FIRST MICROINSURANCE CONFERENCE






17th December, 2008, Islamabad, Pakistan
Organised by the Rural Support Programmes Network in collaboration with the Department for International Development, Asian Development Bank, Adamjee Insurance and Pakistan Microfinance Network

The Rural Support Programmes Network (RSPN) would like to thank the Department for International Development (DFID), Asian Development Bank (ADB), Adamjee Insurance and Pakistan Microfinance Network for their interest and support to the First Microinsurance Conference. We are immensely grateful to all the speakers for their time and insightful presentations. We also thank all the participants and guests for making this conference a memorable experience.

Proceedings of the **First Microinsurance Conference** published in Pakistan (2009) by the **Rural Support Programmes Network (RSPN)**

Project Coordinator: Atif Ahmad
Compiled and Edited by Sumaira Sagheer, Mahvash Haider Ali
Reviewed by Khaleel Ahmad Tetlay, Aadil Mansoor
Art Direction by Sumaira Sagheer
Designed by Uzma Toor at Retroactive Studios, Lahore
Printed at Pangraphics Pvt. Limited, Islamabad

For further information, contact:
RSPN, House 7, Street 49, F 6/4, Islamabad, Pakistan
Tel: (92 51) 2822476, 2821736, Fax: (92-51) 289115
www.rspn.org

FIRST MICROINSURANCE CONFERENCE

17th December 2008, organised by RSPN in collaboration with DFID, ADB, Adamjee Insurance and PMN

The Rural Support Programmes Network (RSPN), in collaboration with Department of International Development-UK (DFID-UK), Asian Development Bank (ADB), Pakistan Microfinance Network (PMN) and Adamjee Insurance organised the First Microinsurance Conference in Pakistan in Islamabad on the 17th of December 2008. The conference was aimed at promoting a broader understanding of microinsurance and provided a platform for sharing experiences and lessons.

A cross section of participants, including practitioners from Rural Support Programmes (RSPs), national and international NGOs, microfinance institutions (MFIs), microfinance banks (MFBs), insurance companies, donors, representatives of the State Bank of Pakistan, and senior government officials, attended the conference to share and debate experiences and best practices in microinsurance for the low-income families in Pakistan and South Asia.

MICROINSURANCE IN PAKISTAN

The microinsurance sector is relatively new in Pakistan. According to the Landscape Report[1], the largest-ever study of microinsurance in a 100 countries, the market for microinsurance is estimated to be 1 billion people globally. According to the Planning Commission (Pakistan), CPRID[2] 2007, 32% households in Pakistan live below the poverty line, creating a large untapped market potential for microinsurance.

For the destitute, economic and natural shocks can mean that the entire family goes into a downward spiral of poverty. According to a World Bank study, 'Social Protection in Pakistan' (October, 2007), 54% of vulnerability of the poor arises from the hospitalisation of one member of the family and 40% are unable to come out of that poverty cycle even after three years.

The Rural Support Programmes Network, and its member Rural Support Programmes, work with a mission to alleviate poverty and increase the standard of living of the poor. In pursuit of this goal, RSPN, in October 2005, partnered with Adamjee Insurance to initiate the first health microinsurance scheme covering hospitalisation and accidents for rural residents in 87 districts of Pakistan through six RSPs. Within the first year, the scheme was able to provide health insurance cover to over 220,000 low-income individuals. The distinct advantage the RSPs brought to this partnership was the existence of Community Organisations through which the scheme was channeled. This enabled the RSPs to have vast outreach. It appears that the first year enrolment in this scheme was greater than any other health microinsurance programme anywhere in the world. As of June 2008, there are more than 764,000 rural clients insured by the RSPs. Currently, the RSPs engaged in this scheme with Adamjee Insurance include National Rural Support Programme (NRSP), Thardeep Rural Development Programme (TRDP), Sarhad Rural Support Organisation (SRSO) and Ghazi Barotha Taraqiati Idara (GBTI).

The Aga Khan Development Network (AKDN) launched its first health microinsurance programme in the Northern Areas in 2005 through National Jubilee Insurance (NJI), and credit life microinsurance with Kashf Foundation. In 2008, the First Microinsurance Agency (FMiA) was established by the AKDN as a corporate insurance agency in the country, currently covering more than 450,000 clients in the urban and rural areas across Pakistan.

1 The Landscape of Microinsurance in the World's 100 Poorest Countries, Roth, J., McCord, M. & Liber, D., The MicroInsurance Centre, LLC, April 2007
2 Centre for Research on Poverty Reduction and Income Distribution (CRPRID)

PROGRAMME

0900 -1000	**REGISTRATION**
1000	**ARRIVAL OF CHIEF GUEST** Mr. Sohail Safdar, Federal Secretary, Planning and Development Division, Government of Pakistan
SESSION 1	**INAUGURAL SESSION**
1000 -1005	Recitation
1005 -1010	**Welcome Address** Shandana Khan, CEO, Rural Support Programmes Network (RSPN)
1010 -1025	**Progress and Evolution of Microinsurance** Captain Mahmood Sultan, Sr. General Manager, Adamjee Insurance
1025 -1040	**Implementation of Microinsurance: The NRSP Experience** Dr. Rashid Bajwa, CEO, National Rural Support Programme (NRSP)
1040 -1100	**Health Insurance – A Regional Perspective** Ms. Rupalee Ruchismita, Institute of Financial Management & Research
1100 - 1115	**Microinsurance International Best Practices** Ms. Jeanna Holtz, International Labour Organization (ILO)
1115	**Key Note Address** Mr. Suhail Safdar, Federal Secretary, Planning and Development Division, Government of Pakistan
	Tea/Coffee/Refreshments
SESSION 2	
1145-1200	**MicroTakaful Beyond Philanthropy** Capt. M. Jamil Akhtar Khan, CEO,Takaful Pakistan Ltd.
1200 -1215	**Microinsurance in Sri Lanka** Mr. Peter Knoll, Financial Sector Specialist, ADB, Manila.
1215 -1230	**Market Demand of Micro Life and Health Insurance in Pakistan** Mr. Kaleem Abbas, CEO, First Microinsurance Agency
1230 -1245	**Crop Loan Insurance Scheme** Mr. Kazi Abdul Muktadir, MD, National, Institute of Banking and Finance
1245 -1300	**Insurance Client Presentations – NRSP and TRDP**
1300 -1330	**Q &ASession**
1330 -1430	Lunch
SESSION 3	**PANEL DISCUSSION**
1430 -1530	Expert Panel Discussion - Microinsurance Policy Framework
1530 -1600	Q & A Session
1600 -1610	Closing Remarks by Mr. Shoaib Sultan Khan, Chairman RSPN
1610	Onwards Tea/Coffee/Refreshments

OVERVIEW OF PROCEEDINGS

The conference was inaugurated by Mr. Suhail Safdar, Federal Secretary, Planning and Development Division, Government of Pakistan. Ms. Shandana Khan, CEO, RSPN opened the floor for presentations from Captain Mahmood Sultan, Sr. General Manager, Adamjee Insurance, Dr. Rashid Bajwa, CEO, National Rural Support Programme (NRSP), Mr. Peter Knoll from the Asian Development Bank, Manila, Ms. Rupalee Ruchismita from the Institute of Financial Management and Research, India, Ms. Jeanna Holtz from the International Labour Organisation (ILO), Geneva, Captain M. Jamil Akhtar Khan, CEO, Takaaful Pakistan, Mr. Kaleem Abbas, CEO, First Microinsurance Agency, and Mr. Kazi Abdul Muktadir, MD, National Institute of Banking and Finance (NIBAF). After the presentations, a panel discussion was held and questions were taken from the audience.

