

>> SOCIAL SECURITY AND MICROINSURANCE IN PAKISTAN

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>> THE ECONOMIC AND SOCIAL BACKGROUND

Pakistan has faced fiscal and monetary constraints since the 1980's and embarked upon the economic reforms process through the Structural Adjustment Programme. One of the targets was to reduce the fiscal deficit to a sustainable level by increasing revenues and/or controlling expenditures. The Government was financing this deficit by borrowing at very high rates of interest which resulted in the rapid growth of public debt. The servicing of this debt was eating up the major chunk of resources, leaving a very little amount for protecting the economy to external and internal economic shocks. The target was set to reduce the fiscal deficit to 4% of GDP either by increasing the tax revenues, controlling the public sector expenditures or through both measures. The evidence shows that the Government successfully controlled its expenditures and the fiscal deficit declined to a manageable level since the year 2000.

Pakistan current rank on the HDI scale is 136 (TABLES A, B, C), which is very low in life expectancy, adult literacy and gross enrolment, almost bringing it close to Sub-Saharan Africa. But surprisingly, the growth rate of Pakistan amounted to 5.8% in 2008 and Pakistan was at a higher GDP per capita (\$2600 USD in 2008, CIA World Factbook) as compared to low ranking in terms of HDI (TABLE D). Therefore, the issue is not the lack of capital, but equitable distribution and allocation of funds amongst the population, particularly among the vulnerable groups.

The labour force participation rate in Pakistan is very low. On the basis of estimated current population, the labour force was estimated around 50 million with the labour force participation rate at 32.2% in 2005-2006. The 2005-2006 Labour Force Survey data further shows that most of these employed persons work in the informal sector constituting 73% of the economy. The under-utilisation of the labour force in Pakistan is about 13% if unemployment and under-employment rates are combined.

Pakistan also suffers from a high inflation rate: in 2008 it rose to 20% (CIA World Factbook). Indeed, according to the State Bank of Pakistan figures, the food inflation in Pakistan reached 30% in 2008 (TABLE E) and food is the primary driver of inflation.

This situation is likely to hit the elderly and poor subgroups the hardest and demands the provision of social protection for these people and their families. Indeed, according to the Planning Commission of Pakistan, CPRID 2007, 32% of the population lives below the poverty line (TABLE F), indicating an overwhelming incidence of poverty in the rural areas, which is close to almost 40%. This is very high compared to the other regions of the world (TABLE G). Therefore, great efforts need to be invested to reduce poverty in rural areas.

Islamabad steadily raised development spending in recent years, and poverty levels decreased by 10% since 2001. However, in the current context of global recession, these are trying times, particularly for those who are already economically disadvantaged.

Plus, according to the World Health Organisation (WHO), 90% of the Pakistanis population had sustainable access to improved water source in 2005 whereas only 54% had access to improved sanitation. 96% of the Population had access to local health services in 2007, i.e. 100% of the urban population and 92% of the rural population.

Regarding access to social services in Pakistan, low budgetary allocations for health and education sector programmes cause inadequate delivery of health care services by the public sector, thereby affecting the poor and elderly dependent families with more severity. Indeed, total public sector expenditure on health in Pakistan amounted in 2006 to Rs 39.203 billion, i.e. only 0.75% of the GDP (TABLES H AND I). Shortages of medical staff and supplies affect many poor families including aged population who can not afford to go to a private facility. The results from a recent study (Mahmood and Ali, Pakistan Institute of Development Economics in Islamabad, 2003) support the evidence that nearly 57 percent of sick persons go to a private facility for treatment and about 45 percent mentioned "no money available" as one of the reasons for not seeking treatment of their illness.

Finally, according to the OCHA (United Nations Office for the Coordination of Humanitarian Affairs) and the Provincial Government, there was in 2008 more than 550,000 families registered as internally displaced persons (IDPs) in Pakistan. Moreover, according to the UNAIDS Indicators, the HIV/AIDS prevalence rate for adults aged 15 to 49 in Pakistan currently reach 0.1%.

>> SOCIAL SECURITY IN PAKISTAN

The implications of economic shocks to the ultra poor households are considerable. According to the World Bank, 54% of people are vulnerable because of the hospitalisation of one member of the family. This shows that if a family member is hospitalised, suddenly the entire budget of that family goes into a spin. Here, the important thing to consider is that 43% of such people, who fell into poverty because of ill health, were unable to come out of the shock even after 3 years.

The implications of hospitalisation for a breadwinner are obvious. First, he gets indebted, then loses non-productive assets like jewellery, and finally sells productive assets which are usually livestock and ultimately even land. Once the land is sold, then the downward spiral forces people to migrate to the outskirts of the metro cities. Karachi is one example, where more than 50% of the population lives in "katchi abadis", i.e. slums.

