available to Beneficiary Receipt	17	30	16	N/A
TOTAL Duration - Event to Beneficiary Receipt	265	224	81	N/A

In the case of health insurance, SEWA is rather efficient in processing the claim. The problem comes in receiving the claim, and then in notifying the clients that the funds are available.

It was explained that SEWA does not notify beneficiaries because of infrastructural and other practical difficulties. Disbursement is made when a beneficiary comes to the office to check on progress of the claim (which adds transaction costs to the client for the many trips made to check progress). This also explains the delay in disbursement of claims from LIC and NIA.

The delay in receipt of claims for the life and accidental death may be related to the detailed paperwork required. These delays should be researched further to identify potential efficiency measures.

It was noted by SEWA Insurance management that one of the reasons they brought the insurance in-house was because of delays from the insurer of 3-4 months for payment of claims. These delays clearly remain with LIC and NIA; however, significant delays are also seen with the products SEWA manages.

The total duration from event to benefit receipt is important especially to vulnerable clients. Because of such delays and the low level of coverage of overall costs of health and property claims, there is a question about the real ability of these insurance products significantly mitigate the shocks of these expenses.

Cost Coverage of insured Events:
The amounts paid by SEWA on the client's claims average 22% for health and 42% on property insurance. A detailed breakdown of average client stated cost versus average SEWA agreed costs versus the average actual sanctioned amount is noted below in Table VII.A.4.

[9] Data includes: Accidental death - 17 claims between 7/99 and 12/99. Natural death – 91 claims between 7/98 and 5/00. Health – 111 claims between 5/98 and 4/00. Property – 10 claims (100% sample) between 4/99 and 5/00. All (except property) chosen randomly from within the files. N/A for property insurance refers to data not available in the SEWA records.

Table VII.A.4: Costs to Claims Paid

	Health Insurance	Amount paid to average cost	Property Insurance	Amount paid to average cost
Average cost claimed by client	US$89.44	22%	US$75	42%
Average cost agreed by SEWA	US$41.90	47%	US$75	42%
Average amount paid by SEWA	US$19.77		US$31	

The client's perception of costs includes their transport and food while hospitalized. It is also subject to moral hazard though must of these claims were fully supported with receipts and other documentation. SEWA disqualifies transport, food, and other items though no clear policy on acceptable charges was provided.

Of the members claiming health care benefits they self-reported their monthly earnings as an average of US$37.23 (again suggesting that it is not the very poor who are insured in this program). On average, after the SEWA claim is paid, these members will have had to pay almost two months worth of earnings to cover the balance of their hospitalization costs based on their own assessment of their total costs. This balance is substantial and offers a high probability of destabilizing the household – even before one considers the cost of borrowing or the impact of sold productive assets needed to pay the bill at discharge. Based on SEWA's assessment of coverable expenses, members would still pay a balance of about 3 weeks worth of earnings, but this excludes additional costs to the client related to the insured event.

One solution to this would be higher coverage amounts on insured events. However, higher priced, broader coverage raises the question of the ability and willingness of the poor to pay the premiums. This question becomes critical if the intended market is the poor, as it is with SEWA. The question must be set against the scenario for the uninsured poor. When the tragedy of illness strikes, the poor will typically borrow from family, neighbors, and/or moneylenders, and will sometimes sell assets, to cover medical costs. It is not just the outflow of resources to pay the medical bills that is the problem, although this is significant enough. They subsequently have fewer productive assets (equipment, land, inventory), reducing earning potential, or fewer household resources (grain stores or cash lost to interest paid for an emergency loan). This often plunges families into greater poverty, and the situation as a whole ultimately increases the vulnerability of the household.

Insurance has the potential to smooth the financial shock of medical crises and health care for the poor. In order to fulfill this role, however, three conditions must exist. First, the cost of premiums must not be so high that it pushes people to sell assets, increasing household vulnerability. Secondly, the coverage should be reasonably comprehensive. The trick, of course, is to satisfy both these conditions with a financially sustainable program. Third, there should be a mechanism that allows clients to pay the premium with a minimum of financial stress.