Presentations on insurance schemes and case studies were made by insurance companies and the role of delivery channel organisations, such as the RSPs and MFIs. A regional perspective was also brought into focus through presentations on experiences in India and Sri Lanka.

In order to understand the demand side of microinsurance, clients from communities working with the RSPs shared their first hand experiences in the microinsurance scheme. A panel discussion, addressing challenges and the future course of the microinsurance sector in Pakistan, was also a part of the agenda. Mr. Shoaib Sultan Khan, Chairman, RSPN concluded the conference with a note of thanks and insight from his years of experience in rural development.

Platform for Sharing Regional Experiences: Considering microinsurance is still at its early stages in Pakistan, the deliberations in the conference offered an opportunity for mutual learning.

A key lesson shared from Pakistan was the Adamjee-RSP experience. Captain Mahmood Sultan of Adamjee Insurance explained that while Adamjee had the expertise and experience of the technicalities of insurance, the RSPs brought in the advantage of being able to reach out to people across Pakistan and 'provide the numbers' (of clients). This could not have been done without the existing outreach of the RSPs to poor clients. Initially, the scheme adopted a cautious approach, as both parties were learning and experimenting. However, this learning was critical and changes in the insurance policy - the premium, and the cover - were made jointly over the years. Progress over the years has resulted in a scheme which, today, covers all age groups, adding new initiatives, such as a full pregnancy cover, transportation charges and induction of credit members.

The second presentation by Dr. Rashid Bajwa stressed on the importance of thinking out-of-the-box to come up with risk management solutions that are sustainable. He called upon the government and policy makers to focus on the rural areas through balancing the distribution of funds for development and non-development expenditures, saying that it was not so much an issue of money but an issue of how that money is allocated and spent, along with the need for serious policy reforms, particularly in the health microinsurance sector.

Rupalee Rushismita highlighted Indian best practices in microinsurance where community health insurance models have become successful over the past 8-10 years. She said that while the government was finally waking up to the fact that health microinsurance seems to be working, Pakistan is one of the few countries in the world where a private insurance company has taken the initiative to partner with RSPs to offer microinsurance. She also gave examples of successful initiatives and interventions in India whereby different models have been able to respond better to their clients' needs as well as address various challenges.

A global view of microinsurance innovations was also given by Jeanna Holtz who presented profiles of four different organisations from across the world which ILO is supporting and highlighted the innovations that set them apart.

The Secretary Planning and Development Division, Sohail Safdar, said that microinsurance is a key, potential contributor to the poverty reduction and social protection objectives of the government. It has also become an important risk mitigation tool for the poor of the country who have been hit hard by recent economic woes. He also explained the government's largest social protection programme, i.e. the Benazir Income Support Programme (BISP), which is a cash grant programme being implemented nationwide and aiming to cover 3.5 million women during its first round (in the current financial year), and, over time, reach out to 7 million rural households under the poverty line. An insurance instrument can later be dove-tailed with programmes, such as the BISP, as their target group is the same.

The presentation by Peter Knoll from the ADB offered insights into the rapidly expanding microinsurance industry of Sri Lanka, where people are quite familiar with microinsurance products, due to extensive outreach of financial services to the poor. Highlighting the role of donor support, particularly the ADB, in steering the course of a grant for microinsurance from the Japan Fund for Poverty Reduction and providing technical support to the governments of Vietnam, Philippines and Sri Lanka, Mr. Knoll cited the case of Sri Lanka, drawing up a close comparative analysis with Pakistan in terms of awareness, outreach and diversity of products and services. Whereas, the case of Sri Lanka offers many best practice examples for understanding the creative evolution of microinsurance in South Asia, Pakistan needs a sustained effort to raise awareness amongst its people with regard to the benefits of insurance, followed by the delivery of insurance products to the poor.

While the RSPs are there to bridge the gap between the buyer and the seller, there is still a large untapped market into which inroads can be made. There is also great scope in Pakistan to diversify microinsurance products, for example, crop insurance.

Kazi Abdul Muktadir, MD, National Institute of Banking and Finance stressed the need for agriculture microinsurance. In case of natural calamities, farmers have to bear the loss of their crop and face default on bank credit. He expressed that the need to cover risks and investment of marginalised farmers is of paramount importance.

Captain M. Jamil Akhtar Khan, CEO, Takaful Pakistan brought in an interesting perspective with the concept of 'MicroTakaful' insurance which offers Islamic Shariah-compliant products. He highlighted the efforts of Takaful Pakistan in covering more than 100,000 low cost houses in the wake of Pakistan's 2005 earthquake which devastated the north of the country.

Kaleem Abbas, CEO, First Microinsurance Agency, talked about the mechanism of ensuring crop insurance for the poor as a successful working model for microinsurance in Pakistan.

The conference concluded with a panel discussion on lessons learnt and Pakistan's future course of action in microinsurance policy. The policy is to be drafted in 2009. Experts analysed the reasons and factors for the success of microinsurance, discussing appropriate policies and products for the poor.

Shoaib Sultan Khan, Chairman, RSPN, concluded the conference by further emphasising the importance of microinsurance for the poor and the timeliness of the conference. He thanked the participants for coming together at a time when Pakistan is a new entrant into this field and can learn much from experiences worldwide.

