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# PROVIDING INSURANCE RESPONSIBLY

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Camyla Fonseca and Craig Churchill  
International Labour Organization



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## EXECUTIVE SUMMARY

Emerging consumers have a real need for protection and insurance holds the promise to reduce their vulnerability to risks while boosting productivity. At the same time, unserved market segments are usually unfamiliar with insurance, may have low trust in this tool or struggle to understand how it works and how it can generate long-term benefits. Therefore, for insurance to have a significant social and developmental impact, these specificities need to be taken into account through a responsible insurance provision approach. But what does *responsible* mean?

Responsible insurance provision can be defined as the delivery of *appropriate* products in an *accessible, transparent, fair, responsive* and *respectful* way to informed consumers who can use those products effectively.

An *appropriate* insurance product is one that provides relevant risk management benefits at an affordable price. For benefits to be relevant, they must be needed or wanted by a targeted market segment, and they must be suited to that segment's context. Products that offer a large number of benefits or riders that are likely never to be claimed are not appropriate. For a price to be affordable, it must be set at a level and paid in a manner that fits the target market's cash flows. Appropriate benefits and costs are what together create the value proposition for an insurance product.

*Accessibility* refers to the ease with which consumers can obtain, understand and use an insurance product. Some of the factors that influence accessibility are: physical proximity, convenience, familiarity, reliability, cultural acceptability, procedural requirements, and the availability and clarity of information.

*Transparency* refers to communicating clearly and openly without deceit. For instance, making use of bells and whistles, such as irrelevant benefits and riders, to increase market appeal and attract more clients goes against transparency. While there is a relationship between transparency and accessibility, a product can be accessible without being transparent, and a transparent product will not necessarily be accessible.

*Fairness* can be described as conforming to the principles of equality and justice. But how can insurers be fair if they are in the business of discrimination? Insurers often discriminate in order to charge appropriate premiums and to incentivize less risky behavior. This kind of discrimination can be fair when the price and benefits are proportional, but it may produce outcomes that society perceives to be unfair (e.g. more expensive health insurance premiums for elderly people). While there is no secret recipe for achieving fairness, insurance providers can take steps to improve the likelihood that they will provide insurance fairly and will be perceived as fair.

*Responsiveness* refers to the speed and attentiveness with which providers cater to clients' requests, complaints or problems. By applying this principle in a proactive manner, providers can continually improve their understanding of clients and provide insurance in a way that generates sustainable value for themselves and their clients.

*Respectfulness* means showing attention and concern for the privacy, rights, traditions and welfare of others. Respectful insurance will take care not to cause harm.

Lastly, a *useful* insurance product is one that enables consumers to protect themselves more effectively from risk. It is not enough for insurance providers to create what they think is a useful insurance product; consumers have to use that product in a way that actually results in more effective risk protection.

The seven principles of responsible insurance can guide insurance providers to make the changes needed to become more responsible. If applied to the five stages of the value chain, namely 1) product

design, 2) marketing, education, and sales, 3) enrolment, renewals, and premium collection, 4) policy administration and servicing and 5) claims management, they can bring substantial long-term benefits not only to clients, but also to providers.

If insurance providers commit to responsible insurance provision, emerging consumers will become more able and motivated to use insurance as a risk management tool. At the same time, from a business point of view, responsible insurance provision may attract new clients, build trust in the brand giving a competitive advantage, increase scale and increase client and employee satisfaction, eventually leading to higher retention, greater productivity, and cost reductions in some areas such as marketing and complaint handling.

## 1. The why of responsible insurance provision

Emerging consumer markets present a promising opportunity to the insurance industry. If this segment was neglected by the industry in the past, it is now more and more possible to find insurance providers willing to test new and creative business models to reach this target population.

This is a positive trend. Emerging consumers have a real need for protection and insurance holds the promise to reduce their vulnerability to risks while boosting productivity. At the same time, unserved market segments are usually unfamiliar with insurance, may have low trust in this tool or struggle to understand how it works and how it can generate long-term benefits. Therefore, for insurance to have a significant social and developmental impact, these specificities need to be taken into account through a responsible insurance provision approach.

If insurance providers commit to responsible insurance provision – that is, the delivery of *appropriate* products in an *accessible, transparent, fair, responsive* and *respectful* way to informed consumers who can use those products effectively – emerging consumers will become more able and motivated to use insurance to protect themselves from risks. At the same time, given that appropriate products and distribution create value and build trust in insurance – while their absence erodes value and destroys trust – insurance providers that aim to cater to unserved market segments can benefit from a more responsible approach to insurance provision.

From a business point of view, responsible insurance provision may attract new clients, build trust in the brand, empower customers, increase scale, and make insurance more affordable. It may also increase client and employee satisfaction, leading to higher retention, greater productivity, and cost reductions in some areas such as marketing and complaint handling, which help to offset the cost of delivering in a more responsible manner. Finally, once an insurer brands itself as a responsible provider, it gains a competitive advantage.

Given the advantages of responsible insurance for both customers and providers, this paper uses case studies to explore the standards, guidelines, and strategies for providing insurance responsibly. These standards, guidelines and strategies are based on the efforts of the Microinsurance Network's Consumer Protection Task Force to create consumer protection standards, the Smart Campaign to develop guidelines for microfinance institutions, and the International Labour Organization's (ILO) Impact Insurance Facility's endeavors to promote quality products at scale.

While the focus is on how insurers and distribution channels (together referred to as insurance providers) can contribute to the responsible insurance agenda, we recognize that other stakeholders such as regulatory and supervisory authorities and insurance associations also play an important role in creating an environment conducive to responsible insurance provision. This paper does not target the role of these actors, but it will be discussed in future ILO publications.

The paper is organized as follows. In section two, we introduce the case studies that will illustrate the discussion on responsible insurance. In section three, we explain the principles of responsible insurance provision. In section four, we apply these principles to the insurance value chain, using the case studies to support the standards and guidelines. Section five and six discuss strategies to ensure internal commitment to responsible insurance and to monitor and evaluate it. Finally, section seven concludes the paper.

## 2. Cases

The majority of the cases presented in this paper feature the experience of insurance providers that have adopted responsible insurance practices. However, a few cases are also presented to show the damages



that can arise from less responsible practices. Following are brief descriptions of the products and organizations featured.

*Jijenge Savings Plan, CIC Insurance Group Ltd., Kenya:* CIC Insurance Group ranks among the fastest growing insurance company in Kenya and the leading co-operative insurer in Africa. In 2011, it introduced a new technology platform called M-Bima (mobile insurance in Kiswahili) to strengthen the scale and efficiency of its microinsurance operations. The first product launched on the M-Bima platform was the Jijenge Savings Plan, a 12-year savings plan with a life cover benefit in case of death which, due to several issues, was eventually discontinued and replaced with a new non-lapsable savings product.

*Crop Insurance, Crezcamos, Colombia:* Crezcamos is a Colombian microfinance institution (MFI) based in Bucaramanga that serves over 70,000 clients with individual small business and agricultural loans. All Crezcamos borrowers have to acquire mandatory credit life insurance, but the MFI also offers different voluntary insurance products to its clients, including a crop insurance product underwritten by Mapfre and introduced in 2014 to cover farmers' production costs. The insurance covers natural disaster risk for a variety of crops that are common in the region and can be purchased by borrowers and non-borrowers who cultivate a covered crop.

*Ecolife, Econet Wireless Zimbabwe, Zimbabwe:* In 2010, Zimbabwe's largest mobile network operator, Econet Wireless, created a life insurance product called EcoLife. The scheme provided life insurance to all Econet Wireless customers who enrolled by sending an SMS. Policies were activated as soon as customers spent the minimum required amount on air time. Ecolife was provided through a tripartite partnership between Econet Wireless, First Mutual Life (a Zimbabwean insurer), and Trustco (a Namibia-based technology service provider that supplied the insurance platform).

*Pashu Dhan Bima, IFFCO-Tokio General Insurance Co. Ltd., India:* IFFCO-Tokio General Insurance Co. Ltd. (ITGI) is a joint venture between the Indian Farmers Fertilizer Cooperative Ltd (IFFCO) and Tokio Marine and Nichido Fire Inc. of Japan. In 2009, ITGI launched a product called Pashu Dhan Bima (livestock wealth insurance) a credit-linked cattle insurance product for farmers taking loans that protects them against the death of insured cattle due to disease or accident. Radio frequency identification devices (RFIDs) are used to identify cattle and reduce fraud. After the pilot, it also became available to farmers not taking loans.