At SEWA, the cost is low though the mechanisms for paying the premiums, with respect to the poor, are too rigid, and the compensation appears too low. In creating and managing insurance programs for the poor, one of the most difficult issues is this balance between premiums and levels of coverage. SEWA has addressed this by integrating its insurance program into an array of supporting services. For health, primary and preventive care units support the insurance program. The Bank and housing units support the property insurance. These provide clients with a much more comprehensive system of care than the insurance can offer. Then the insurance helps to cover larger events. It is important to see this insurance as part of an integrated system, even though, taken alone, the insurance appears insufficient to mitigate serious household stress in times of need.

SEWA states that their pricing decisions are based on discussions with clients and knowledge of client needs. This typically leads to low levels of coverage because people often report what they "can" pay based on the value they perceive. A better approach, though one certainly should not ignore the abilities of potential clients to pay, might be to develop a more comprehensive coverage within a range of cost that could be covered by clients if they have an efficient mechanism to pay the premiums in smaller installments. The mix of how much people can pay with the mechanism of payment is critical to the ability of an insurer to offer more comprehensive coverage to clients without damaging their household financial situation. By making smaller consistent premium payments painlessly, insured clients may be able to afford much more comprehensive coverage. The key then becomes the efficiency of the institution to collect and manage those payments. This also may be a way to get poorer people covered by insurance. The relatively large fixed deposit and the single annual premium are difficult mechanisms for the poor to manage.

Detailed Procedures:
Operationally, SEWA's procedures have been weak on the level of detail needed to adequately manage an insurance business. The weakness in not maintaining detailed procedures and policies documents, and the problems this can cause, were made very clear during the visit. Ahmedabad had suffered serious flooding just prior to the field visit of the authors. This offered the "opportunity" to view the insurance staff in action dealing with a crisis. On the first business day after the floods, clients were already arriving with claims. Claims staff were being taught how to use a camera to provide verification of damage, and then were sent out to begin the claims assessment process.

The coverage, as indicated on the SEWA insurance marketing poster (translated into English), is for "Damages to house and assets due to flood/fire/riots/cyclone. Maximum annual – Rs 5,000". The several instances the "Approach and Procedures"[10] document calls for coverage in the case of "Loss of Asset in flood, cyclone, riots, and fire." The procedure is explained as follows:

1. "When such incidents occur, it is reported to the Social Security Department and a claim in form of a small letter giving details about the incident is submitted.
2. Field Workers would inspect the house in the place where such incident as occurred and a report is submitted to the Social Security Department.
3. The claim is put to a committee that consists of the coordinator, SEWA Bank's Manager, and two leaders of the SEWA Committee which review the claims and assess the extent of loss. Occasionally, members of the committee also visit the house of the claimant.
4. If the Committee has sanctioned the claim, than the payment is made through their SEWA bank's Savings Account."

Very quickly, SEWA insurance management recognized the potential for massive hemorrhaging of their insurance reserves due to the mass nature of the damage. Their members, the poor and very poor, are known to have their homes in areas that would be most badly impacted by such floods.[11]

During the week that followed, daily crisis meetings were held and new rules about the policy emerged. There were limited guidelines as to how the claim amounts are determined within the Rs. 5,000 limit. Initially, they sent claims staff to the field to assess the total damage to the house and business assets with coverage of up to Rs2,000 for business assets, and Rs3,000 for the house. In deciding how to assess the house damage, they decided to offer Rs750 for each wall destroyed. After a subsequent meeting, they decided the Rs3,000 would be allocated at Rs500 for each wall, the roof, and the floor. Finally, they decided to accept claims only up to seven days after the floods. At each

[10] Jayshree Vyas, "Integrated Insurance Scheme for Women Workers in Informal Sector: Approach and Procedures." P. 32.
[11] This mass nature of such risk (with insured concentrated in areas of likely flooding), coupled with the frequency with which it actually occurs, and the low premium, is exactly why, as SEWA management reported, UIIC wanted to drop this line of business from those products offered to SEWA members. SEWA decided to take on this line themselves, without any adjustment in the premium or fully assessing the potential risk, approximately two years before these floods.

step, management saw a lobby full of claimants consistently surpassing their estimates of the number of likely claims making them worry about the ability of their reserves to handle the crisis. This led to an ad hoc redefining of the policy to protect the institution. In the end, they accepted relatively few claims. It was stated that over 75% of the claims were rejected, and the ones that were paid were limited due to the progression of policy adjustments.