Once the implications triggered by these economic shocks are understood, it becomes obvious that the ultra-poor need health care and social security coverage, and in particular hospital treatment and hospitalisation cover, which are not offered by even the best of the primary health care facilities and Basic Health Units (BHUs) in Pakistan. Now, if we look at the tertiary hospitals like teaching hospitals, for example, the Pakistan Institute of Medical Sciences (PIMS), we see that, for a fortunate few, the subsidy is only in the form of a bed, and perhaps, free consulting services after a person gets hospitalised. However, the cost of surgical and medical supplies comes out from the pocket of the patient or his/her relatives. So, hospitals are not providing medicines, which is a major cost that may paralyse and impoverish the entire household of the hospitalised. Consequently, the implementation of an efficient social security system is fundamental to reduce poverty and vulnerability.

The International Labour Organisation (ILO) adopted various recommendations and conventions on social security, which provide a comprehensive definition of social security. Pakistan has ratified three of them ([C18 on Workmen Compensation \(Occupational Diseases\)](#), [C19 on Equality of Treatment \(Accident Compensation\)](#), [C118 on Equality of Treatment \(Social Security\)](#)). According to the ILO: "Social Security refers to the protection society provides to its members through a series of public measures against the economic and social distress. The social security cover must be provided in case of sickness, maternity, employment injury, unemployment, invalidity, old age and death. The provision of medical care and subsidies for families with dependent children is also included in the social security coverage".

In the South Asian region, India and Pakistan are the only countries which cover all sorts of contingencies recognised by ILO conventions. The percentage of workers covered under these schemes is relatively high as compared to other countries of the region, but still very low as compared to developed countries of the world.

In Pakistan, social security and pension schemes sponsored by the Government actually benefit a small proportion of the population in the formal sector, even though a number of programmes are in place. The first law for social Security in Pakistan came out in 1972 but was never implemented. The current law was enacted in 1976 and implemented old-age benefits.

Pension and social security in the formal sector is currently provided through social insurance programmes and other employer benefit schemes. The current schemes can be divided into two main categories:

- The first category consists of the "general" or "by default" schemes. These are the Government schemes that employers in firms of 10 workers or more are required to contribute to, unless they have been specially exempted by legislation. The coverage is voluntary for employees in firms of less than 10 workers. The Employees Old Age Benefits Institution (EOBI) is a federal body that provides age, disability and survivors pensions. The Employees Social Security Institutions are provincial bodies (ESSIs) that provide health services and some cash benefits to retired and senior citizens. The EOBI covers approximately 1.3 million workers, while the ESSIs cover only 850,000 (2007).
- The second category consists of schemes that are specific to particular sectors or enterprises and are specifically exempted from membership of the general schemes. The main category exempted consists of Government workers, members of the armed forces, and some others. Besides, commercial and industrial establishments with 50 employees or more must provide group insurance for temporary and permanent disability and death benefits for employees earning less than 3,000 rupees a month.

For more details about the eligibility conditions, the exclusions, the level of premiums and benefits depending on the risk covered (sickness, maternity, employment injury, unemployment, invalidity, old age and death), please visit the following website (Pakistan page in the US Social Security Administration website):

www.ssa.gov/policy/docs/progdesc/ssptw/2002-2003/asia/pakistan.html

The pension and social security coverage is thus limited to the formal sector whereas the informal or unorganised sector fall outside the purview of the statutory provisions usually administered through registered public and private enterprises. As mentioned before, the structural adjustment policies have reduced social budgets, privatised public sector units and downsized Governments. These policies and programmes have in turn tended to reduce the number of individuals covered by the pension and social security schemes as incremental employment is generated in the informal sector.

Consequently, a major strategic issue is how to extend benefits to the informal sector. This is not only an issue about how much money would be available but also about mechanisms to accrue benefits to all categories of employees.

In Pakistan, the informal sector contributes about 70% of total employment indicating 31.5 million out of 43.2 million employed workers, and a substantial number of employees work for themselves (selfemployed).

Government-funded social protection schemes in the informal sector refer to programmes that transfer money or goods to individuals that are not linked to contributions. The main governmental organisations providing social assistance are Zakat (since the Zakat and Ushr Ordinance of 1980) and Bait-ul-Mal (since the Baitul Mal Act of 1991) which perform a wide range of programmes.

For workers employed in the informal sector, there are also civil society organisations such as mosques, financial institutions, non governmental organisations, and private philanthropists which are involved in the distribution of social services besides Government institutions. There is however no umbrella institution to coordinate the services provided by these institutions for better coverage and delivery. The social safety nets are heavily favourable to the workers in the urban formal sector whereas the majority of the population lives in rural areas and employed in the informal sector.

>> MICROINSURANCE IN PAKISTAN

The purpose of a microinsurance scheme is to provide insurance coverage to persons excluded from formal systems of social protection – mainly informal economy workers and their families. The term "micro" does not refer so much to the size of these schemes as to their social moorings.

The microinsurance sector is relatively new in Pakistan. The first microinsurance providers were created in the 1980's and in the 1990's.