*Index-based Livestock Insurance (IBLI), International Livestock Research Institute (ILRI), Kenya:* ILRI is a research institute that works with partners to enhance the roles that livestock play in food security and poverty alleviation, principally in Africa and Asia. First launched as a pilot in 2010, IBLI is an index insurance product designed to protect Kenyan pastoralists against prolonged forage scarcity and compensate them for livestock losses due to drought. Currently underwritten by APA Insurance and Takaful Insurance of Africa, IBLI does not cover livestock mortality due to other causes, such as predators and disease.

*Afitna (previously called Caregiver), Microfund for Women (MFW), Jordan:* MFW is a private non-profit company that provides financial services to low-income and small business women in Jordan. In 2010, MFW started offering the Caregiver as a mandatory product to their clients to help offset the cost of accessing health care facilities for emergencies and more serious illnesses, in particular to cover the incidental costs of travel to the hospital and lost wages incurred during a longer hospital stay. Later Caregiver turned into Afitna, but it continues to be offered and has been expanded to benefit spouses and dependent children as well as to offer a credit life component.

*Nirapotta, SAJIDA Foundation, Bangladesh:* SAJIDA Foundation is a non-governmental organization working with the low-income population in six districts of Bangladesh. SAJIDA's microinsurance product addresses multiple life-cycle risks with fixed benefit amounts. The product includes benefits for inpatient



health care, loan and life insurance, fire insurance and education scholarships, as well as legal aid and other value added services. Recently, SAJIDA has also introduced a product targeted to cattle and crop farmers and another targeted to micro entrepreneurs.

*Family Care Insurance, Tigo Ghana, Ghana:* In 2010, Tigo Ghana partnered with the mobile insurance provider Bima to create a mobile-based life insurance product to increase customer loyalty. The Family Care Insurance life product was launched in December 2010. At first, it provided free life insurance coverage to Tigo customers based on the amount of airtime they used during a given month and later became a fully-paid product.

### 3. What does responsible mean?

Responsible insurance provision can be defined as the delivery of appropriate products in an *accessible, transparent, fair, responsive* and *respectful* way to informed consumers who can use those products effectively (see Table 1). But what do these *seven principles* really mean?

An *appropriate* insurance product is one that provides relevant risk management benefits at an affordable price. For benefits to be relevant, they must be needed or wanted by a targeted market segment, and they must be suited to that segment's context. Products that offer a large number of benefits or riders that are likely never to be claimed are not appropriate. For a price to be affordable, it must be set at a level and paid in a manner that fits the target market's cash flows. Appropriate benefits and costs are what together create the value proposition for an insurance product. That is why they are discussed in this paper as one responsible insurance principle and not two – an affordable insurance product that does not meet its market's risk management needs is not responsible.

*Accessibility* refers to the ease with which consumers can obtain, understand and use an insurance product. Some of the factors that influence accessibility are: physical proximity, convenience, familiarity, reliability, cultural acceptability, procedural requirements, and the availability and clarity of information.

*Transparency* refers to communicating clearly and openly without deceit. For instance, making use of bells and whistles, such as irrelevant benefits and riders, to increase market appeal and attract more clients goes against transparency. Obviously, there is a relationship between transparency and accessibility, but a product can be accessible without being transparent, and a transparent product will not necessarily be accessible.

*Fairness* can be described as conforming to the principles of equality and justice. But how can insurers be fair if they are in the business of discrimination? Insurers often discriminate in order to charge appropriate premiums and to incentivize less risky behavior. This kind of discrimination can be fair when the price and benefits are proportional, but it may produce outcomes that society perceives to be unfair (e.g. more expensive health insurance premiums for elderly people). While there is no secret recipe for achieving fairness, insurance providers can take steps to improve the likelihood that they will provide insurance fairly and will be perceived as fair.

*Responsiveness* refers to the speed and attentiveness with which providers cater to clients' requests, complaints or problems. By applying this principle in a proactive manner, providers can continually improve their understanding of clients and provide insurance in a way that generates sustainable value for themselves and their clients.

*Respectfulness* can be defined as showing attention and concern for the privacy, rights, traditions and welfare of others. Respectful insurance will take care not to cause harm.

Lastly, a *useful* insurance product is one that enables consumers to protect themselves more effectively

from risk. It is not enough for insurance providers to create what they think is a useful insurance product; consumers have to use that product in a way that actually results in more effective risk protection.

**Table 1. Seven principles of responsible insurance**

|                 |   |
|-----------------|---|
| Appropriateness | Offering relevant risk management benefits at an affordable price   |
| Accessibility   | Being easily obtained, understood and used                          |
| Transparency    | Communicating clearly and openly without deceit                     |
| Fairness        | Conforming to the principles of equality and justice                |
| Responsiveness  | Reacting quickly and attentively                                    |
| Respectfulness  | Recognizing the privacy, rights, traditions and welfare of others   |
| Usefulness      | Enabling consumers to protect themselves more effectively from risk |

It is important to emphasize that a responsible approach is one that upholds the interests of all stakeholders. It is not only about clients; it is about being internally transparent, fair, responsive, and respectful to other stakeholders as well.

Lastly, it should also be highlighted that responsible insurance is not an absolute or finite goal, nor should the seven principles described above be thought of as a checklist of items that can be ticked off and forgotten about once they are achieved. Each of the principles highlights a specific trait of responsible insurance culture. An insurance provider may fulfil one principle but not another. It may fulfil all principles today and only some tomorrow. And even if it fulfils all principles to some extent, it can always become more responsible in the future.

**4. Building a responsible insurance value chain**

The seven principles of responsible insurance provide practical and detailed guidance to insurance providers on how to make the insurance value chain more responsible. In the next subsections, we will explore the standards (see Table 2) and guidelines that the five stages of the insurance value chain should meet in order to comply with the seven principles of responsible insurance. The discussion will draw on the example and experiences of the organizations described in Section 2. Standards (levels of quality to be achieved) will be identified with the letter “S” and guidelines (tips on how to achieve a certain level of quality) with the letter “G”.

**Table 2. Responsible insurance standards per stage of the value chain**

| Product design  | Marketing, education, and sales   | Enrolment, renewals, and premium collection                                  | Policy administration and servicing  | Claims management  |
|---|---|--|--|--|
| 1. Product addresses consumers’ priority risk management needs. | 1. Consumers are provided the financial education and tools required to make an informed decision about | 1. Enrolment procedures are sufficiently clear and simple that consumers can | 1. Policies are administered and serviced as per the terms of each contract; clients | 1. Procedures and documentation requirements for filing and supporting a claim are accessible, |

|  |   |   |   |  |
|--|---|---|---|--|
| <p>2. Product offers valuable yet affordable benefits.</p> <p>3. The timing of benefits helps consumers to prevent or effectively cope with shocks</p> <p>4. Exclusions, waiting periods, and documentation requirements are limited and easy to understand.</p> <p>5. Consumers are protected against the negative impact of product failure.</p> | <p>an insurance purchase (when voluntary), to effectively use insurance as a risk management strategy, and to seek out additional information when necessary.</p> <p>2. Product is explained to consumers before enrolment in a manner that is transparent and not misleading.</p> <p>3. Information is communicated to clients using language that is appropriate for their level of financial literacy.</p> <p>4. In case of mandatory group policies, distribution channels and aggregators treat insurance as a complementary service and make efforts to inform clients of its usefulness and value.</p> <p>5. For active sales, no high-pressure sales techniques are used.</p> <p>6. Consumers have adequate time before enrolment to review the terms and conditions, consider the purchase decision, ask questions, and have their questions answered.</p> | <p>easily and effectively implement them.</p> <p>2. Procedures for maintaining and renewing policies minimize the risk of an unintended cancellation or lapse in coverage, or in the case of automatic renewals, the risk of unintended continuation.</p> <p>3. In the selection and treatment of clients, insurance providers do not discriminate inappropriately against certain categories of clients.</p> <p>4. Consumers' data and money are safeguarded sufficiently.</p> | <p>are notified in a timely and appropriate manner of any changes.</p> <p>2. Those who administer and service insurance policies, as well as those who provide value-added services, do not discriminate inappropriately against certain categories of clients.</p> <p>3. Clients have access to the support they need to use their product effectively and have their complaints handled adequately.</p> | <p>understandable, and flexible as possible, given the need to prevent fraud and unauthorized claims.</p> <p>2. Claims are processed and paid in a fair and timely manner.</p> <p>3. Claimants are notified when claims are received and when they are settled or denied. When a claim is denied, claimants are provided the reason for rejection and a reasonable time period during which to correct any deficiency.</p> <p>4. Consumers have adequate and accessible opportunities to seek redress for denied claims through internal and/or external channels.</p> |
|--|---|---|---|--|

#### 4.1. RESPONSIBLE PRODUCT DESIGN

**S** **The product addresses consumers' priority risk management needs.** Emerging consumers may not afford insurance to manage all their risk exposures, so they need insurance providers to focus on their priority needs – the ones that are not being addressed effectively through other available mechanisms. By helping emerging consumers address their most serious risk exposures, insurance can generate maximum social and economic impact for clients, and the greatest likelihood of sales for insurers.