This event and much of what was witnessed points out the critical needs for:

- Comprehensive and detailed procedures and policy guidelines. Before an insured member is in crisis, they need to understand the policy, and have confidence that the insurer will not change the rules when they need the coverage.
- Detailed assessment of the premium based on actuarial data for the target market. SEWA was warned by the UIIC about the heavy risk of such occurrence, but SEWA did little to prepare themselves.

The lack of addressing these critical needs was evident with SEWA's other insurance products. As another example, it was related that SEWA took over the health insurance product for several reasons including that the insurer would not cover maternity. When SEWA took on the health insurance, they copied the coverage and premium of the UIIC, and added a maternity cash payment of Rs 300, without any reassessment of the risk or cost to SEWA. When older members complained that they could not take advantage of this benefit, SEWA offered cataract operation, hearing aids, and denture coverage (for maximum coverage of Rs1,200, 1,000, and 600, respectively). Again, this was done without any analysis or premium adjustment.

Client Perspectives on the Products:

Health Seeking Behavior

Poverty and the working conditions of informal sector women greatly increase SEWA women's susceptibility to illness. Women mentioned diarrhea, ulcers, TB, and injuries from accidents, as being common. In terms of treatment, women will first go to the corner drugstore and purchase whatever pills the (untrained) pharmacist suggests. If this does not help or if the illness seems serious, they will go for ayurvedic treatment which is generally less expensive. Only in the most serious cases will they seek out modern medical care. There is also a hierarchy in who seeks treatment. Children and men receive medical treatment more often than women.

In India, government hospitals provide medical care at highly subsidized rates. However given the limited access for the poor, the low quality of care, and the tendency of doctors themselves to push for private health care where they receive higher earnings, poor women noted a greater preference for private clinics. The attention they receive in private clinics is considered better than that in government hospitals, though private clinics charge higher prices and there is widespread prevalence of over-prescribed drugs. We noted several cases of such private treatment where expenses were way beyond what is covered through the SEWA insurance plan; often more than ten times as much.

Health seeking behavior has not changed much since the introduction of SEWA insurance. People still seek out (uncovered) ayurvedic medicine for some problems; for more serious cases they still go to private medical practitioners. In fact, the prevalence of such health seeking behavior, coupled with the expectation of reimbursement from insurance, has led to disappointment and frustration, when insurance payouts end up covering only a small portion of costs.

Client Understanding of the Product
Clients report that they often lacked clear information on premiums, coverage and claim procedures.

Women with life long insurance coverage through fixed deposits generally knew that they were covered. However there were instances of women who had paid for the fixed deposits at the time of receiving large loans but did not know they had insurance coverage.[12] They often assumed that it was an additional fee for the loan.

> Monjuben is married and has three children. Her husband drives a lorry. Monjuben however makes ' agarbati' (incense sticks) at home and sells it to the wholesalers. Her daughter helps her when she is not in school. Manjuben wants to contribute to the household earning. In fact, she helped pay for the TV that proudly sits in a corner of her small two-room house. Manjuben has received loans from SEWA a few times. She took a housing loan for 25,000 Rs a couple of years ago. The SEWA women had deducted 500 Rs for an insurance plan. She however does not know what it is for; only that it is a 'vima' (insurance). She had been severely ill last year and had spent a few thousand Rupees for hospitalization and treatment. She did not file for claims. She did not know she could. No one told her.

Some women seemed confused that they were not covered because their annual premiums had run out. No one told them, they claimed, that premiums were due. A couple of women said they applied for reimbursements only to find out that their insurance coverage had expired.

Women often did not have adequate information on coverage. During the July 2000 floods in Ahmedabad, clients were angry to find out that damage to their food stock or clothing was not covered. Some were annoyed that the extent of payment for damages was only a small portion of actual loss. One woman said she had sprained her ankle and spent Rs 300 for the treatment. When she took her receipts and asked for reimbursement, she was told that sprained ankles were not covered by the insurance. Often actual expenses far exceeded reimbursements.