Since 32% households in Pakistan live below the poverty line, there is a large potential for microinsurance. If properly designed and delivered, microinsurance would help in reducing the vulnerability of low-income households.

There are examples of community health insurance within Pakistan; this involves not-for-profit pre-payment plans with voluntary membership. In general, the cost implications of administering policies in far flung rural areas when transferred to the insured generally make the premium unaffordable and standalone. However, microfinance institutions (MFIs) in Pakistan are attempting to address this issue by offsetting administrative costs in pilot projects; some initial encouraging results have been demonstrated. However, these systems suffer from the risks associated with their size and vulnerability.

At present, there is a panel of about 150 hospitals listed for health microinsurance clients all over Pakistan. The profit they earn out of the treatment of these clients is invested in the infrastructures, cost of radiology, lab facilities, operation theatres and many other amenities.

Pakistan still needs a sustained effort to raise awareness amongst its people with regard to the benefit of insurance, followed by the delivery of insurance products to the poor. There is also great scope in Pakistan to diversify microinsurance products, for example, crop insurance. Indeed, there is a dire need of agriculture microinsurance: in case of natural calamities farmers have to bear the loss of their crop and face default on credit. The need to cover risk and investments of marginalised farmers is of paramount importance.

Existing microinsurance providers in Pakistan : (alphabetical order)

- AKDN Aga Khan Development Network (www.akdn.org)
- BRSP Balochistan Rural Support Programme (www.brsp.org.pk)
- Development Action for Mobilization and Emancipation (DAMEN) (www.damen-pk.org)
- GBTI Ghazi Barotha Taraqati Idara (www.rspn.org/files/mo/gbti.htm)
- Kashf Foundation (www.kashf.org)
- NRSP National Rural Support Programme (<http://nrsp.org.pk>)
- PRSP Punjab Rural Support Programme (www.prsp.org.pk)
- Sindh Agriculture and Forestry Workers Coordinating Organization (SAFWCO) (www.safwco.org)
- SRSO Sindh Rural Support Organization (www.sindhrrsp.org)
- SRSP Sarhad Rural Support Programme (SRSP) (www.srsp.org.pk)
- SUNGI Development Foundation (www.sungi.org)
- TRDP Thardeep Rural Development Programme (www.thardeep.org)

For more information, also visit: www.rspn.org Rural support programme Network

>> GOVERNMENTAL STRATEGIES TO EXTEND MICROINSURANCE

In Pakistan, serious efforts for microinsurance at the national level only picked up in the last decade with the advent of Microfinance institutions (MFIs) and a mushrooming growth of NGOs. However, there is still scope for extensive growth in this area. The Government has been doing its part by providing support to the RSPs through the creation of SMEDA (Small and Medium Enterprises Development Authority) and recently by the State Bank of Pakistan's directive to all banks to have at least 20% of their branches in the rural areas. This will open up new avenues to infiltrate financing into crops, livestock and other basic requirements.

The Government of Pakistan is thus fully cognisant of the important role that microinsurance plays in providing risk-coverage to the poor, and also promotes microinsurance in the field of social protection. According to the Government of Pakistan, the Planning Commission of Pakistan is committed to developing and adopting "people-centric" development policies that meet the aspirations of the poor. The Government intends to focus on all concerned sectors like health, employment, food security, housing and social safety nets and deliver a comprehensive package for the poor. It is also working on microfinance policy. The Government is involved in many social protection programmes, one of which

is Benazir Income Support Programme (a cash grant programme being implemented nationwide and aiming to cover 3.5 million women during its first round).

The Planning Commission is also committed to organising roundtables workshops for gathering the viewpoints and perspectives of various experts and professionals for the development of the microinsurance policy.

Besides, the Asian development Bank (ADB) is also playing an important role in Pakistan in the microinsurance sector. From 2001-2008, the ADB had a \$150 million Microfinance Sector Development Programme which included \$80 million for on-lending, \$40 million for social development and \$20 million for community infrastructure. A more recent programme from 2006-2008 has been improving access to financial services of which one is microinsurance. A \$20 million grant has been given to the Government by the ADB which will be administered through the State Bank of Pakistan over the next 2 decades.

>> NATIONAL INITIATIVES TO EXTEND MICROINSURANCE COVERAGE

>> THE RSPN-ADAMJEE HEALTH MICROINSURANCE MODEL

The Rural Support Programmes Network (RSPN) was registered in 2001 under Pakistan's Companies Ordinance (1984) as a non-profit company by the Rural Support Programmes (RSPs) of Pakistan. RSPN is a network of ten RSPs. The RSPs involve poor communities, mainly but not exclusively rural, in improved management and delivery of basic services through a process of social mobilization. RSPN is a strategic platform for the RSPs, providing them with capacity building support and assisting them in policy advocacy and donor linkages. Currently the RSPs have a presence in 94 of the country's 138 districts and 2 Fata (Federally Administered Tribal Areas) Agencies.

Adamjee is a private company providing insurance. Pakistan is thus one of the countries in the world where a private insurance company has taken initiative to partner with RSPs to offer microinsurance.