**G** *Invest in market research.* Market research can ensure that product design is informed by the risk

management needs and priorities of the target market, their willingness and ability to pay, and their understanding and use of insurance. If conducted properly, it can improve an institution's client value proposition and bottom line. Tigo's Family Care Insurance, for example, was launched in 2010 after findings showed that only 4.1 percent of the country's population held any formal insurance policy, even though the Ghanaian culture strongly valued the ability to provide a proper funeral for family members (Tappendorf et al., 2014). MFW's Caregiver, launched in 2010, was also developed after extensive market research indicated clients' dissatisfaction with public healthcare in Jordan for emergency and more serious illnesses, and that women mostly used savings and borrowings to cover for health expenses (Impact Insurance Facility, 2013b).



*Leverage what exists.* It is possible to add value to tools and strategies currently used by the target market to manage risks, such as loans and savings, or by simply building on existing relationships and infrastructure that effectively cater to the target market. For instance, distributing the product through channels that are already visited and trusted by the target market and building on existing communication channels that function in a transparent manner are some of the alternatives available to providers to leverage on what exists (and works well).

Tigo's Family Care Insurance is the perfect example of how to use existing infrastructure to distribute insurance. The life product was introduced in the Ghanaian market in 2010 and relied on Tigo's network, the second largest mobile network operator in the country, for distribution (Tappendorf et al., 2014). In addition to the network of agents that were hired for this purpose, all Tigo customer service centers were trained to distribute the product. Additionally, the life cover was linked to airtime purchases at no additional charge. After a large take-up of the free product, Tigo began offering clients the option of doubling their coverage for a fee, and now that the product is a success and demand has been created, the monthly premium is fully paid by customers.



**The product offers valuable yet affordable benefits.** Responsible insurance products need to offer benefits that enable clients to better protect themselves from risk in the form of cash payouts, in-kind transfers, asset replacement, or value-added services, but they cannot cost more than what clients are willing and able to pay. Effectively serving emerging consumers requires a careful balance between the quantity and quality of benefits and their price.



*Provide sustainable value.* Taking a long-term perspective is vital, especially in new markets. Setting prices, terms and conditions in a way that is affordable to clients while covering provider costs is, therefore, very important and should be always considered in product design. In addition, make sure that all stakeholders benefit sufficiently from participating in the value chain, otherwise sustainability may be compromised.

The Tigo's Family Care Insurance product not only helped Ghanaians address an important risk management need in line with their ability to pay, but it also generated premium revenue and increased customer loyalty for Tigo. By using TigoCash to pay claims, it increased the usage of Tigo's mobile money platform while keeping costs low and shortening payout times (Tappendorf et al., 2014).



**The timing of benefits is adequate to help clients prevent or effectively cope with shocks.** Policyholders require rapid claims settlement. In the absence of a timely insurance payout, they may have to resort to high-cost coping mechanisms, such as asset selling or reduction of consumption, severely diminishing client value.



*Think beyond the payout.* Clients do not assess the value of insurance solely on the basis of cash received during the coverage period; they also look at the timing and accessibility of the payout, service quality, non-financial benefits and value-added services. Value-added services, for instance, can help align incentives between clients and providers by simultaneously improving value and

reducing costs, and are simpler to manage than more comprehensive insurance coverage. They may also help consumers prevent or effectively cope with shocks even if they do not receive a claim payout.

For example, SAJIDA Foundation designed its Nirapotta insurance product to cover the most important risks faced by its clients, and to provide tangible benefits even in the absence of a claim (Rendek et al., 2014). SAJIDA's community health workers located in each branch, known as Bondhus, performed basic health check-ups, gave health advice, identified pregnant mothers and children at risk, and helped clients use the health insurance. This way, even clients who never made a claim saw the value of being insured.

MFW's experience is also interesting. By regularly monitoring key performance indicators (e.g. number of policies, claims frequency and cost, and claims ratio), the organization was able to identify improvements to the Caregiver product (Microinsurance Innovation Facility, 2013). As it had low claims, there was an opportunity to increase client value which was done by reducing the premium charged, increasing the maximum number of days for which benefits could be paid and removing the limitations on benefits in the case of pregnancy. If claim ratios had been consistently above the target, this would instead have signaled a need to reduce product benefits to achieve a necessary balance between value for clients and product viability.

**S** **Exclusions, waiting periods, and documentation requirements are limited and easy to understand.** This standard is important for clients as well as distribution partners. Products that are too difficult to administer or do not create a positive first-time experience may not be successful.

**G** *Start simple.* Simple products can provide value to clients, are easier to understand, and are easier for staff and agents to communicate clearly. Overly complex products on the other hand, can fuel distrust. There are simple options across all product lines, for example: hospital cash, credit life, funeral and fire. Simplicity can also be achieved by, whenever possible, designing products that have few or no exclusions, limited waiting periods and documentation requirements that are easy to understand and comply with. However, simple products often respond imperfectly to consumers' needs, so it is important to expand the offer as the market develops. MFW, for instance, opted to start offering Caregiver as a mandatory product covering solely its loan clients. Only after two years of constant monitoring and improvements was the voluntary benefit to family members launched. On top of that, MFW already had previous insurance experience from a credit life product launched in 2006.

**!** Contrarily, CIC's Jijenge Savings Plan is an example of how a complex product can backfire (Impact Insurance Facility, 2014). While the initial take-up of Jijenge confirmed high demand for medium-term savings needs, the complex design of the product made it difficult to understand for both clients and agents. Clients who lapsed or surrendered felt cheated because they did not understand the product's conditions and this fueled distrust. For this and other reasons, CIC's Board made the decision to discontinue the product and to return clients' savings, even though they were not obligated to do so. A new non-lapsable savings product was developed to replace Jijenge, and clients were encouraged to transfer their savings balance to it.

**S** **Consumers are protected against the negative impact of product failure.** Although product failure is inherent in the development of a new market, it can stunt market development if it harms clients. For emerging consumers who are new to insurance, such exposure reinforces the prevailing negative view of this financial tool. This is a particular concern with mobile insurance products which can scale quickly and fail overnight. Even in mature markets, consumers should be protected against the risk of product failure.

**G** *Create a living will.* Living wills, commonly known as 'Recovery and Resolution Plans', became



popular after the 2007-2008 financial crisis when governments became concerned about underwriting the losses of banks upon a failure. A similar approach can be taken by insurance providers, especially for mobile insurance schemes, given their potential scale (Leach, 2013). Stakeholders in the value chain should agree upfront how they will wind down a scheme, for example, by providing a sufficient and well-communicated notice period in the event of product cancellation, by making alternatives available to clients before the scheme is stopped, or by monitoring and addressing queries and complaints for a set-period following the end of the cover.

**!** The Ecolife case demonstrates how the lack of living will for a product that scaled quickly, but failed overnight, can end up affecting the whole market through negative market discovery and general distrust of insurance (Leach and Ncube, 2014). When the partnership agreement between Econet and its technology service provider, Trustco, was terminated due to a dispute concerning royalties payable seven months after the launch of the product, Econet decided to suspend the Ecolife product. Overnight and unexpectedly, 1.6 million subscribers, approximately 20 percent of the Zimbabwean adult population, lost their Ecolife cover and were not compensated. On top of that, only 17 percent of Ecolife clients claimed they had received formal notification of the product's discontinuation.

Demand side research conducted in 2013 to test the impact of the failure of Ecolife on the Zimbabwean market showed that 42 percent of the individuals surveyed were dissatisfied with insurance and 63 percent ruled out use of similar products in future. Although failure is an inherent part of the financial system, the Ecolife case shows how thinking upfront about the living will helps to ensure that if a product fails, the failure will be managed in a way that limits its impact on the market.

## 4.2. RESPONSIBLE MARKETING, EDUCATION, AND SALES

Insurance marketing is the process of communicating the value of the product to customers for the purpose of selling that product. Insurance education refers to a systematic effort to raise awareness on the potential risks to which individuals are exposed and the means by which insurance can contribute to managing those risks.

Though at first glance it may seem like marketing and education are distinct and separate activities, this is not necessarily true. If conducted responsibly, they can jointly contribute towards improving customers' and potential customers' knowledge of insurance, and increase uptake.

**S** Consumers are provided the financial education and tools required to make an informed decision about an insurance purchase (when voluntary), to effectively use insurance as a risk management strategy, and to seek out additional information when necessary. The goal should be to make consumers independent and informed to make the best possible decisions for themselves.