SUHAIL SAFDAR
Federal Secretary, Planning and Development Division, Government of Pakistan

Mr. Suhail Safdar is serving as the Federal Secretary, P&D Division since April 2008. He has helped in preparing the Annual Development Plan (2008-09) for the Government of Pakistan. Mr. Safdar holds a Masters in Management (MSM) from USA and a Masters in English Literature from Lahore. He belongs to the 1973 Batch (1st Common) Training Programme of Pakistan Audit and Accounts Service (PMS) and was inducted into the Secretariat Group as Additional Secretary in October 2002. He served at various important positions such as Secretary Inter-Provincial Coordination Division, Secretary Women Development Division, DG Audit Punjab, DG Pakistan Audit and Accounts Training Institute, DG Accounts Works, DG Audit, Post, Telegraph & Telecommunication and DG Performance Evaluation (of public sector enterprise), Department of the Auditor General of Pakistan. He was elected as the President of the Pakistan Institute of Public Finance Accountants, Karachi in the year 2000. Mr. Safdar is also the author of four books of poetry in English and Urdu.

INAUGURAL ADDRESS

Mr. Suhail Safdar began by talking about the global recession and how these are trying times, particularly for those who are already economically disadvantaged. Microfinance - i.e. microcredit and microinsurance - is an important risk mitigation and poverty alleviation tool for the poor and potentially a key contributor to the poverty reduction and social protection objectives of the government. Currently, there are more than 4 million poor people who need to be served immediately and, microinsurance is a financial service which provides risk coverage to the poor. If properly designed and delivered, microinsurance would help in reducing the vulnerability of low-income households.

Mr. Safdar further added that the Planning Commission 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. He explained that the government is also working on a microfinance policy to develop cottage and agro-based industries in the country, especially in the rural areas.

The government is involved in many social protection programmes, he said one of which is the recently launched Benazir Income Support Programme (BISP) - a cash grant programme being implemented nationwide and aiming to cover 3.5 million women during its first round (in the current financial year). In the second phase, the programme would be enhanced to cover about 7 million households. To ensure transparency and the most effective utilisation of funds, the programme is working with different partners, like the National Rural Support Programme (NRSP) and the World Bank. Considering that there are about 40 million potential microinsurance clients in Pakistan, an insurance instrument can later be dove-tailed with programmes, such as the BISP, as their target group is the same.

Speaking on behalf of the government, Mr. Safdar said it is fully cognisant of the important role microinsurance plays in providing risk coverage to the poor, which has been amply demonstrated by the success of the RSPN-Adamjee initiative. The Planning Commission is committed to organising roundtable workshops for gathering the viewpoints and perspectives of various experts and professionals for the development of the microinsurance policy, the report on which will be taken to the Prime Minister for action. Mr. Safdar concluded his address by saying that the role of the Planning Commission is to act as a platform and help the policymakers arrive at the best possible solutions for the people of Pakistan.

CAPTAIN MAHMOOD SULTAN
Sr. General Manager, Adamjee Insurance, Pakistan

Captain Mahmood Sultan started his professional life as a seafarer. A master in navigation, he commanded ships around the world for fourteen years. He left the sea after 22 years of service and joined Adamjee Insurance in 1988 with full insurance qualifications which he acquired by passing the highest examinations in the industry. He is a fellow of International Chartered Shipbrokers London and also a fellow of the Chartered Insurance Institute, London. Captain Mahmood heads the Corporate Division of Adamjee and is the person who pioneered microinsurance in Pakistan through the RSPs.

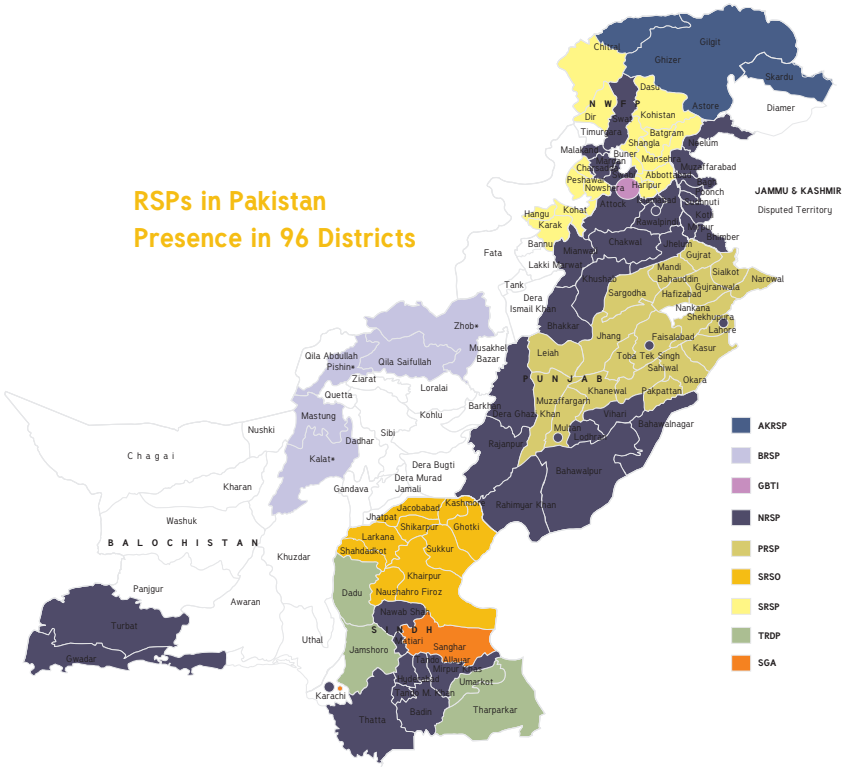
1. PROGRESS AND EVOLUTION OF MICROINSURANCE

Captain Mahmood Sultan deliberated on the partnership between Pakistan's largest commercial insurer, Adamjee Insurance Company Limited (Adamjee), and the Rural Support Programmes Network (RSPN) - the largest network of Rural Support Programmes (RSPs) in Pakistan. The Adamjee-RSPN partnership started on 1st October 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 idea of providing insurance protection to the poor communities of the rural areas was inspired by Captain Sultan's chance visit to the remote and marginalised communities of Northern Pakistan. While the RSPs were geared towards improving the quality of life of the poor, both anecdotal and other evidence suggested that the presence of a safety net for dealing with health and illness was needed. A serious illness, an accident or death, particularly of the bread earner means the entire family goes into an endless spiral of poverty. According to a World Bank study, 54% vulnerable poor arise from the hospitalisation of one member of the family and 40% do not recover from it even after 3 years. The issue was serious and had to be dealt with.

An insurance company, on its own, has to spend huge sums to mobilise a large field force to transfer insurance to grassroots policyholders, which makes the whole scheme unsustainable. RSPN and RSPs demonstrate successful grassroots initiatives based on the participatory approach of community mobilisation. The presence of the RSPs at the grassroots level, with outreach to two million rural households and a network of 130,000 Community Organisations (COs) across 93 districts of Pakistan, presented a tremendous opportunity to tap into an already established large spread of community organisations for the launch and transfer of health microinsurance to the grassroots communities across Pakistan. The larger the spread (outreach), the less costly it becomes to transfer the insurance to policyholders.