The Adamjee-RSPN partnership started in 2005 – the very first health microinsurance scheme in Pakistan, providing hospitalisation and accident insurance to low-income rural population across the country who have organised themselves into community organisations (COs) fostered by the RSPs.

The RSPN-Adamjee health microinsurance scheme is Pakistan's first initiative of a kind designed to protect low-income people against a major health risk. The first policy for 'Hospitalisation and Personal Accident' was issued in 2005. The cover was simple and paid for hospitalisation charges due to illness or accident, and compensation in case of permanent disablement or accidental death. Six out of the ten RSPN members decided to participate: Balochistan Rural Support Programme (BRSP), Ghazi Barotha Taraqati Idara (GBTI), National Rural Support Programme (NRSP), Sarhad Rural Support Programme (SRSP), Sindh Rural Support Organisation (SRSO), and Thardeep Rural Development Programme (TRDP). RSPN took the lead in brokering the partnership with Adamjee Insurance for its member RSPs.

Within the first year, the scheme was able to provide health insurance cover to over 220,000 low-income individuals. Up until now, the RSPN-Adamjee model has

been able to reach out to almost 800,000 clients through an already established network of Rural Support Programmes (RSPs).

Initially the policy targeted the age group of 18-60 years only, whereby the issuance of policy and renewal were carried out on quarterly basis for a batch of insured persons as it was difficult to entertain people on an individual basis due to lack of software and adequate know-how. However, with the acquisition of technology, knowledge and expertise, now there is no age limit and, whenever a person wants, s/he can get a 12 month policy on a one-to-one basis. Furthermore, the RSPN-Adamjee policy was initially designed to provide cover for complications arising due to pregnancy and natural child birth was not catered for. However, at present, everything is covered by the policy for expecting mothers. The RSPN-Adamjee health microinsurance also decided to include the cost of transportation to medical facilities in the cover.

In the beginning, policy renewal presented a serious bottleneck with as low as 21% renewals per term as it was impossible to convince ordinary people from village communities to pay the premium again while they had not taken any claim. A lot of difficulty was encountered until an innovative idea was introduced by the National Rural Support Programme (NRSP). NRSP started capitalising on the programme's credit members as ambassadors for spreading the word about this scheme. The persons who took credit were also provided with insurance cover. The strategy was also effective in ensuring a quick spread. The enrolment increased, covering non-credit members also.

There is a potential risk attached to the credit provided to people regarding repayments in the event of the death of the person who has borrowed. Therefore, the same amount of premium also covers for the balance owed to RSP. In case of a natural death of credit members, if there is any balance left out of the sum ensured, it is paid out as a funeral expense to the family.

As compared to the credit members and the people who can afford to pay Rs.200-250 premium, there is a population that exists at the bottom of the heap - the people in the lower poverty band having no money. Since they cannot pay they don't come for credit to the RSPs. These are the people that need to be served. To reach out to this target population of the underprivileged and underserved, Adamjee and RSPN are working with the Government to pay the premium on their behalf and provide health care and personal accident insurance to them.

The claim status clearly establishes it as making perfect business sense. The loss ratio is around almost 50% at the moment, which essentially shows that the insurance company is also making profit. So, the people are provided a service and the insurance company also gets to make it a profitable business venture. The claims ratio of 39% makes good business sense for the Adamjee insurance company.

The data show that 65% are medical claims and 35% are surgical claims, whereby 69% of the medical claims are due to water borne diseases. Hence, one message for the policymakers is about ensuring adequate provision of safe drinking water.

>> MICROTAKAFUL IN PAKISTAN: THE TAKAFUL PAKISTAN MODEL

97% of the population in Pakistan are Muslim. Microtakaful are therefore very relevant in this country. Indeed, the takaful is an Islamic insurance concept based

on the principle of Ta'awun (mutual assistance) and Tabarru (voluntary contribution) where the risk is shared collectively by the group. It is operated on the basis of shared responsibility, brotherhood, solidarity and mutual cooperation or assistance, which provides for mutual financial security and assistance to safeguard participants against a defined risk.

There are many types of Microtakaful products available in Pakistan, which include property, health care, life and even education insurance. Potential areas of action are already being explored which are based on the immediate concerns of poor families, from the birth of their children to their education, business failure, unemployment, prolonged illnesses and deaths to marriages and construction of houses.

The insurance company Takaful Pakistan has already taken certain initiatives in this regard. It has already provided coverage to over 100,000 low-cost houses against earthquakes and other calamities. Takaful Pakistan is currently the only rated takaful company in Pakistan with nationwide presence in 14 cities. Takaful offers a viable alternative in the form of Islamic Shariah-compliant insurance - a form which has already been hailed as an ethical way of insurance due to better transparency and accountability.