While it may be argued that this should not be a standard for insurance providers to meet, it is important to remember that a lot of harm can be caused by providing insurance to consumers who do not fully understand it, leading to negative business implications. Responsible insurance providers need to address this challenge by making sure that consumers are provided with knowledge and tools before they have the opportunity to benefit or be harmed by a product.

**G** *Collaborate with others to implement cost-effective consumer education initiatives:* This is as an important strategy for managing the costs of education and the challenge of avoiding harm. Although the potential benefits of engaging insurers in consumer education are great, so is the potential for confusion and misalignment of interests among sales staff that are asked to both educate consumers and promote a particular set of products. One way for insurers to protect themselves from this risk and ensure that consumers receive appropriate and unbiased information is to collaborate with



stakeholders such as government agencies, educational institutions or consumer advocates who can provide general financial education that insurers can then reinforce.

On top of that, experience to date suggests that the effectiveness of both information and marketing may be enhanced by a collaborative approach. The theory of financial education states that improving awareness and knowledge of insurance is the first step needed to move consumers towards changes in attitudes, increased skills and eventually behavior change. However, poor understanding is only one part of the problem. Many other factors can prevent people from purchasing insurance, including the lack of products available on the market. Without an available product, consumers may become frustrated and not have an opportunity to use the education and information they have received, while without education and information, they may not know when to purchase or how to effectively use an insurance product. Therefore, combining efforts to guarantee that products are available at the time when education initiatives are implemented can be an effective alternative.

**S** **The product is explained to consumers before enrolment in a manner that is transparent and not misleading.** This includes avoiding information in small print text or hidden in formal and technical language. As a rule of thumb, insurance providers' marketing efforts should aim to clearly communicate product-specific details before a sale is finalized. This includes information on policy coverage and cost, how to claim, how to ask questions, and how to make a complaint.

**G** *Build consumers' financial capability as part of the long-term process of creating lifetime customer relationships:* While the ultimate goal of marketing is to commercialize a product, in order to guarantee the success of a business it is important to nurture relationships and think about customers in the long term. By constantly engaging with customers and embedding education components within marketing and sales strategies to leverage existing contact points, providers can build customers' financial capability and ensure they get the support they need, while also nurturing long-term relationships.

There are several good reasons for taking a long-term approach. Without application or reinforcement, people quickly forget most of what they learn. This helps to explain why no short-term financial education initiative will enable consumers to make an effective purchase decision a year or more after information is received. Repetition strengthens mental connections and aids memory. This can be facilitated by periodic interaction with consumers to reinforce information provided earlier.

In addition to this, while consumers need to have the appropriate knowledge to make effective use of insurance, providing them with lots of information will not necessarily result in greater understanding: information overload is a real risk. However, if information is communicated over a period of time, in batches or packages that are relevant for a particular stage of the customer journey, it is more likely to be useful. Following this logic, a provider could deliver more high-level information on how to claim during enrolment (without getting into the specifics), for example, and leverage another moment, such as a client visit to repay a loan, to convey the detailed information on the documents needed to file a claim.

Another reason for taking a long-term approach is that insurance providers can make a series of smaller investments rather than a massive upfront investment which can make the cost of education more manageable. To the extent that providers can integrate education into existing business processes – not just marketing, but enrolment, renewals, servicing and claims – costs can be reduced. In fact, education may even make processes more efficient.

Finally, only a longer-term process can enable insurers to develop lifetime relationships with their customers. The goal is not simply to help customers get through their purchase decision. The goal is to provide an experience such that customers will keep using insurance, purchase additional products, and recommend insurance to others. A long-term approach, therefore, requires ongoing marketing and

education.

**S** **Information is communicated to clients using language that is appropriate for their level of financial literacy.** It is important to remember that limitations can exist with respect to consumers' ability to read, write, or perform calculations, that they may be the result of a disability or of lack of education, and that they may also exist in one language (e.g., a national language), but not in another (e.g., a vernacular language).

**G** *Maximize the effectiveness of marketing and education efforts for staff and clients:* Even when staff and clients want to learn, their attention will be divided. Any marketing or education effort has to find ways of competing with other demands on learners' time and energy. If trainings, job aids and learning materials are fun, social, and experiential, designed to facilitate memory, and delivered just-in-time for use, they will be more effective at achieving their goal.

This was the challenge faced by ILRI in Kenya. Misinformation spread by agents risked damaging the reputation of the product before it reached critical mass. One of the solutions being tested by ILRI involves the use of mobile learning (mLearning) combined with gamification and financial incentives (Wandera, 2015).

By definition, mLearning optimally comes in the form of 3–10 minute lessons delivered through mobile phones. With this in mind, ILRI developed a simple mLearning training program consisting of micro-lessons that could be conveniently read by their agents. Prior to the 2015 sales window, the mLearning app Pocket IBLT was installed on the agents' phone to trial the utility of the approach. To assess agent comprehension and motivate participation, micro-lessons include simple quizzes connected to a central server as well as computer game elements such as badges and leaderboards.

Many of the techniques that make a marketing message effective for those with literacy limitations also make marketing messages more effective for the general population. For example, communicating important messages through two different channels (one visual and one verbal) ensures that those who are visually- or hearing-impaired receive the message, but it also helps everyone avoid miscommunication by reinforcing the content of a message.

**S** **In the case of mandatory policies, distribution channels and aggregators treat insurance as a complementary service and take marketing efforts to inform clients of its usefulness and value.** The marketing of mandatory insurance will be worthwhile only if it enables consumers to understand and find value in their insurance coverage.

**G** *Provide standards, training, and job aids teaching staff and agents to communicate effectively:* Insurance providers can always invest resources in training, job aids and incentives, but that can be expensive and some things are hard to teach (e.g., how to get consumers to trust you and the product you are selling). At same time, they do not just cost money; they can contribute to saving money if they give clear guidance that reduces mistakes, complaints, and questions, and make it easier to sell a product. Insurance is not part of the core business of the distribution channel (especially when it comes to alternative channels such as mobile network operators or retail chains), which means that the staff may not be too familiar with this tool, may have the same concerns as the market they are trying to reach or may simply not have sufficient time to dedicate to selling insurance. It is important, therefore, that educating staff and agents, just like clients, becomes an ongoing activity. Attitudes are rarely changed overnight and reinforcement facilitates clarity and efficiency.

At Crezcamos, a standardized sales protocol and correlated tools were developed to support loan officers in selling their new and complex crop insurance product (Zimmerman et al., 2016). This protocol consisted of five steps, including: 1) sensitizing clients to the risk, with reference to past experience with

weather-related damage to the farmer's or his neighbor's crops and stating four introductory points about the product; 2) showing a video that explains the product features and offers a brief testimonial from a claimant; 3) calculating the exact premium and benefit amount for the client's situation using a worksheet; 4) managing questions and concerns from the client; and 5) completing enrolment forms if the client chooses to purchase the insurance.

Loan officers received training on the product details and on the protocol prior to using it. They also received a script to follow when explaining the crop insurance, as well as a sheet of frequently asked questions from clients. While some loan officers, especially those who already had experience selling insurance, failed to follow the protocol, most of them remembered, used, and appreciated the tools created.

**S** In the case of active sales, no high-pressure sales techniques are used. Under no circumstances should consumers be forced or tricked into signing a contract.

**G** Provide incentives or rewards that motivate responsible marketing and education and put controls in place to detect and correct aggressive or abusive treatment by staff and agents:

There is a distinction between communication that is accidentally misleading and communication that is deliberately misleading. One way to avoid misleading consumers deliberately or accidentally is to build opportunities into the sales process for consumers to reflect on the information they have been given and to ask for clarification. Crezcamos' sales protocol previously described offers a good example of such practice. Another useful tool is mystery shopping. Mystery shoppers usually perform simple tasks such as buying a product, asking questions or filling complaints, and their feedback on the treatment received can help measure the quality of a provider's service or its compliance with certain standards and regulations.