> For the last year, Raniben was very sick. She was taken to her to a private doctor who told her that she had a liver problem. She had to see specialists and make many visits to the doctors. Raniben went into debt paying for all the bills. She received money from friends and relatives and borrowed on interest. She kept careful receipts, and their total expenses were Rs 35,000. Raniben approached SEWA but was disappointed to learn she was covered for only 1,200 Rs.

At least one women Chandaben said she thought the insurance covered health problems only. She had her house burnt down in a riot in 1995-96. She did not make any claims. She did not think she had insurance coverage.

It seemed that SEWA workers themselves were not always clear about the extent of coverage. It also seemed that messages were not being provided or not repeated often enough to ensure that clients would be aware of the times for premium payments. There was also great confusion regarding the accumulation of monthly savings towards the fixed deposit for insurance.

Dissatisfaction with Product

There was also some dissatisfaction with the product. Women complained that long-term illnesses were not covered by insurance. They did not like the fact that children were not covered. Members complained about the long delays, often three to six months, in getting reimbursed, and they saw the

[12] SEWA has required insurance coverage for loans under certain circumstances and members will typically create the fixed deposit account from the proceeds of the loan. This dramatically increases the cost of borrowing.

rules for filing claims as being too rigid at times. The paperwork was difficult since doctors often did not provide receipts.

Client Satisfaction and the Role of the Health Program

There was also considerable satisfaction with the product. Women have had access to medical benefits, which they might have had to forego due to the costs involved. Life insurance, maternity benefits, and dental care coverage have been well received.

SEWA's health insurance program works best where their separate unit on primary and preventive care is also active. SEWA health workers provide advice on preventive health care, provide very basic medicine, referrals to doctors and clinics where women receive treatment at affordable rates, and assist in filing for claims.

> A SEWA woman, who had been a member for 15 years, was getting old and losing her vision. She needed a cataract operation. The SEWA health worker took her to the government hospital. It is generally difficult to get a "seat" (admissions) at the government hospital for surgery. However, the SEWA worker spoke to the administration and to the doctors and arranged for everything. The cataract operation was successful and now she can see. Her total bill was Rs 1200. She received Rs 900 from her insurance. She could pay the remaining Rs 300 from her savings. If she had gone to the private clinic, it would have cost her Rs.3000. She would have had to borrow to pay the private clinic. She said that the doctors were very nice to her and treated her very well.

The health workers have the benefit of being in the field with the clients while the insurance personnel have wider market areas, and much less interaction with their clients. The two services together create an important synergy that benefits the overall SEWA client.

> Chanduben, who is about 70 years old, has been a vegetable vendor all her life until she got too old to work. She has been a SEWA member for over 15 years. She has also had insurance for about 5 years. Three years ago her husband died and she received Rs 3000 from SEWA. She immediately put aside RS 500 for a fixed savings. She spent the remainder on the funeral expenses. Last year she had cataract surgery, which cost about Rs 1200. The SEWA worker helped her by taking her to the civil hospital, by introducing her to the doctors and by helping her purchase medicine. She however lost her receipts and could not file her claim. The SEWA worker informed the insurance office and she was granted an extension. Chandaben finally got all her receipts and filed them after the 3-month deadline. She received Rs 1200.

The health workers appear very committed to their communities and their work. The story of Mainaben (below) helps to illustrate the work of the health workers and how they assist clients of the insurance program.

Mainaben has been a SEWA member for 27 years. She has been a fish vendor for all her life (She is now over 50). She has taken loans from SEWA for her business and for her house. Six years ago there was a plague epidemic in some parts of India. SEWA arranged a special community cleanup awareness program to protect communities against the plague. Mainaben was made an organizer to promote community cleanliness in Chamanpura. She spoke to the local people about keeping their houses clean, and she petitioned the Municipal Corporation and the State for garbage clean ups. The Corporation was so annoyed with her constant petitions and her threats to demonstrate against them that at one time they even sent in the police to scare her. However, Mainaben prevailed, new garbage bins were provided, and regular garbage cleanups were organized.