Takaful Pakistan has built synergies with NGOs to work collectively towards a common goal. It has also addressed an extremely vital area, that of the workforce. Tailoring products according to needs, Takaful provides coverage for employees for accidental death, which offers compensation not just for that particular employee, but also covers the educational expenses for the children of the deceased employee. Other specially tailored products include coverage for ransom for kidnap, and hospitalisation benefits which are extended to family members. There are covers for factory workers, daily wagers, and students, credit coverage for Islamic microfinance - a form of microinsurance which does not have the riba element - and plans are already underway for crop Takaful. As per the principle behind MicroTakaful, all these are done on a 'no profit basis'. This does not mean that Takaful is in it for charity, but according to the concept of Takaful, the profit is transferred to the individual participant and translated to benefit the customers.

Sources :

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Updated in August 2009

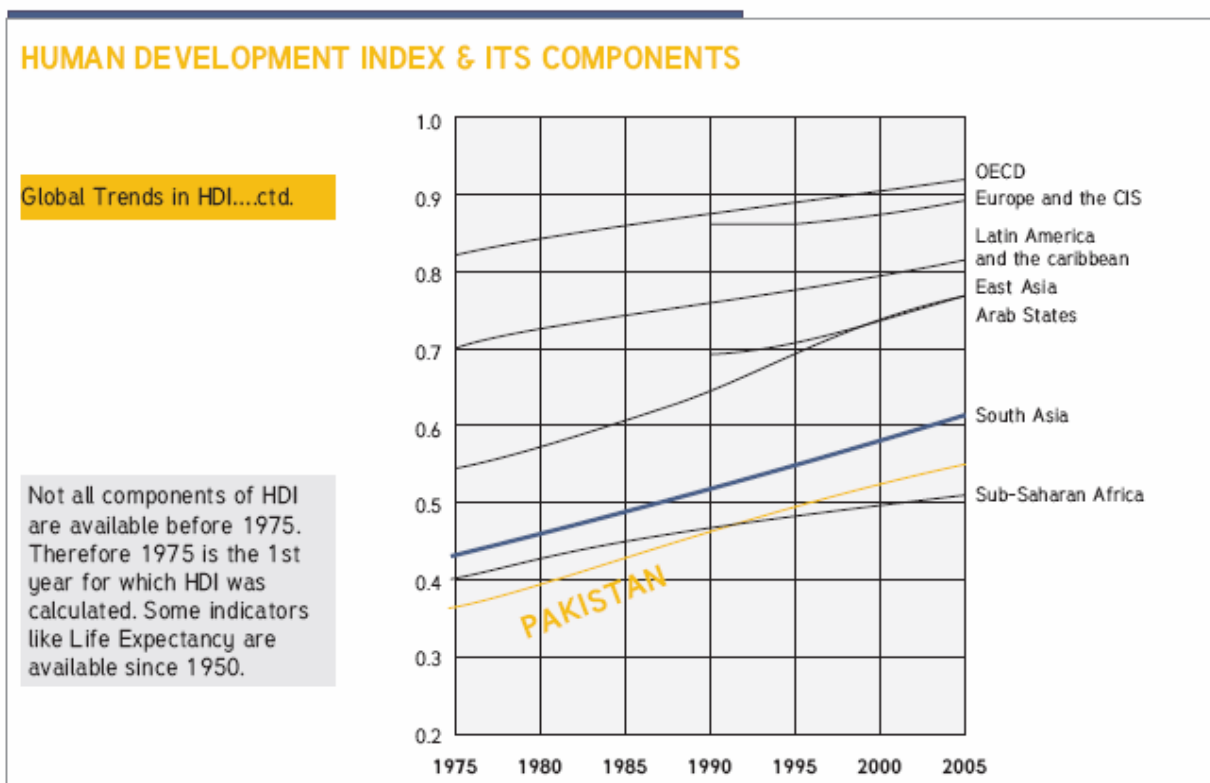
TABLES

A

HDI & PAKISTAN IN GLOBAL CONTEXT			
Life expectancy at birth (years)	Adult literacy rate (% ages 15 and older)	Combined pri., sec. and tertiary gross enrolment ratio (%)	GDP per capita (PPP US\$)
1. Japan (82.3)	1. Georgia (100.0)	1. Australia (113)	1. Luxembourg (60,228)
121. Bhutan (64.7)	122 Mauritania (51.2)	156. Ethiopia (42.1)	125. Papua New Guinea (2,563)
122. Bolivia (64.7)	123. Timor-Leste (50.1)	157. Papua New Guinea (40.7)	126. Ghana (2,480)
123. Pakistan (64.6)	124. Pakistan (49.9)	158. Pakistan (40.0)	127. Pakistan (2,370)
124. Comoros (64.1)	Cote d'Ivoire (48.7)	159. Senegal (39.6)	128. Angola (2,335)
125. India (63.7)	126. Nepa- (48.6)	160. Cote d'Ivoire (39.6)	129. Guinea (2,316)
177. Zambia (40.5)	139. Burkina Faso (23.6)	172. Niger (22.7)	174. Malawi (667)

Source: UNDP Human Development Report 2007-08: Pakistan ranked 136th / 177 with a HDI 0.551.