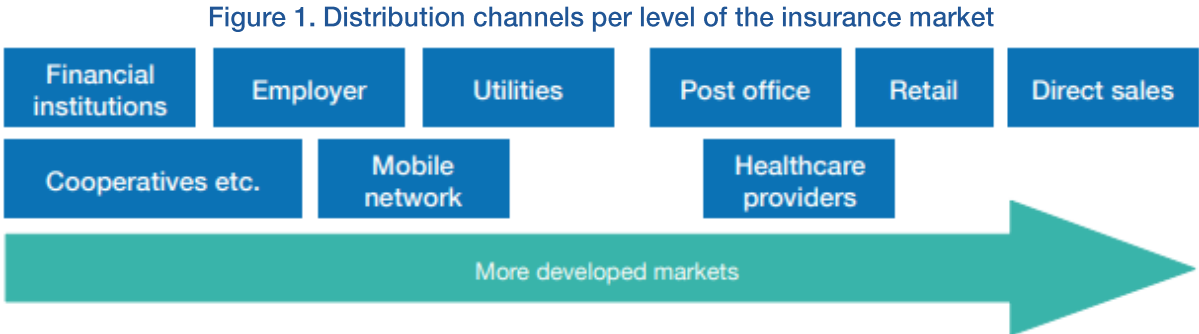
If carefully designed, incentives and rewards can also have promising results. For instance, giving employees and agents free or discounted access to insurance products as a reward can also provide them with the opportunity to learn by doing, fostering better understanding of how they work and of their value. Mixed forms of agents' remuneration – combining fixed salaries and commissions, for example – such as the one used by Tigo and Bima at the early years of the Family Care product, can also reduce the incidence of high-pressure sales techniques by guaranteeing security of income.

**S** For voluntary products and mandatory ones with optional covers, consumers have adequate time before enrolment to review the terms and conditions, consider the purchase decision, ask questions, and have their questions answered. Regardless of whether providers choose a high-touch marketing strategy (e.g., face-to-face meetings or personalized phone calls) or a low-touch one (e.g., SMS messages or television commercials), they need to make sure that the individuals or institutions that are doing their marketing have the time, ability and motivation to provide the support required by a particular product and target market.

**G** Select distribution channels that can offer the level of service required by a particular product and market: Insurers often consider knowledge and skills when screening potential distribution channels, but they should also consider other resources that may be brought to the table, such as time, motivation, and the nature of any existing relationship with the target market. Even within one distribution channel category (e.g., MFIs), potential partners can differ greatly in their skills, attitudes, motivation and time. If time is a scarce commodity, effective marketing may be impossible without large incentives, increasing cost. However, if a distribution channel believes that insurance will support its mission to serve a particular market segment, it is more likely to commit the energy and time to market insurance effectively. This reduces the need for external incentives.

When entering a new market or introducing a new product, insurers should look for distribution channels

that are trusted and know how to communicate with their target market. As products become more complex, insurers will need distribution channels that can make sense of the complexity and are willing and able to help consumers do the same. Figure 1 gives a rough idea of the most appropriate channels per level of development of the insurance market.



❗ CIC’s Jijenge example shows the importance of selecting an appropriate channel for the success of a product (Impact Insurance Facility, 2014). The distribution model selected by CIC was inappropriate given the state of market development in Kenya as it relied mostly on mobile money outlets which were not sophisticated enough to sell complex insurance products and seemed to have better business opportunities than insurance. The transactional nature of mobile money business meant that agents valued present revenues much more than future ones, so it was difficult to build their Jijenge portfolios over time.

Although face-to-face interaction seems critical for first-time users to realize the value of insurance, providers should be able to take advantage of lower-touch, more cost-effective methods over time as the client base becomes more educated and the convenience of service or the quality of technical advice becomes more important than the friendly face extending it. Besides, low-touch mechanisms also have the potential to be responsible. As consumers become more experienced with insurance and comfortable using mobile phones for purchases and education, USSD-type service could be appropriate if they want to renew a policy or purchase a simple product they are already familiar with. This is particularly true if it is just one of several channels through which consumers can communicate with the insurance provider.

Delivering a product responsibly through the wrong distribution channel can be quite challenging, so this is an important guideline for insurers that are trying to provide responsible but cost-effective marketing and education.

**4.3. RESPONSIBLE ENROLMENT, RENEWALS, AND PREMIUM COLLECTION**

Purchase decisions are often postponed when clients encounter too many obstacles to enrol, pay premiums, or renew an insurance policy, or when they have difficulties in understanding product logistics. Providers should aim to minimize these challenges by following the responsible insurance standards and guidelines discussed below.

**S** Enrolment procedures, including premium collection, are sufficiently clear and simple so that consumers can easily and effectively implement them. Burdensome documentation requirements, physical remoteness of the enrolment facility, and premium collection barriers such as lack of access to accepted payment methods can negatively impact the customer experience.





*Offer “one-stop” solutions with suitable locations and timing:* Insurance providers have increasingly sought ways of easing the enrolment process by providing one-stop solutions which offer simple enrolment procedures and facilitate clients’ sign up. Since the time taken for clients to travel to the enrolment venue can be costly, distance should be considered. Lastly, it is also important to offer clients convenient scheduling and adjust enrolment windows to their needs. By developing simple procedures that do not require repeated contact, providers can facilitate clients’ lives. Crezcamos’ enrolment approach, which has already been described in the previous subsection, illustrates well how to put this guideline into practice.



*Leverage technology to minimize paperwork, facilitate identification, and remove cash from payment processes:* Technology is a great enabler that can optimize client-facing transactions, allow clients to conveniently navigate simple procedures and reduce costs. Web portals, online applications, smart cards, and mobile money are just some of the tools that can be used to reach these goals. However, while technology brings great promise in terms of increased efficiencies, reduced costs, and increased outreach, it can also alienate and confuse customers, especially those from nascent markets who may prefer to connect with a trusted partner or receive personalized advice. Another issue that can arise from the use of technology innovations is a mismatch between the solution being proposed and the technical capacity of clients. In both cases, balance must be achieved with the help of a thorough analysis of the market to test whether clients are overwhelmed by complexities, or that technology works sufficiently well not to threaten the process.

Tigo’s Family Care Insurance offers an example of how to sequence the adoption of technology innovations for enrolment (Tappendorf et al., 2014). When first introduced in the Ghanaian market in 2010, the life product was mostly distributed through a network of roaming agents whose sole task was to register and educate clients on the product. These specialists had face-to-face interaction with clients throughout the country, though primarily in urban areas. In addition, all Tigo customer service centers were trained to be familiar with the product and enroll clients.

As the cover became widely known, Tigo developed self-registration for customers directly via mobile phone using USSD technology in 2012. Customers only needed to dial a number to activate their policy, start paying the monthly premium, and provide data on both themselves as the primary policy-holder and one other family member as the beneficiary.



**Procedures for maintaining and renewing policies minimize the risk of an unintended cancellation or lapse in coverage, or in the case of automatic renewals, the risk of unintended continuation.** While insufficient client satisfaction will almost always prevent a renewal, regardless of how straightforward the renewal process may be, satisfied customers may fail to renew due to being unaware of the policy expiration, or due to burdensome administrative requirements.



*Create mechanisms that enable people with low and/or irregular incomes to remember and make payments in a way that avoids any lapse in coverage:* In some cases clients may face difficulties paying the insurance premium all at once and prefer smaller but more frequent payments. However, the more frequent the payments, the more chances clients have to not pay due to cognitive biases (e.g., planning fallacy) or simply because they may forget. Providers need to factor these constraints into the design of products and processes to help clients make good choices. Simple mechanisms, such as monthly SMS reminders, automatic premium deductions or incentives that encourage payment discipline can make a significant difference, as long as the product is relevant and appropriate to the market.



CIC’s Jijenge Savings Plan, for example, had a very generous policy on lapses and made many attempts to reinstate the policies, but the complex product design made it difficult for both clients and

agents to understand it (Impact Insurance Facility, 2014). Even when clients understood the concept of lapsing, the lack of flexibility in the product design did not suit the irregular cash-flows of emerging consumers and they were unable to stay on track.

**G** *Inform clients before any lapse, expiration or cancellation of an insurance policy and give them an opportunity to prevent it:* Responsible renewals make sure that clients who are willing to renew are duly informed and that their re-enrolment is facilitated by a convenient process. Alerts should also be given for products that are automatically renewed which give notice and an opportunity to opt out of renewal for voluntary products. Testing different ways of contacting clients in order to avoid relying on one single communication channel is a smart and responsible move to take.

**S** **In the selection and treatment of clients, insurance providers do not discriminate inappropriately against certain categories of clients.** If any differentiation exists in terms and conditions based on risk, mission-driven targeting, or special needs, these should be stated in advance, applied consistently, and designed to benefit clients. While ease and convenience are usually the key words that come to mind when talking about responsible enrolment and renewals, non-discrimination is also very relevant.