Mainaben caught SEWA's attention and was trained and employed as a health worker. She received training from SEWA for two days every month for 3 years. She covers a community of 200 households. She sits at SEWA's clinic from 10:30 in the morning to 1:00 in the afternoon. From 1:30 to 4:00, she makes the rounds of her neighborhood. She visits each house at least once a week. She provides information on disease prevention; she provides basic medicine to SEWA women (at a cost of Rs 2 (US$0.045) for children and Rs 4 (US$0.09) for adults), makes referrals to doctors and hospitals, and follows up on patients.

The women in the community depend on her for all medical advice. They rely on her to take them and their children to the doctors. She takes women in for TB treatment working to help maintain their secrecy, lest they be ostracized from the community. Mainaben takes them to the SEWA TB clinic, to the SEWA medicine shop and to government hospitals so that medical costs are low. She knows very well that private clinics charge too much and people can easily go into debt paying off their medical bills.

Mainaben encourages everyone to take out health insurance. She tries to convince women to enroll in the fixed savings program. If they cannot, she tries to convince them to pay annual premiums. A few women save with her to accumulate the 700 Rs for the fixed plan. Women will contact Mainaben for all their insurance claims. She tells them to save all receipts, she takes the receipts to the SEWA office, follows up on the approval process, and she takes women into the SEWA bank when payments are made. Women in the community say that they appreciate Mainaben and her health care advice. She has assisted in the people in her community to obtain better, and, more importantly, more affordable health care.

VII.B Corporate Culture

SEWA considers itself a movement, with roots in the cooperative, labor, and women's movements. It sees itself in a continuous struggle to bring about social and economic empowerment to the poor, self-employed women of the informal economy. SEWA activities are two fold: (1) It builds institutions that are essentially service providers (be it health care, education, or housing) and (2) it organizes for struggles for higher wages, better working conditions and fundamental rights. It is also a policy advocate working to influence state and national policy towards the improvement of conditions for their members. SEWA has successfully campaigned nationally and internationally for the rights of home based workers. In 1996, a SEWA led movement finally persuaded the ILO to vote for according home based workers full rights as workers. SEWA has also been at the forefront of an international struggle for rights of street vendors and an architect of the 1995 Bellagio International Declaration of

Street Vendors. SEWA has also campaigned nationally for the rights of construction workers, forest workers, and minimum wages for informal sector workers.

SEWA's corporate culture is best exemplified by the statement commonly heard during the visit: "At SEWA, we think with our hearts, and not with our heads". While efficiency and financial sustainability are often set as guiding objectives for the service delivery programs, there is a clear sense of overriding human concern for the membership it seeks to serve. There is greater emphasis on working with the membership, in ensuring that they are not left behind, than in achieving financial targets. In many ways the addition of the insurance products and the subsequent insurance business are merely extensions and manifestations of the corporate culture that has guided SEWA through the years.

SEWA is finalizing its transformation strategy and new business plan leading to a regulated insurance cooperative. This calls for significantly greater institutionalization and growth at all levels. The corporate culture will need to evolve much more rapidly as the business is forced to improve its professionalism to come in line with norms and expectations of regulators. New people with very different skills and experience bases will need to be brought on to make this business successful. The addition of these skilled technical personnel will likely result in a shift in the corporate culture responding to a greater recognition of the professional requirements of an insurance company insuring a quarter- to a half-million poor people.

This is not to suggest that the concern for its clients needs should be minimized. Rather, it advocates that a healthy balance between concern for responding to client's demands and abilities, and concern for the needs of a sustainable business, will ultimately prove most beneficial to clients.

VII.C Product Development Process

Demand for services coupled with bold attempts to satisfy them drove the product development process. The process has not been the result of detailed plans and objectives, controlled sample introductions, and then managed review, alteration, retesting, and finally rollout. The process evolved from SEWA's responses to reported needs of clients, and ad hoc adjustments to the policies and their coverage without any formal assessment of the potential financial impact and risk of the business to SEWA. Pricing and costing analysis was dramatically absent from the product development process. SEWA simply listened carefully to clients, and added and altered insurance benefits over time that responded to the perceived needs through SEWA's integrated services and member surveys.