B

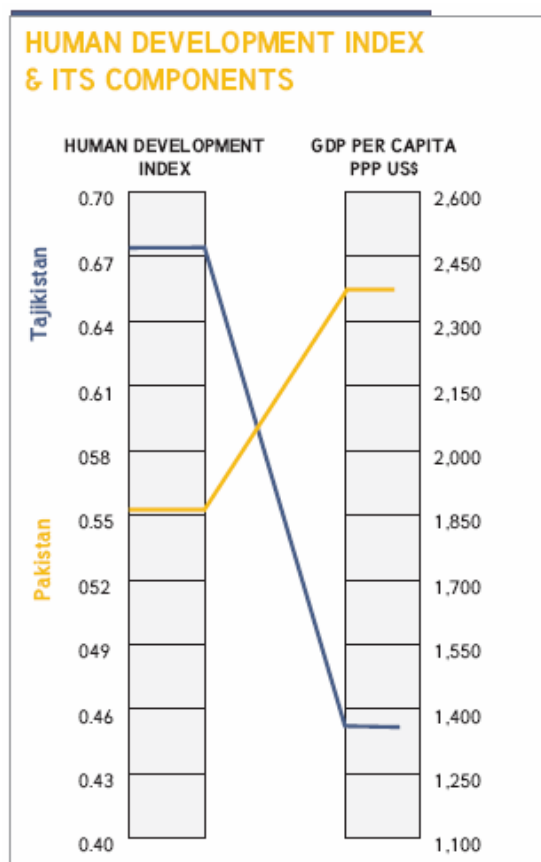


Source: Indicator table 2 HDR 2007/ 2008

C

PAKISTAN – KEY STATISTICS IN HUMAN DEVELOPMENT		
Sources #1: Pakistan MDGs Report 2004, United Nations Population Division #2: Pakistan Social and Living Standard Measurement Survey (PSLM) 2004/05 #3: World Health Report 2006 #4: Human Development Report 2005 #5: World Development Indicators 2005 (World Bank)	Total population (2005)(Ref 1)	157, 935 000
	% under 15 (2005) (Ref 1)	38
	Annual population growth rate (Ref 2)	1.92
	Total fertility rate (Ref 2)	4.07
	Population distribution % rural (2005) (Ref 1)	65
	Life expectancy at birth (2004) (Ref 3)	62
	Under-5 mortality per 1000 (Ref 2)	98
	Maternal mortality ratio per 100 000 live births (Ref 2)	350
	% GDP spent on health (Ref 2)	0.6
	Government expenditure on health as % of total government expenditure (Ref 2)	6.4
	Human Development Index Rank, out of 177 countries (2003) (Ref 5)	136
	Gross National Income (GNI) per capita USD (Ref 3)	600
	Population living below national poverty line % (1990-2002) (Ref 4)	32.6
	Adult (15+) literacy rate (Ref 4)	50
	Adult male (15+) literacy rate (Ref 2)	64
	Adult female (15+) literacy rate (Ref 2)	36
	% population with sustainable access to an improved water source (Ref 2)	90
	% population with improved access to Sanitation (Ref 2)	54