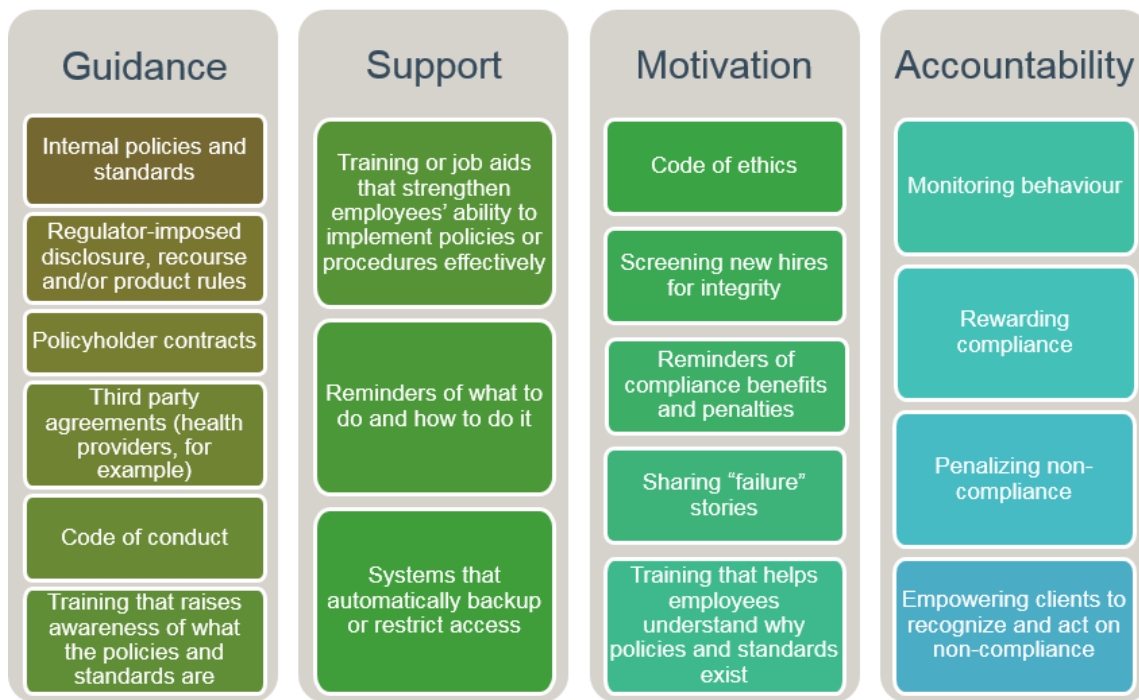
**S** **Consumers' data and money are safeguarded sufficiently.** When enrolling or renewing a policy, customers trust insurance providers with their money and confidential information. To maintain customers' trust, it is important that both are duly protected and respected by providers.

**G** *Put standards and controls in place to protect clients against discrimination, mis-selling, fraud, and inappropriate use of their data or funds:* While regulatory and supervisory authorities play a big role in preventing unfair insurance practices, providers can also take steps to eliminate such practices among their staff. Trainings on sales and ethics, codes of ethics and conduct, and supportive job aids are some tools that can help them in this task. For instance, a supportive job aid can take many forms, such as a checklist of items to review with clients at the time a policy is renewed or a mobile app which employees could use to find answers to their client protection-related questions. For example, "how can I reduce mis-selling within my team" or "what should I do if I hear a rumour about an agent committing fraud?"

Table 3 introduces a series of strategies that providers can use to guide, support, motivate and increase accountability of their staff when it comes to protecting clients.

**Table 3. Strategies to make staff more responsible**





In order to be responsible when it comes to enrolment, renewals and premium collection, insurance providers need to think beyond efficiency and cost control. Investments in staff may look costly, but tend to pay dividend in the long term.

#### 4.4. RESPONSIBLE POLICY ADMINISTRATION AND SERVICING

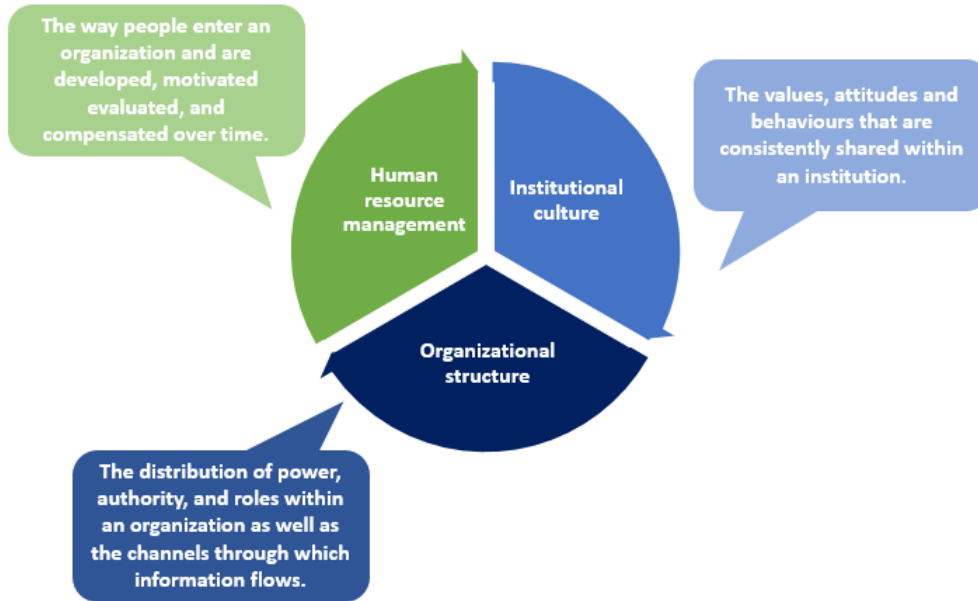
Responsible insurance is normally only thought in the context of the first three stages of the value chain. However, the last two stages – policy administration and servicing and claims management – are equally important. Policy administration and servicing is often the most neglected phase when it comes to responsible insurance, but in fact it is the first crucial moment when issues around the actual delivery of value need to be dealt with.

**S** Policies are administered and serviced as per the terms of each contract and clients are notified in a timely and appropriate manner of any changes. Playing according to the rules contributes to building clients' trust, promoting long-term success.

**G** Create an organizational architecture that encourages and empowers providers to listen and respond to clients: Organizational architecture consists of three main components (see Figure 2):

- 1) Human resource management: the way people enter an organization and are developed, motivated, evaluated and compensated over time;
- 2) Institutional culture: the values, attitudes and behaviors that are consistently shared within an institution;
- 3) Organizational structure: the distribution of power, authority and roles within an organization as well as the channels through which information flows.

Figure 2. The three dimensions of an organization architecture



An organization’s architecture is strongest when key values are firmly entrenched in its culture, when people, functions, and systems are structured to facilitate those values, and when staff, agents, and partners are recruited, trained, motivated and held accountable for upholding them. In the case of insurance provision, the key value responsibility – appropriately listening and responding to clients – should be reinforced throughout the whole organization. Table 4 provides some ideas for creating an organizational architecture that encourages and empowers providers to listen and respond to clients.

**Table 4. Ideas for an organizational architecture that encourages and empowers providers to listen and respond to clients**

| Human resource management  |
|--|
| <ul style="list-style-type: none"> <li>• Communicate the importance of listening and responding to clients in new staff orientation</li> <li>• Train employees on the complaints mechanism and how to appropriately manage it</li> <li>• Provide training and coaching to strengthen listening skills</li> <li>• Monitor satisfaction with the way clients have been listened and responded to, share this feedback with staff, and jointly celebrate or plan how to learn from the feedback</li> <li>• Promote staff that demonstrate the ability and willingness to listen and respond to clients</li> </ul> |
| Institutional culture  |
| <ul style="list-style-type: none"> <li>• Identify listening and responsiveness as institutional values</li> <li>• Articulate why listening and responding to clients is important</li> <li>• Share client responsiveness success stories and appreciate those who write or tell them</li> <li>• Listen and respond to staff in a way that models the behaviour desired for clients</li> <li>• Recognize and reward those who serve as client champions</li> </ul>  |
| Organizational structure   |
| <ul style="list-style-type: none"> <li>• Identify a client-value champion within each business unit who ensures that clients are heard</li> <li>• Invite a client representative to serve on the Board of Directors, or regularly meet with a client advisory group</li> <li>• Create a 24/7 hotline to which clients can report any grievances or suggestions</li> <li>• Schedule a regular customer satisfaction survey</li> <li>• Negotiate service level agreements with distribution channels, technology providers and value-added service providers</li> </ul>  |

added services, do not discriminate inappropriately against certain categories of clients. As mentioned in previous sections, fairness is a big part of being responsible.

**G** *Set and enforce service standards for third party service providers and actively manage the quality of services provided, particularly for health care:* Third parties may deliver services that are quite distinct from insurance (e.g., health care or agricultural extension services) yet have a major impact on the value of an insurance product and consumers' experience with it. Unless some effort is made, insurers will know little about, and have little control over, the quality of service delivery by these third-party providers. SAJIDA Foundation, recognizing that the lack of reliable health service providers in Bangladesh discourages some consumers from purchasing insurance (many people refuse to buy insurance to access a bad quality service), also provides health care through its own hospitals in and via community health workers (Rendek et al., 2014). While SAJIDA's case is the exception, not the rule, encouraging responsible performance of third-party providers, especially those who interact directly with consumers during the provision of services or value-added services, needs to be standard practice.