VII.D Plans for the Future

In their new business plan, in preparation in early 2001, SEWA intends to transform into a regulated insurance company and seek a partner for reinsurance to reduce risk to SEWA of claims costs exceeding paid-in premiums. With privatization of the insurance sector, SEWA has decided that they would be better equipped to set up an insurance company to cater to the needs of poor women than other potential private sector insurers, some of whom have approached SEWA to work with them as partner-agents.

This strategy for the future is highly dependent on satisfying capital and other requirements mandated in the insurance law. Success under this structure will require a substantial improvement to systems, staffing, and management capacity.

VIII. SUMMARY OF LESSONS LEARNED

- ✓ SEWA has been innovative in developing mechanisms to assist members in saving for their premium payments. Some the lessons from this experimentation:
    - Linking insurance to the SEWA Bank has produced important benefits, including:

        - Management of the funds of the insurance unit by the Bank
        - Allowing an easy mechanism for members to save for premiums by virtue of regular savings accounts and the fixed deposit.
    - In assessing SEWA against other insurance programs in the overall study, only SEWA had an acceptable member retention rate. This is very likely because SEWA is able to lock in membership through the fixed deposit account. The fact that members do not have to generate premiums each year is a big incentive to continue.
    - That being said, the fixed deposit concept becomes very complicated when there is a need for upward pricing adjustments, or downward interest rate adjustments. As an example, at a 10% interest rate, if the insurance premium increases by 10%, the member must deposit 100% of the new total premium into the fixed deposit account in order to cover the increase through interest earned, plus they should have to pay the 10% for the current year also.
    - SEWA created an account that allowed poorer members to save up to the required fixed deposit balance over two years. Once the account was opened with a minimal balance, the members were afforded full insurance coverage. The vast majority made few if any additional deposits to the account. Ultimately SEWA identified this as a failure and shut down the option. Potential insurees should have to pay in advance of coverage for whatever insurance they wish to obtain.
- ✓ As a stand-alone product, the SEWA insurance is too limited to make a significant impact. However, as a component of an integrated system within the broad SEWA structure, they are able to improve the overall effectiveness of their care for members.
- ✓ It is questionable if the health insurance benefits have a significant positive impact on clients given the amount of time it takes from hospital discharge to receipt of the claim proceeds. Clients often must borrow from expensive moneylenders to cover the immediate costs of care. After waiting almost three months for an average health claim disbursement, the member likely pays more in interest alone than the reimbursed amount they receive from SEWA.
- ✓ Complete and detailed documentation on policies and procedures is critical. Clients and staff must know very clearly the details of their coverage. They need to understand not just what is covered, but how to claim, time limits for claims, and the specific terms of coverage. When this is not clear, as was the case with the SEWA property insurance claims resulting from floods of July 2000, management scrambles to concoct new rules governing the product in an effort to protect the insurer and not the client. This leads to significant loss of goodwill, and a loss of institutional credibility.
- ✓ Simply because a development institution thinks they can do better than a professional insurer, does not mean that they necessarily can in all areas. Some SEWA controls appear strong with several levels of claim review, though the underwriting side of operations is extremely weak. Compared to their historical insurance partners, SEWA does offer a broader product range (inclusive of maternity, cataracts, dentures, and hearing aids), and reduced some of the requirements for claims. However, many of the concerns that led them to take on the insurance themselves have remained. These include:
    - Significant delays in processing and disbursing claims
    - Most restrictions on coverage were retained, and coverage remained very limited.
    - In a crisis situation, SEWA reverted to institutional protectionism in redefining claims policies to the benefit of the institution.
- ✓ Financially, SEWA has been able to continue insurance operation because of the endowment grant from GTZ and the requirement to retain its value. This subsidy allows them to cover for a very modest back office (which should be assessing premiums, reviewing the product mix, and improving operational effectiveness), and allows for maintaining relatively low premiums, without reassessment of the cost. This clearly points to the question of what is the real need for subsidies in such insurance programs, a question that requires additional consideration.