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 on 1st October 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 Taraqiati 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.

The popularity and success of this programme can be seen in Figure 1, which shows the number of persons insured. Starting off with the enrollment of 220,932 members insured for the first time in their lives, the number is reaching 800,000 within 3 years. It appears that the first year enrolment in this scheme was greater than any other health microinsurance programme in the world at that time.

Initially, the RSPN-Adamjee scheme adopted a cautious approach as both parties were learning and experimenting. However, this learning was critical and changes in the insurance policy i.e. the premium and the cover, were made jointly over the years. 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 cost of transportation to medical facilities is a very big impediment in rural areas, particularly for people living in remote and harsh areas like Thar or the northern areas of Pakistan. In order to transport a sick person, a vehicle has to be hired and the cost of rent is anywhere between Rs. 3000 to Rs. 5000. So, the RSPN-Adamjee health microinsurance decided to include this 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

GoPs POVERTY BANDS IN AN AVERAGE UC

GoP Def:	RSP Def:	%	Households
Non poor	Rich	15	425
Transitory non poor	Well to do	32	895
Transitory Vulnerable	Better off	20	567
Transitory Poor	Poor	20	559
Chronically Poor	Very Poor	10.4	289
Extremely Poor	Destitute	1.6	44
Total Households		100	2,781
Target Households			1,460

Source: Planning Commission, CPRID 2007

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. As the scheme was good enough to generate its own publicity whenever claims were received in the far flung corners of the rural areas, the whole neighbourhood eagerly asked for cover. The enrolment increased, covering non-credit members also. It was an important lesson to learn from.

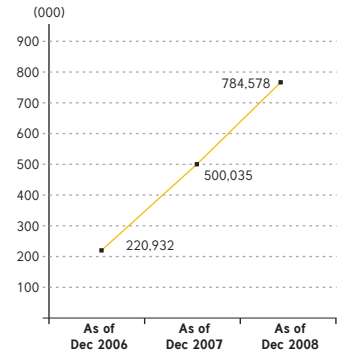
There is a potential risk attached to the credit provided to people regarding repayments in the event of the death of the person who has borrowed. Therefore, the same amount of premium also covers for the balance owed to RSP. In case of a natural death of credit members, if there is any balance left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

Two cases were cited to further reinforce the importance of the health microinsurance cover for the entire family. In one instance, that took place in Nagar Parkar of District Thar, a young woman lost her husband in a road accident. Left with two small children, she could have been quite vulnerable if her husband had not taken the insurance. She received a sum of Rs. 25,000 from the DCO of Nagar Parkar as part of the insurance cover, which helped her buy a cow and start her life all over again. In another case, there was a person in Mithi, District Thar, whose son was bitten by a snake. Since he had taken the insurance, he called for a vehicle and took his son to the Mithi hospital, where anti-venom and other treatment facilities were readily available to help save the life of his son. In a similar incidence, a young boy with a snake bite was taken to a local saadhu (quack) instead of a certified doctor since the family had no means to generate money for proper hospitalisation of the boy, and consequently, he could not survive.

The biggest spin-off, as a result of the health microinsurance programme, has been the unusual increase in the number of clients for private hospitals, along with improvement in the access and provision of medical facilities in rural areas. Previously, the local people could not afford private hospitals, and therefore, ended up in the government hospitals. All of a sudden, the private hospitals found themselves dealing with an increased number of patients from rural areas because now their bills were settled by insurance companies. This has been a positive development regarding access to quality health facilities at the grassroots level.

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 infrastructure, cost of radiology, lab facilities, operation theatres and many other amenities. The most important factor that has added value into the system is the

MICROINSURANCE OUTREACH



introduction of lady doctors who were previously usually reluctant to work in these areas. For instance, in the last 60-year history of Pakistan, there was never any hope for the people of an area as remote as Mithi in District Tharparker to receive treatment in gyneacology. Today, there is even the facility to do caesarean operations. This is a remarkable achievement. The hospitals in these areas do all kind of operations, and treat pregnancy-related complications in Mithi, Nagar Parkar, Umerkot, and Southern Punjab.

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. For example, in the province of Sindh, an arrangement is being finalised to reach out to 450,000 - 600,000 households in 23 Districts. If this comes through, this programme will have a tremendous boost at the provincial level as others will also follow suit in Punjab, NWFP and Balochistan, bringing those people, who cannot benefit from microinsurance schemes if left on their own. Table 1 indicates the immediate jump this programme will have in Sindh only.

TABLE 1: MICROINSURANCE FUTURE ROADMAP

Family Package for the Province of Sindh	
450,000 to 600,000 Households/Year	
Proposed Date January 1st, 2009	
Profile of Sindh Rural	
Districts	23
Rural Union Councils	885
Total Rural Households	2,978,107
Average Households/Union Council	3,365
Average Goth in Union Council	20
Total Union Councils in Sindh	1,100

Source: GOS LG Dept

DR. RASHID BAJWA
Chief Executive Officer, National Rural Support Programme, Pakistan

An eminent development professional, Dr. Rashid Bajwa is leading the only countrywide development programme (National Rural Support Programme) in Pakistan. He holds an MPH degree from the UK and an MBBS from Pakistan. He has extensive experience in the fields of management, social mobilisation, community development, microfinance and policy. Dr. Bajwa is implementing one of the largest microfinance programmes in Pakistan; has helped in setting up Khushaali Bank, Pakistan while also providing guidance to other non-profits as Chairman of Pakistan Microfinance Network, Director of Khushaal Pakistan Fund, Punjab Rural Support Programme and Sindh Rural Support Organisation.

2. IMPLEMENTATION OF MICROINSURANCE - THE NRSP EXPERIENCE

According to Dr. Rashid Bajwa, for microinsurance to fulfill its potential, it is necessary to design out-of-the-box, risk-management solutions that are affordable as well as sustainable to respond to the primary needs of the poor in Pakistan. He made a case by referring to the position of Pakistan on the global Human Development Index (HDI). It is alarming to know that Pakistan ranks 136 on the HDI scale, which is very low in life expectancy, adult literacy and gross enrollments, almost bringing it close to Sub-Saharan Africa.

Surprisingly, Pakistan is at a higher GDP per capita as compared to low ranking in terms of HDI. Therefore, the issue is not the lack of capital, but equitable distribution and allocation of funds amongst the population, particularly the vulnerable groups.