**S** **Clients have access to the support they need to use their product effectively and have their complaints handled adequately.** This includes maintaining the policy, filing claims, accessing value added services and resolving questions or problems.

**G** *Remind clients periodically of the benefits, rights, and obligations associated with their insurance policy and refer them to information or people that can assist them in using insurance effectively:* Once a policy is sold, clients need to be able to make effective use of it. Providers could deliver their product exactly as promised, but if consumers have difficulty obtaining the information needed to use it, insurance will not be as effective as it could be. Therefore, making it easy for clients to obtain information "on demand" as they need it to use a product, through face-to-face solutions (such as meeting an agent or visiting a distributor branch) or technology-enabled solutions (such as reaching a call center or visiting a website), is of extreme importance. SAJIDA Foundation, for instance, relies heavily on its community health workers, the Bondhus, to educate clients and help them use the health component of Nirapotta when needed (Rendek et al., 2014).

**G** *Ensure clients have multiple channels to their insurance providers for communication and grievance resolutions:* Clients need to be able to communicate quickly with their provider in case of need. For instance, if insurance providers make mistakes in delivering the product and consumers have a way to seek redress, the product can still be useful as long as action is taken quickly. For this reason, an effective grievance mechanism is a basic requirement for responsible policy administration and servicing.

In Ghana, Tigo ensures very high standards by guaranteeing that customers are given feedback on the progress of their complaint not later than an hour after filing it (McKee et al., 2015). While full resolution is expected to be given within 24 hours, in the meantime customers receive a ticket number and regular updates about their complaint. On top of that, an emergency procedure is triggered by the system whenever more than five customers have unresolved complaints within a 30-minute window.

As the guidelines show, a big part of being responsible during the fourth stage of the value chain involves communication. Cost-effective communication is key for responsible policy administration and servicing as it contributes to client awareness and trust.

#### 4.5. RESPONSIBLE CLAIMS MANAGEMENT

There is no doubt about the importance of claims management in building trust and a client value proposition. Claims management is only one stage of a process, and insurance cannot be provided responsibly without the other stages, but this is the stage at which clients expect to see the biggest benefit. If clients do not receive a payment when and how they expect to receive one, significant damage can be done. Conversely, a payment received that enables the insured to cope more effectively with the impact of a risk event benefits clients, their families, their communities and all the other actors in their insurance value chain.

**S** **Procedures and documentation requirements for filing and supporting a claim are accessible, understandable, and flexible as possible, given the need to prevent fraud and unauthorized claims.** Claims documentation requirements need to be sufficient to manage fraud, but should not be excessive. The time and cost to acquire documentation and make a claim can often outweigh the expected benefit, especially if it involves travel or taking time off from work. Simplifying requirements for clients to claim can improve the accuracy of claims submissions and minimize the number of claims requiring follow-up or extra assessment.

**G** *Support clients in making claims:* Rather than avoiding claims, successful insurance providers are making a special effort to support clients through this stage to demonstrate that their loss matter and the utility of insurance. Focused client communications and mechanisms for resolving complaints and disputes, via local branches, call centres, or online claims applications, can support clients through a difficult period of loss. It is also important to make sure that benefits are provided in a convenient form. In many cases, logistical challenges, such as remote locations, lack of bank accounts and technology limitations, may necessitate alternative arrangements to ensure that the benefit reaches the beneficiary in a reasonable amount of time.

In order to support clients, ITGI bears all claim processing costs, including veterinarians' fees and post-mortem examinations (Matul et al., 2013). This is a major benefit for clients who previously had to travel to initiate a claim and pay veterinarian fees costing 50 percent to 60 percent of the annual insurance premium. ITGI does not mind bearing the costs as it provides greater control and reduces the chances of collusion between farmers and veterinarians. The company is also able to negotiate lower fees with veterinarians in return for higher volume business.

SAJIDA Foundation also provides a good example of how to make clients' lives easier during a difficult loss period (Rendek et al., 2014). The NGO allows clients to submit their Nirapotta claims directly to their SAJIDA local branch, by informing a field officer at mandatory weekly center meetings, or by contacting one of SAJIDA's community health workers.

**G** *Streamline processes through standardization, automation, and decentralization:* Insurance providers are able to provide quick responses to claims if they streamline their claims processes through standardization, automation, and decentralization. The claims process needs to be easy not only for clients, but also for those who are trying to support them. Workflow analysis and process maps can help to identify areas where increased standardization may improve operations. Claims decision flowcharts or assessment protocols are also useful tools for streamlining the process and improving the consistency of results. Standard processes, claims coding, and a claims decision hierarchy are especially important considerations for products that generate high volumes of claims. Automated processes for low-risk claims are also an option.

SAJIDA Foundation, while analyzing its business model and value proposition in 2012, implemented a number of changes to streamline workflow and improve claims submission and decision-making procedures (Rendek et al., 2014). These included decentralizing the process to more than 100 branches,

re-engineering workflow, and simplifying the claims documentation required. On top of implementing an integrated claims software and creating detailed process maps, SAJIDA developed a simple claims decision protocol for use in the field. This online claims settlement tool consists of a series of questions with yes or no answers, and is used by a branch manager to determine whether claims can be settled directly at the branch or if they need to be transferred to head office for approval.

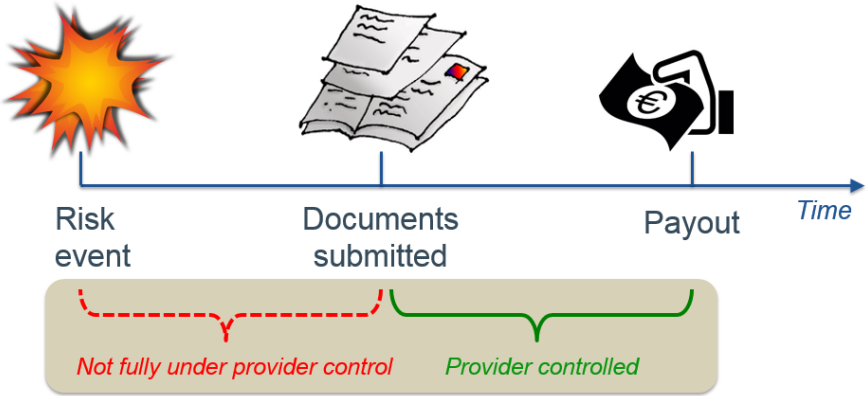
In conjunction with other process improvements, the use of the settlement tool reduced SAJIDA’s health claims turnaround times by more than half. On average, the claims settlement time was cut reduced from 25 days to 10 days, although it varies according to the covered risk. For fire/disaster coverage, the claim is usually settled in 24 hours.

MFW’s claims experience is also worth highlighting. In 2011, after evaluating the Caregiver product’s initial performance, it selected a new insurance partner and negotiated the right to authorise claims for six days or less by itself (claims for seven or more days would continue to be serviced by the insurer). As it assumed this new responsibility, MFW took several steps to strengthen its capacity to manage and control fraudulent claims, such as: 1) training loan officers to make sure they fully understood the product’s benefits and limitations, including the risk of fraudulent claims and how it might badly affect the policy; 2) communicating to clients the disadvantages of submitting fraudulent claims before enrolment; 3) establishing an Insurance Department and hiring two pharmacists who were specialists in claim processing, with their main role being to identify fraudulent claims; and 4) developing clear and transparent procedures to deal with fraudulent claims, once detected (Impact Insurance Facility, 2013b).

**S** **Claims are processed and paid in a fair and timely manner.** A loss event is already a difficult time for the client. Uncertainty about the timing and amount of the benefit adds to that and may cause more anxiety than the settlement time itself. Transparency and timeliness are vital in this context; it means that claims activities are conducted in an open and expedient way so that clients and other stakeholders can be confident that procedures are fair and honest.

**G** *Aim to minimize total time from loss to payment:* The need for fast access to funds or insurance benefits is important for most emerging consumers, especially those that have limited savings or other financial resources to turn to in the period immediately following a loss. From the client’s point of view, it is not the internal claim processing speed that matters as much as the total time elapsed from loss to payment (see Figure 3). Although the claim reporting period may be beyond the control of the insurance provider, tracking it may help identifying challenges clients face to submit their documents or how well clients understand the product benefits and how to make a claim. Monitoring the total claim turnaround time, from date of loss to receipt of benefit, and working to reduce it in its entirety, can go a long way in improving client satisfaction with the claims process.