- ✓ SEWA found that 80% of insured clients dropped out of the insurance program once it shifted from compulsory to voluntary. At least initially, insurance programs should offer their products on a voluntary basis to clients so they can assess the real demand for the product.
- ✓ Pilot testing of new insurance products can help to address many problems of product, procedures, and policies before the client base becomes so large that simple problems are dramatically magnified simply by volume. SEWA managed no such formal pilot test and this clearly left them at a disadvantage in their redesigns of the products.
- ✓ The relationship between the comprensiveness of the insurance coverage and the ease of paying the premium by the clients is critical especially when designing products for the poor. Although somewhat mitigated by the option for the fixed deposit account, SEWA appears to have restricted membership to the better off poor by virtue of the difficulty of the poor to accumulate an annual premium. This is a common problem with both formal and unregulated insurers who offer only annual premiums.

APPENDIX 1: MANAGING INSURANCE RISKS

The strategies used by SEWA in the provision of life, property, and health insurance to clients are detailed below in Table A-1. This table notes the risks and general strategies that are often used in insurance programs to address them. The specific strategy notes how SEWA controls reflect the general strategy.

Table A-1: SEWA Strategies for Managing Insurance Risks

Risk:	General Strategy[13]:	Specific Strategy:
Moral Hazard	Pre-selected providers	Any public or private medical facility for medical issues, none otherwise.
	Claims limits	Per event claims limits are set relatively low and certainly protect SEWA. See Table V.1 Current Benefits and Premiums for details of the claims limits. No annual or lifetime limits are set.
	Co-Payments	Technically none, though clients pay a substantial portion of the bill due to limitation on claims amounts
	Coverage restrictions	Medical coverage for hospitalization of at least one day, except for injuries. Property must be business assets or walls, roof, or floor of residence.
		Only covers woman members comprehensively. Husbands can be covered for life (widowhood insurance), and recently for health.
	Loss review	Loss review conducted only on a per claim basis where the claim is reviewed by SEWA Insurance staff, a medical doctor, and the SEWA claims committee prior to sanctioning the claim (this extensive review structure is partly the result of weak written procedures). No overall periodic overall loss review was evident.
	Exclusions	Pre-existing conditions are excluded
		Only those 18-58 are eligible
		Husbands only access to the insurance is through their member wives
	Waiting periods	Single entry period (July 1) acts as waiting period
		Maternity, cataracts, dentures, and hearing aids not available until the second year of insurance
	Proof of event	For death claims - the bill for funeral expenses (Hindus – bill for firewood; Muslims – bill for digging the grave), death certificate (original), autopsy and police report if accidental
		For property loss – visual assessment plus photo are required.
		For health – the hospital invoice, all other related bills, the medical report of tests, prescriptions, and a doctor's certificate

[13] General strategies are taken from Brown, Warren and Craig Churchill. Providing Insurance to Low Income. Part 1 – A Primer on Insurance Principles and Products. Microfinance Best Practices project, DAI, Bathesda, MD, 2000.

Risk:	General Strategy[13]:	Specific Strategy:
		Insurance companies also confirm with claimant
	Client identification	SEWA insurance certificate
		Claims staff visit each claimant in their home
		India has no national ID system
	Pre-approval of treatment	None required
	Expense verification	Expenses verified through review by SEWA Insurance staff, a medical doctor, and the SEWA claims committee before sanctioning the claim.
		No price lists for common procedures was available. It was offered that the medical doctor who reviews claims "knows" the prices. No price rejections or comments questioning any price were noted during the review of claims files.
	Clinical treatment verification	SEWA uses part time medical doctor consultant to review all bills. No rejections or significant comments noted from this activity.
	Deductibles	No deductibles were required
	Initial exams	Not offered and not covered
	Use of preexisting groups	SEWA offers this product only to current members.
	Use of committee for claims approval	All final claims decisions are made by the SEWA insurance claims committee
Adverse Selection	Membership from existing groups only	Product is only offered to existing SEWA members. This is done on an individual basis and does not significantly limit adverse selection.
		Virtually no limits to membership minimizes this as a control for adverse selection.
	Whole family membership required	Only women members may join and optionally include their husbands for limited coverage.
	Required membership within groups	None
	Defined risk pools	Defined as self-employed SEWA members. No separation or premium adjustments for business activity risk or other differential risk factors.
		Members are priced differently from their husbands for health care. Women's premiums are higher (Rs 30 for women and Rs 20 for men) this is likely to cover the additional risks of women's gender ailments.
	Waiting periods	Single annual entry point acts as waiting period
	Tying insurance to other products	Insurance is tied to SEWA membership, bank accounts, and certain loans
Cost escalation	Periodic cost evaluation	These are not conducted. However, since SEWA pays only to a very limited maximum clime amount the cost escalation risk is borne by the insured.
	Preset pricing agreements with providers	None. Provider decision is made entirely by the insured who bears cost risk.