HDI & PAKISTAN IN GLOBAL CONTEXT

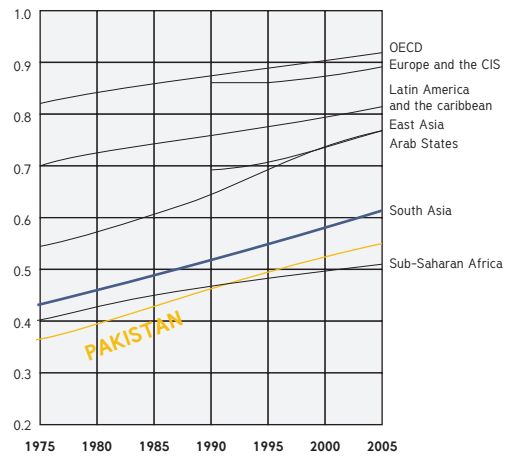
Life expectancy at birth (years)	Adult literacy rate (% ages 15 and older)	Combined pri., sec. and tertiary gross enrolment ratio (%)	GDP per capita (PPP US$)
1. Japan (82.3)	1. Georgia (100.0)	1. Australia (113)	1. Luxembourg (60,228)
121. Bhutan (64.7)	122 Mauritania (51.2)	156. Ethiopia (42.1)	125. 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'Ivore (48.7)	159. Senegal (39.6)	128. Angola (2,335)
125. India (63.7)	126. Nepa- (48.6)	160. Cote d'Ivore (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.

HUMAN DEVELOPMENT INDEX & ITS COMPONENTS

Global Trends in HDI....ctd.

Not all components of HDI are available before 1975. Therefore 1975 is the 1st year for which HDI was calculated. Some indicators like Life Expectancy are available since 1950.



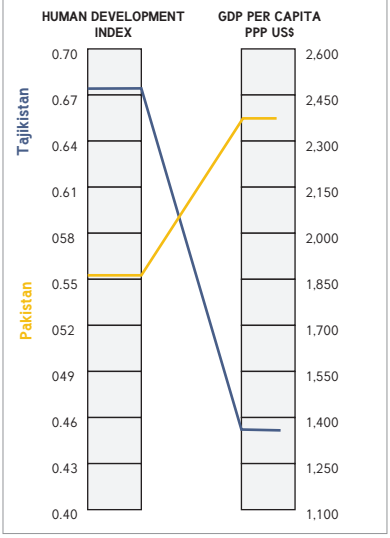
Source: Indicator table 2 HDR 2007/ 2008

PAKISTAN - KEY STATISTICS IN HUMAN DEVELOPMENT

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

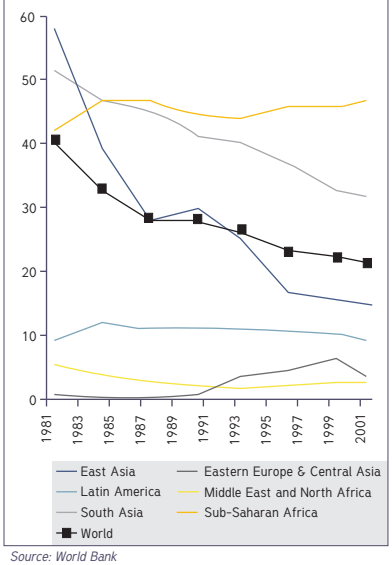
Sources
#1: Pakistan MDGs Report 2004, United Nations Population Division
#2: Pakistan Social and Living Standard Measurement Survey (PSLM) 2004/05
#3: World Health Report 2006
#4: Human Development Report 2005
#5: World Development Indicators 2005 (World Bank)

HUMAN DEVELOPMENT INDEX & ITS COMPONENTS



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

PERCENTAGE LIVING ON LESS THAN $1 PER DAY

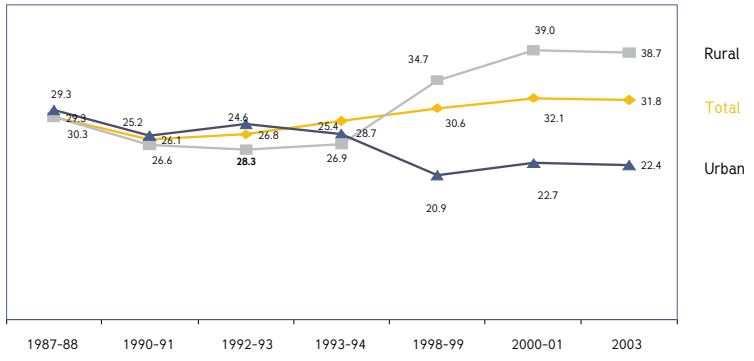


Source: World Bank

According to the Government of Pakistan's estimate, 32% of the population lives below the poverty line, indicating an overwhelming incidence of poverty in the rural areas, which is close to almost 40 percent. So, it becomes obvious that greater efforts need to be invested in rural areas. To this end, the Rural Support Programmes are making their contribution felt as vehicles for service delivery by reaching out to the poorest and most vulnerable population in the rural areas of Pakistan. However, this does not imply that one moves away from the urban areas. The focus of microinsurance should be inclusive, extending coverage to the needs of low-income people everywhere.

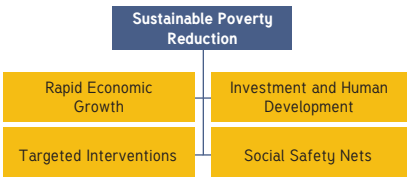
The above figure is taken from the Planning Commission that offers a model for Sustainable Poverty Reduction developed by the Government of Pakistan, including four key areas of Rapid Economic Growth, Investment and Human Development, Targeted Interventions and Social Safety Nets. What just might be added is an RSP perspective of community mobilisation. It is difficult to achieve success at the grassroots until and unless the communities are mobilised and organised, ensuring representation and participation of the poorest. Therefore, the overarching agenda for action is

PERCENTAGE LIVING ON LESS THAN $1 PER DAY



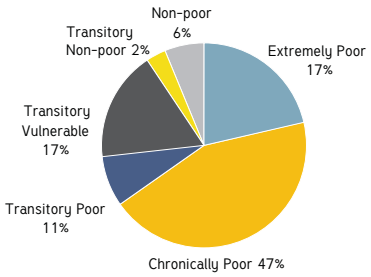
Source: Planning Commission ' Pakistan Economic Survey', 2002-03 (page 49) Centre for Research and Poverty Reduction and Income Distribution, Pakistan Economic Survey 2003-04 (page 43)

CONCEPTUAL DESIGN OF POVERTY REDUCTION STRATEGY IN PAKISTAN



Source: Dr. Ishrat Hussain, Ex Gov. SBP

ZAKAT RECIPIENTS IN UC 65 VEHARI



'social mobilisation' which sits on top of the mandate for poverty reduction.

Targeted Interventions refer to off-farm, skills enhancement, rural works programme, income generation for the bottom poor and microfinance. With respect to Social Safety Nets, there's an interesting example of a Union Council (UC) in Vehari, where NRSP has implemented the poverty score card.