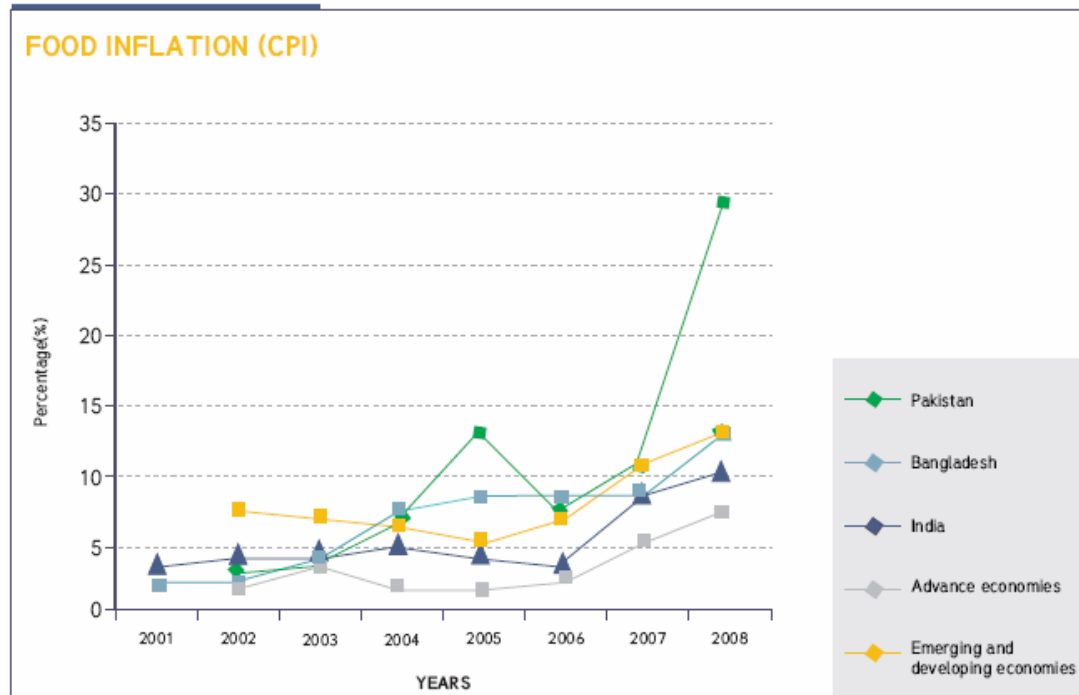
D



HDI and GDP data refers to 2005 as reported in the 2007/2008 report

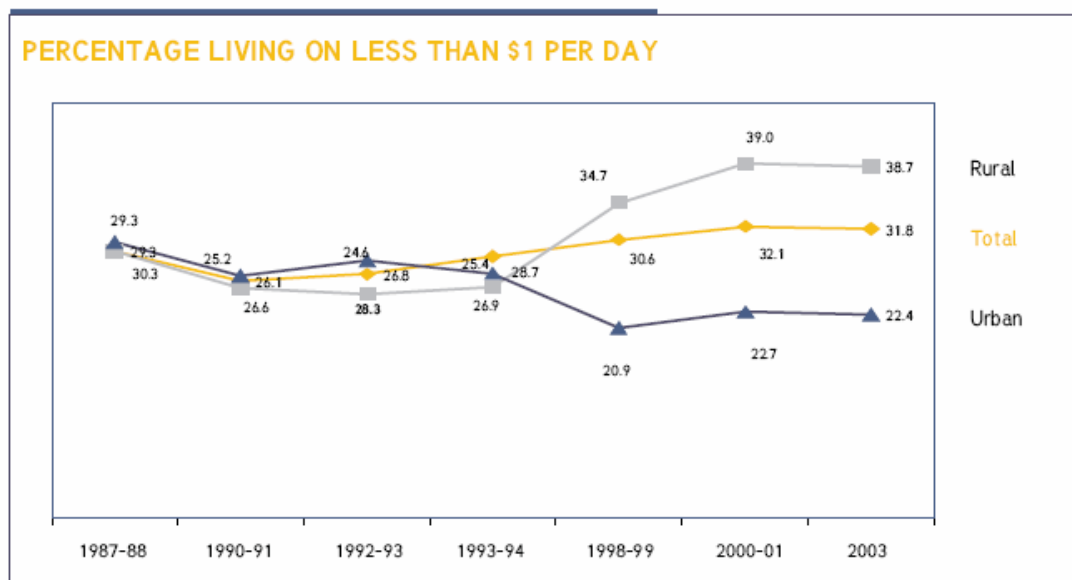
Source : UNDP Human Development Report 2007-2008 (idem supra)