**Figure 3. Turnaround time from the client’s point of view**





To address this challenge and reduce fraud, ITGI designed a livestock product named Pashu Dhan Bima that uses radio frequency identification devices (RFIDs) – microchips that are inserted into the hide behind an animal's ear (Matul et al., 2013). The technology allowed ITGI to accurately identify insured cattle and reduce fraud. It was also popular with clients because it was less visible than an ear tag (so it was not obvious that its owner was in debt) and less traumatic for cattle.

ITGI used the introduction of the technology as an opportunity to change its claims management process. To file a claim, an insured farmer calls the local ITGI representative when an insured animal dies (or their milk society, which then calls the ITGI representative) and an ITGI employee visits the farmer within four to six hours of notification, usually with a veterinarian. They inspect the carcass, read the RFID chip to check that it matches the identification number on the policy, and help the farmer complete the claim documents. Claims are then processed within 15 to 20 days, which represents a major improvement over other livestock insurance products that have turnaround time of up to six months.

**S** **Claimants are notified when claims are received and when they are settled or denied. When a claim is denied, claimants are provided the reason for rejection and a reasonable time period during which to correct any deficiency.** Regular client communication contributes to client awareness and trust.

**G** *Play by rules that demonstrate fairness:* Establishing, communicating, and holding everyone accountable for adhering to rules that are designed to process claims fairly helps create realistic expectations about how insurance works and what it can deliver. Communication with respect to claims payments, including denied claims, is important to clients. Claims rejections need to be communicated carefully, in order to maintain trust in the process, and rejections must be fully justified based on clear policy terms. Collecting feedback and instituting appropriate dispute mechanisms are also important components of transparent processes. To the extent that such rules help insurers deliver what they promise, they can go a long way towards building trust in the market.

**S** **Consumers have adequate and accessible opportunities to seek redress for denied claims through internal and/or external channels.** Important elements for transparency include appropriate processes to make complaints and resolve claims disputes.

**G** *Prepare staff to manage claims disputes effectively:* Staff and agents will not be able to support clients effectively in processing claims unless they are prepared to do so and unless facilitating systems exist. Even if the rules are fair, they can be misinterpreted and mistakes can be made. An environment needs to be created in which insurance providers and consumers can learn from mistakes. Staff need to have the knowledge, skills (soft skills included) and attitudes necessary to receive a claims dispute respectfully and process it in a way that facilitates learning, minimizes future rejections and makes customers feel valued and understood.

While these guidelines can help providers to make claims management more responsible, being responsible is also about sustainability – balancing business and client value perspectives. For instance, how to be flexible in responding to various client needs and preferences (e.g., language, mode of payment, documentation availability, etc.) while effectively managing insurer costs and risks. There is no single solution to balance business and client value perspectives, and any provider must decide how to achieve the best results by considering factors such as the programme design, and the regulations in effect. It is possible to opt for a higher cost option if it improves client value, retention and client understanding, because eventually this will translate into business viability. However, expectations need to be clearly stated up front.



## 5. Ensuring commitment to responsible insurance provision

In the previous sections we have discussed what responsible insurance provision is, why it is important and how to create an insurance value chain that is more responsible. The next logical step is to discuss commitment. For instance, if insurance providers consider responsible insurance a task to be done, they will only do what they are required to do in order to comply with the rules, such as keep their license or a stable client base. Their focus will be on compliance. If, however, providers really commit to responsible insurance, their focus can be on enabling consumers to use insurance more effectively to protect themselves from risk and far more can be achieved in the spirit of commitment than through a compliance-based approach that guides staff to do only what has been mandated.

Commitment can be defined as the act of assigning, dedicating, or devoting resources to a particular purpose or project. It involves some degree of loyalty and belief. It is also deliberate, as it requires that an individual or institution make a conscious decision and take responsibility for that decision.

Getting staff committed to provide insurance responsibly involves the same basic process as getting someone committed to any other objective. Previous sections have already discussed the importance of providing guidance through standards, of supporting staff and agents through training, coaching and job aids and of motivating them through incentives. What may not have been discussed sufficiently is the importance of a client-centric culture.

To ensure commitment to responsible insurance provision, providers need to convince their staff and partners that responsible insurance provision matters. There are two main ways to do that: the first, by linking penalties and rewards to responsible insurance standards; the second, by building an institutional culture that believes in providing responsible insurance because of the positive impact that it has on the lives of emerging consumers and the company's bottom line.

The problem with the first method is that it typically leads to a compliance-based approach that can be very costly. If a provider has to provide direction, incentives, and accountability for all responsible insurance actions, it will be expensive and overwhelming. It is also impossible to provide guidance for every scenario and, even if it were possible, people would not be able to remember all the instructions. Establishing a client-centric institutional culture, on the other hand, can help staff, agents, and partners understand the values and priorities that should guide decision-making and enable them to make responsible choices even when specific directions are unavailable.

In the best-case scenario, a client-centric institutional culture can strengthen people's intrinsic motivation to be responsible because they want their work to have a positive impact, and they believe it can. In turn, this can increase the quality of insurance provision without increasing costs. However, it is not easy to create a client-centred culture in an organization that does not already have it. It will affect all departments and challenge entrenched attitudes, habits, and power structures. Providers will need to proactively manage the change required, just as they would manage any other major change.

## 6. Measuring and evaluating responsible practices

Insurance providers should always measure and evaluate the provision of responsible insurance. Systematically monitoring whether responsible standards are being upheld at both the insurer and distributor levels not only ensures that these institutions are effectively and efficiently achieving their goals, but also sheds light on the areas where more work is needed. But how can responsible insurance provision be measured?

The most cost-effective approach is to incorporate responsible insurance metrics into ongoing business processes and periodic assessments that are already in place. Ongoing business processes may include

customer satisfaction surveys, mystery shopping, internal audits, and key performance indicator analysis (Wipf and Garand, 2010; Sandmark, 2013) measuring both the financial and social performance of an institution. Periodic assessments (see Box 1) can also provide strategic insights into usefulness of insurance provisions or the integrity of one's overall approach to providing insurance responsibly.

### **BOX 1. Client-centric periodic assessments**

**PACE Tool:** The Product, Access, Cost and Experience (PACE) Tool can be used by providers to assess the value of any insurance product from a client's perspective in relation to alternatives providing protection for similar risks. It identifies strengths and weaknesses that inform product development or refinement.

**MILK's Client Math:** The Microinsurance Learning and Knowledge's (MILK) Client Math research methodology uses detailed surveys to compare how insured and uninsured cope with the financial consequences of a shock (Magnoni et al., 2012). It offers insight into the ways that a particular insurance product is used and provides a quantitative assessment of the plausible benefits of insurance coverage. It can only be used with products that have paid claims and does not allow for statistical evidence.

**Social Performance Management Audit:** This assessment has an institutional rather than a product focus. It can help any financial institution working in emerging markets to evaluate the extent to which its management practices are helping it make progress towards its social goals. The tool is freely available for guided or self-assessment.

**Impact studies:** These assessments help insurers learn more about the effects of their products on the insured and their communities. Many different types of impact studies in the context of microinsurance are explained in Radermacher and Roth (2014).

## 7. Conclusion

Being more responsible along the insurance value chain can bring substantial long-term benefits to both clients and providers. However, there are also tensions that challenge responsible insurance provision and that should not be ignored.

Perhaps the most common is the tension between one's desire to be responsible and the cost of being responsible. While the benefits of being more responsible will surpass costs in the long term, the upfront financial investment may prevent providers from being more responsible in the beginning. Consequently, providers may end up believing that the seven principles of responsible insurance provision look great on paper but are impossible to implement in practice.

One thing insurance providers need to remember is that responsible insurance provision is a process, not a finite goal. While it does take time and money to put all seven principles into practice effectively, insurers can find creative ways of being more responsible that are less costly and still contribute to their long-term goal, such as using claims data to optimize product design, calculate more accurate premiums, and reduce claims rejections.

Every insurance provider can identify quick wins that do not require substantial funding to be implemented. Quick wins have the power to build momentum, push providers in a forward direction, and provide the demonstration case that is vital to gain buy-in and make investments for further progress.

If we want clients and providers to reap the benefits of responsible insurance provision, it is better to take small steps in the right direction than no steps at all.

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## SOCIAL FINANCE

The ILO's Social Finance Programme works with the financial sector to enable it to contribute to the ILO's Decent Work Agenda. In this context, we engage with banks, microfinance institutions, credit unions, insurers, investors and others to test new financial products approaches and processes.

## IMPACT INSURANCE FACILITY

The Impact Insurance Facility contributes to the Social Finance agenda by collaborating with the insurance industry, governments and partners to realize the potential of insurance for social and economic development.



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