After surveying each household in this particular UC, a high incidence of poverty was noticed, with the extremely poor and chronically poor population as 17% and 47% respectively. Vehari is the key area of cotton production and if this is the situation there, one can imagine what is happening elsewhere. A look at the distribution of Zakat in Vehari shows that the recipients include not only the 'deserving poor' but even the 'non-poor' - which is 6% - and the transitory vulnerable. So, this validates the argument that if there is a skewed and uneven distribution, then the efforts of the government will not produce encouraging results. Perhaps it is a consequence of these actions which places Pakistan in the lower rungs of the HDI.

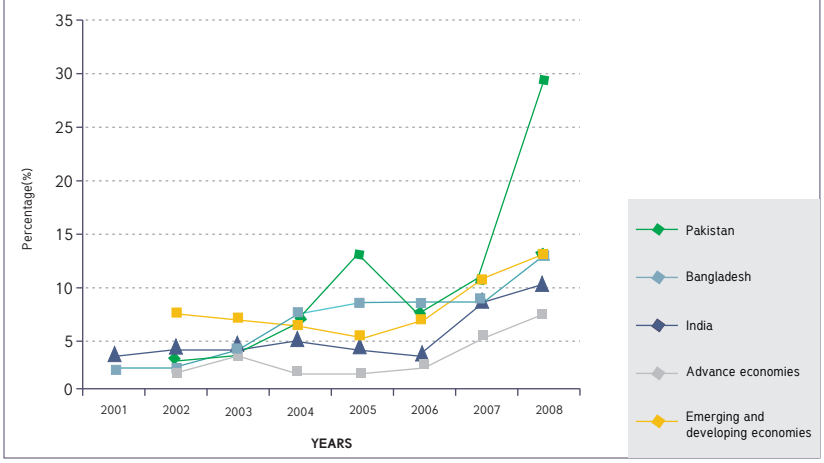
All this gives rise to some fundamental questions. Do social safety nets matter? Particularly, do they matter to people who do not have any disposable income; people who are assetless and can only earn enough to eat and survive? What is the vital link between social safety nets and health investments - the health insurance? And does the combination of a social safety net and health investment have a different affect on poverty or not?

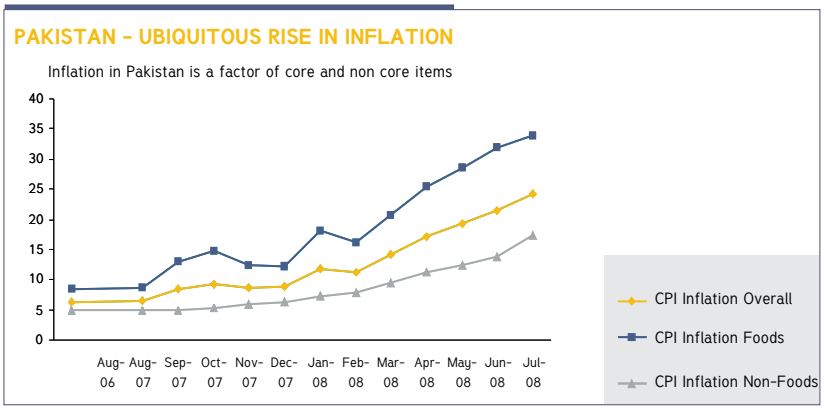
Implications of Economic Shocks to the Ultra Poor Households:

This is a graph which shows inflation in food prices over the years. It is alarming to see where Pakistan is heading. What happens to those people who just have enough income to eat? One can only guess that they are reducing their intake of calories, and becoming susceptible to more health hazards.. The trend is getting higher with ubiquitous rise in inflation. According to the State Bank of Pakistan figures, food is the primary driver of inflation.

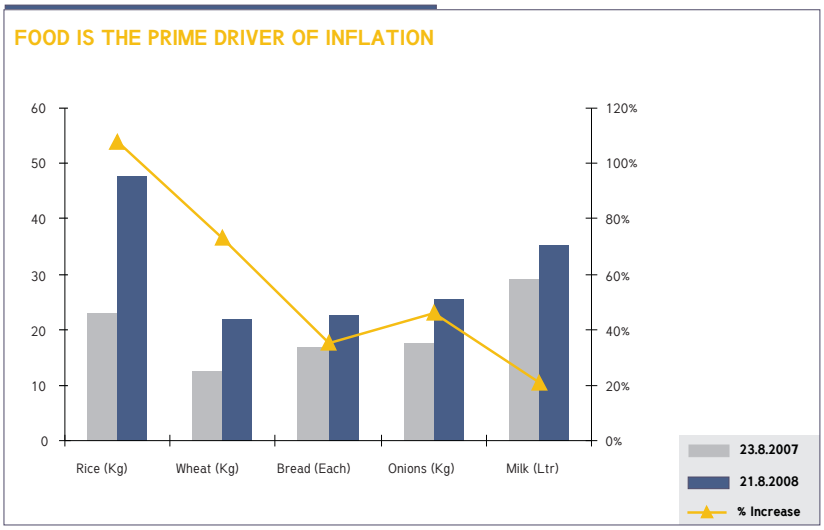
Linking the above-mentioned phenomenon with a World Bank report on Pakistan published in 2007, the implications of economic shocks to the ultra-poor households can easily be identified. According to the World Bank, 54% of people are vulnerable because of the hospitalisation of one member of the family. This shows that if a family member is hospitalised, suddenly the entire budget of that family goes into a spin. Here, the important thing

FOOD INFLATION (CPI)