E



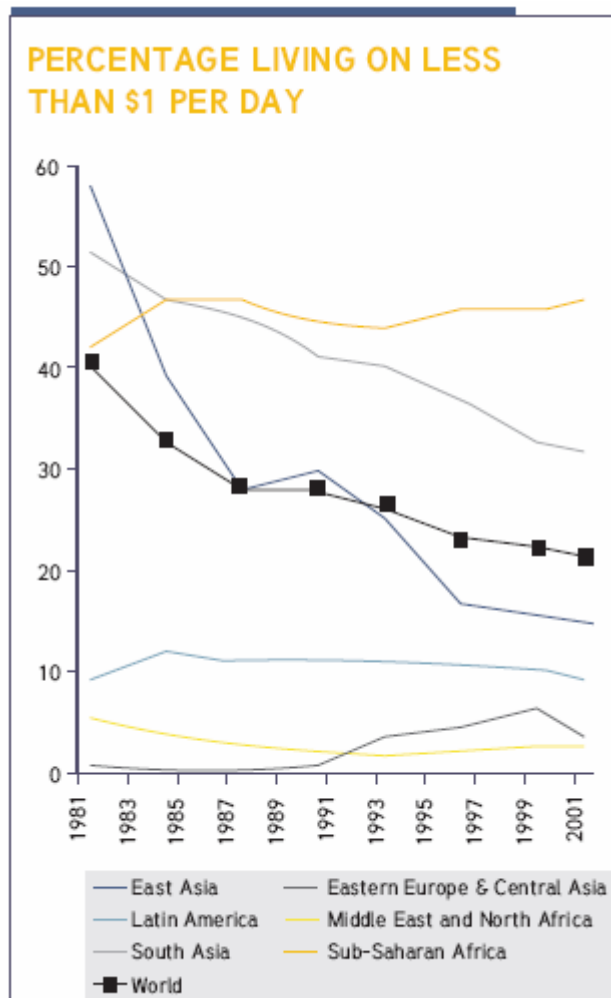
Source : Pakistan State Bank

F

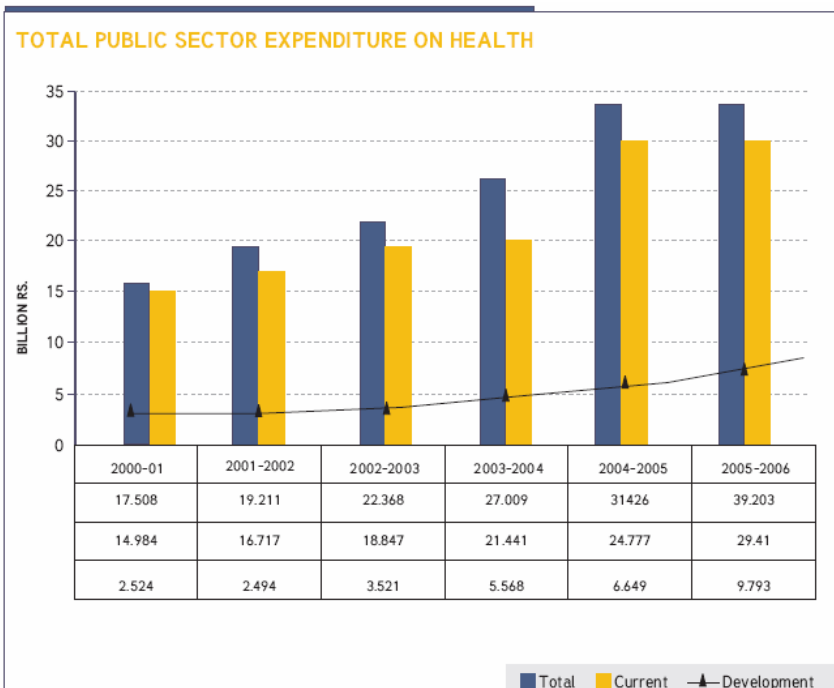


Source: Planning Commission 'Pakistan Economic Survey', 2002-03 (page 49) Centre for Research and Poverty Reduction and Income Distribution, Pakistan Economic Survey 2003-04 (page 43)

G

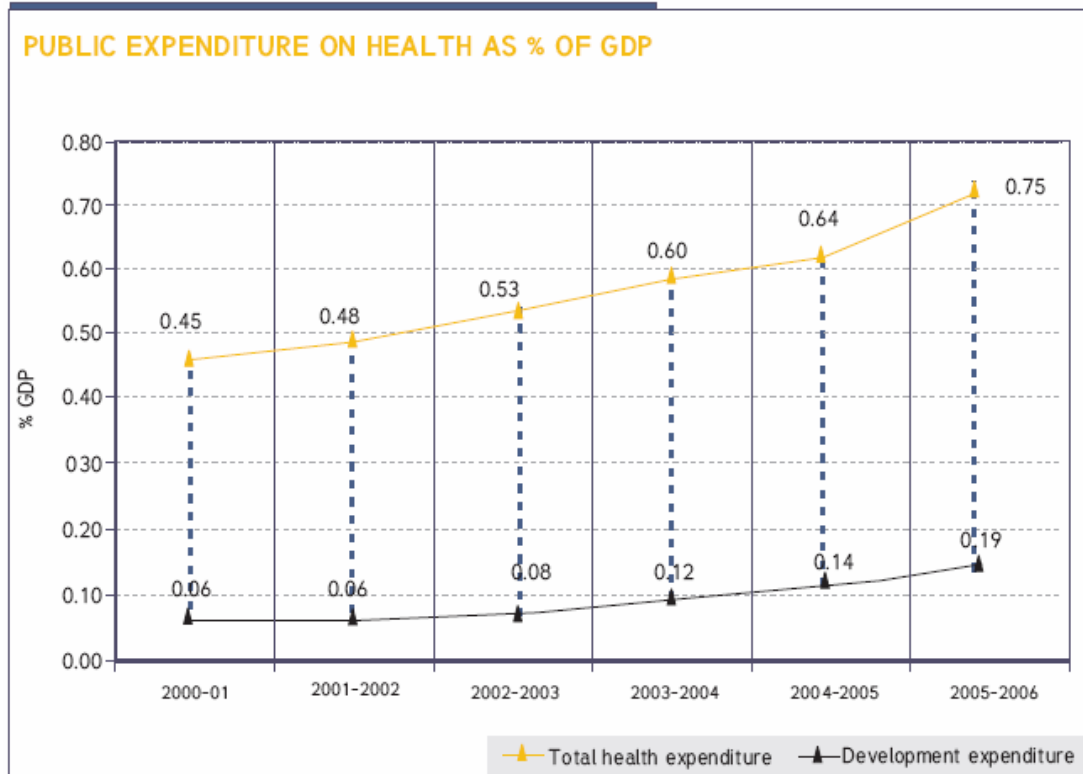


H



Source : NRSP with governmental figures ...

I



Source : NRSP with governmental figures