Risk:	General Strategy[13]:	Specific Strategy:
	Preset drugs list	None.
Fraud and Abuse	Co-payments	None. Low cost coverage serves the same purpose.
	Computerized ID systems	None
	Coverage limits	Set relatively low with a substantial portion of the health care cost born entirely by the insured (on average insurance covers 22% and 42% of client's stated total cost for health care and property costs, respectively.
	Claim scrutiny	Claim examination by claims staff, doctor, and claims committee.
	Financial Accountability:	Very limited. No complete disaggregated financials for the insurance business are prepared. This dramatically limits accountability.

APPENDIX 2: SEWA SWOT ANALYSIS

Table A-2 provides an analysis of the strengths, weaknesses, opportunities, and threats of and to the SEWA insurance program. These are based on information gained by the authors in July 2000 and do not reflect any subsequent alterations made by SEWA management of staff. The purpose here is to provide readers with an overview of some of the issues that SEWA faces concerning its offering insurance using the full-service model.

Table A-2: Strengths, Weaknesses, Threats and Opportunities of SEWA

Strengths of the program
Very large market of over 250,000 members of SEWA
Very clear client needs focus with a demand driven response
Professional insurance executive on staff (Sayeeda Chauhan, though her time is limited due to grant obligations)
Integration with health workers (very clear benefits in areas where the health workers assist clients in accessing health insurance coverage – providing primary care, directing clients to public hospitals, assisting with claims)
Fixed savings program (makes it easy for clients to pay premiums)
Treating the GTZ funds as an endowment
Linkage with LIC and NIA
Linkage with SEWA drug shops, SEWA health care workers, and TB clinics. The integrated approach provides many benefits to clients.
Very strongly committed staff
WEAKNESSES of the program
Product accounting weak (no complete, consolidated, comprehensive insurance financials)
Client communications (coverage unclear to some clients, including those who took insurance with large loans; property insurance coverage had very limited understanding; limited notification on renewal requirements of annual insurance)
Non-life coverage relatively low (average cost of Health treatment claimed in sample = R3,957, receipted = R1,844, average sanctioned amount = R870.) (Cost of property repair much greater than R400 per wall, floor, roof)
Claim processing delays (release to sanction dates, average = 81 days; claim to sanction average = 28; plus 2 – 3 weeks to collect claim payment)
Incentive structure gets people to spend more on health care (due to minimum 24 hour hospitalization requirement)
Product pricing procedures and review inadequate (coverage added without proper assessment and analysis)
Inflexibility of fixed deposit program (with regards to re-pricing the insurance product; also SEWA bank pays penalty for prepayment of interest), and rate likely too high w/only 5% spread between FD and loan rates.
Reimbursement structure creates additional costs to client and thus clinical review only protects SEWA
Lack of reinsurance
THREATS to the program
Property and health insurance highly susceptible to climatic, political, and institutional risk. This is enhanced by limited professional insurance operations, policies and standards
Losses suffered by LIC and NIA likely to result in increased premium costs (LIC has already increased rates based on 28% historical gross loss margin through 11/99 inclusive of government subsidy)
OPPORTUNITIES for the program
Likely strong demand for SEWA clients from private sector insurance companies (This will make them professionally adaptive to the needs of this market. A tender offer should be prepared)
Large membership base of SEWA (only 25% currently on the insurance program)
SEWA Bank has an opportunity even without an insurance program to develop specialized savings products which can, and should, act as a member's first line of insurance for predictable and relatively inexpensive events.