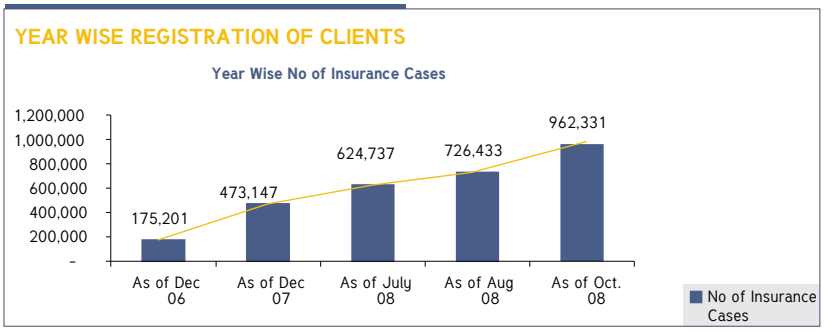
Source: State Bank of Pakistan



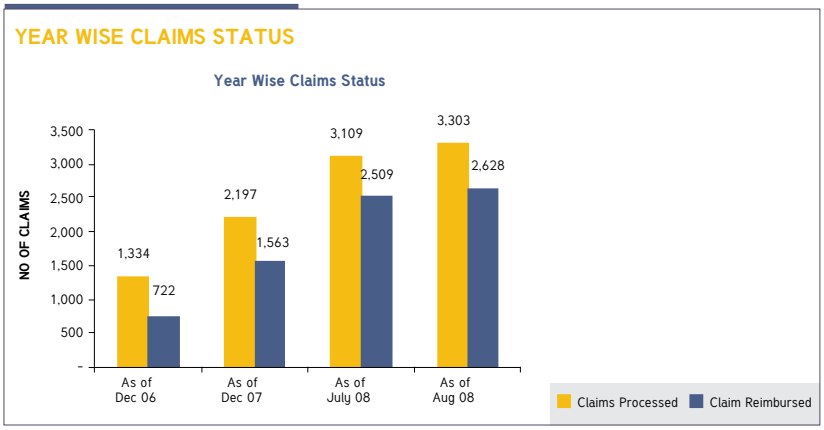
to consider is that 43% of such people, who fell into poverty because of ill-health, were unable to come out of the shock even after 3 years. The implications of hospitalisation for a breadwinner are obvious. First, he gets indebted, then loses non-productive assets like jewellery, and finally sells the 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 (slums). Once the implications triggered by these economic shocks are understood, it becomes obvious that the ultra-poor need 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 our tertiary hospitals like teaching hospitals, for example, the Pakistan Institute of Medical Sciences (PIMS), what do we see? 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.

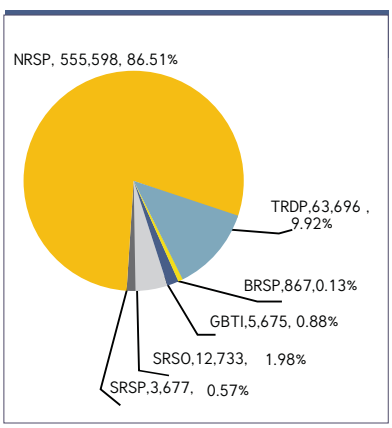
What are the options? One option is that the government provides hospitalisation cover through some insurance mechanism. But it can only do so if the price and transaction cost of the premium is affordable and sustainable. In other words, if a premium is to be paid (by the individuals or households on one to one basis), then the cost of



Clients information Submitted to Adamjee Insurance

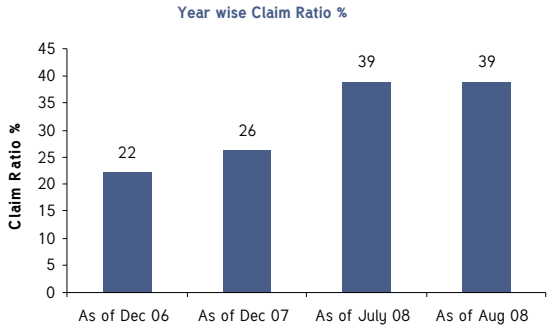


collection of the premium must be less than the premium itself. This is one key consideraton for the insurance provider. If the premium is small, and the cost to collect the premium is high, then it never becomes sustainable. For instance, if one goes to a village to collect one or two hundred rupees, the issue is not that people are not willing to pay that amount; the real issue is actually the operational cost to collect these two hundred rupees, which amounts to perhaps three hundred rupees. So, it's a "zero sum" game, which ultimately becomes non-sustainable. The only way it can become sustainable is when the cost of recovery of that premium is less than the premium itself. That's why the National Rural Support Programme (NRSP) linked up with the credit clients for the implementation of health microinsurance. The model worked as the credit clients were already coming to NRSP and it just happened to dovetail this service to an already established distribution channel. This involved no collection cost. Dr. Bajwa proposed that such a model has to be exercised by the government because the government spends a lot of money on social protection measures. However, the government, obviously, will be interested, if it is affordable and sustainable.



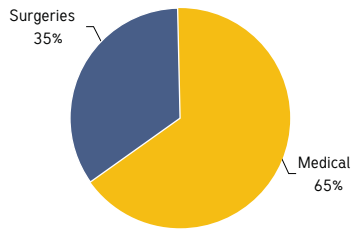
The RSPN-Adamjee model works in Pakistan. Up until now, it has been able to reach out to almost 800,000 clients through an already established network of Rural Support Programmes (RSPs). There are various aspects of how this model is made to work; for instance the sustainability is not just by the provider who is collecting the premiums. The sustainability factor has to come from the service provider also - the insurance company. Unless, the insurance company feels that the proposition makes profitable business sense, why would it be interested? 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

YEAR WISE CLAIMS STATUS

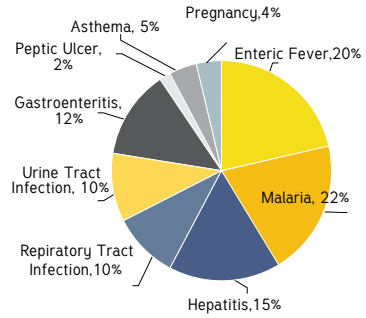


Adamjee is making profit; people are benefiting; RSPs poverty agenda is being met

TYPE OF HOSPITALIZATION CLAIMS

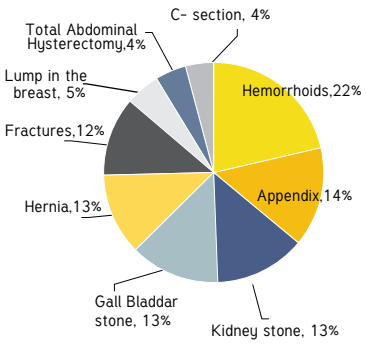


DATA OF MICRO HEALTH INSURANCE MEDICAL CLAIMS



69% water borne diseases Development

SURGERIES



profitable business venture. This emphasises the difference a good implementation strategy can make between a scheme's success and failure.

Another important factor that comes out from the data is 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. It is not enough to have one treatment unit in one UC nor is it going to solve the problem. Pakistan's Clean Drinking Water Initiative (CDWI) has to have a coverage which is universal, which can save 65% of its ailing population. This has nothing to do with either immunisations or the role of the Lady Health Workers. These initiatives are already in effect, yet despite that, this is what is happening on the ground. Out of the 35% on the surgical side, 22% are for the treatment of hemorrhoids because of adulterated oil and ghee (saturated fat). There are a lot of policy outcomes linked with this kind of data. For instance, the 5% increase in breast cancer in the country is alarming and must be addressed.

The claims ratio of 39% makes good business sense for the insurance company – and for everyone else. Although some are of the view that it is too low and that people are not being told that it is an insurance product, but this is just the beginning, and as the programme gains further momentum, and lessons are learnt, there will be supporting information and education campaigns to spread further awareness about health insurance and its benefits to the poor.

What are the challenges for RSPN-Adamjee Microinsurance Model:

1. Delinking microinsurance with the credit client and expanding outreach: The National Rural Support Programme (NRSP) linked microinsurance with credit, it was called Credit Insurance for poor clients. As a compulsory product linked to an existing delivery channel, it proved to be a viable model, creating a clear management focus for achieving efficiency. Now the next step is to delink it with the credit client and link it with poor clients to expand across populations.
2. Accessing government's social protection: If the government looks at it as a social protection measure, then it obviously provides a cover across the population and that is something which can be done very easily. And if it is already done for the first million clients, the model can be replicated for others also.
3. Integration of technology: The next important aspect is integration of technology through which the cost can be brought further down. And by reducing

the operational cost by the intermidiary and acturial cost by insurance provider, the total premium becomes even more affordable.

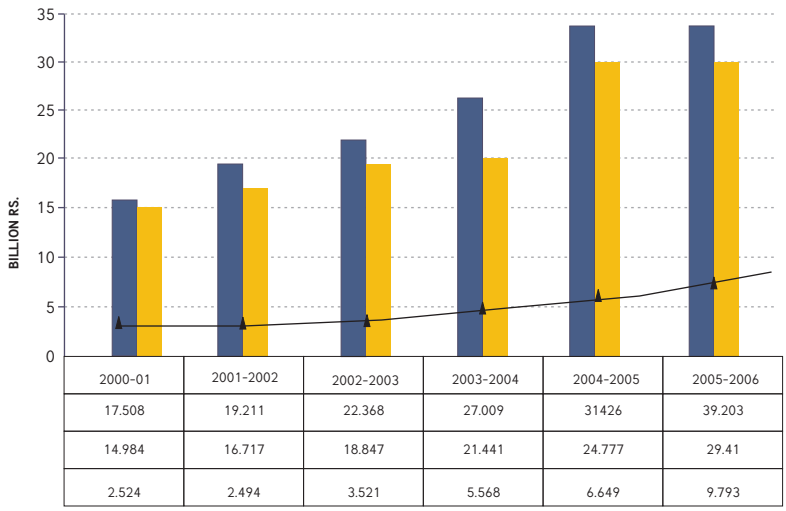
4. Shift from reimbursement to direct payment: Another important factor is to create a shift from reimbursement basis to direct payment, which means that the client comes and pays for the hospitalisation. NRSP has tried and tested the cash-less system. For higher population coverage, it is impossible to do this on reimbursement basis, because of the probability of high incidence of frauds. So, the disbursement mechanism needs to be reviewed carefully.
5. Diversify to include affordable medical day care: With increasing number of medical claims, a change in the policy from expensive hospitalisation for medical treatment to an inexpensive day care system must be considered, particularly for general ailments where a patient needs simple care, unless it is a serious injury or some other medical complaint that needs immediate hospitalisation.

A message for the policymakers:

- **Seeking balance:** The state spends only 0.75 % on health care services depending on the development and non-development side of the health expenditure. One can see the expenditure increasing, but that rise is mostly towards the non-development side catering to more staff, doctors and nurses. The expenditure tends to be low on the development side in terms of provision of medicines, and goes static as shown in the given figures on the next page. The non-development side started from 0.45% of the GDP in year 2000 and has gone up to 0.75%. Therefore the policymakers need to look into this area, as an equitable balance must be struck between the development and the non-development expenditure.
  Pakistan spends 80% of its meagre health care budget on tertiary services utilised by only 15% of the privileged population, which is absolutely unacceptable! There is need for a firm policy reform in this case.
- **An out-of-the-box approach:** One has to creatively devise models which work. If we implement microinsurance across the population, what should the price be? As shown in the figure ('The Bill' on the next page), we are a nation of 160 million, with an estimated 40% of the population living below the poverty line. If the price (premium) is Rs. 100 per head, including overheads and other expenses, it is still only Rs. 6.4 billion (US $ 80 million) for one year. In terms of purchasing power parity GDP, it is only 0.02 percent, and in terms of real GDP, it is 0.06 percent.

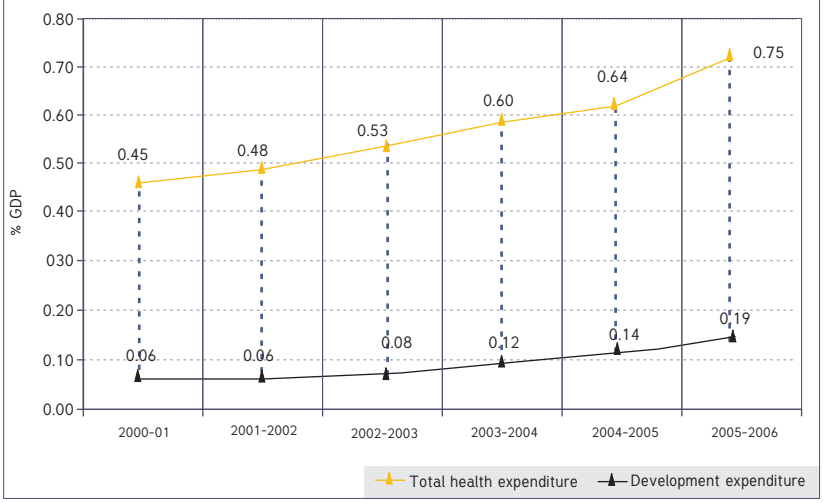
To this end, the Government of Pakistan is planning to implement the Union Council-wise holistic development plan and health microinsurance is one component of this package.

TOTAL PUBLIC SECTOR EXPENDITURE ON HEALTH



	2000-01	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006
Total	17.508	19.211	22.368	27.009	31426	39.203
Current	14.984	16.717	18.847	21.441	24.777	29.41
Development	2.524	2.494	3.521	5.568	6.649	9.793

PUBLIC EXPENDITURE ON HEALTH AS % OF GDP



THE BILL

Total Pop.	160,000,000
Pop. Below Poverty line @40%)	64,000,000
Insurance cost @ Rs. 100 per capita (all overheads)	6,400,000,000
% of Total GDP (ppp 2006* rates)	0.02%
% of total GDP (real 2008):	0.06%

The Way Forward:

Focus on technology will reduce the intermediation cost, the loss ratio and premiums will become more affordable.

Change agents to champion a cause across the board are also needed. For example, when NRSP started with 3 BHUs in Lodhran, it took about 6 months to manage them. Later, when Mr. Jehangir Tareen championed it, it became the Chief Minister's Punjab Primary Health Care Initiative, then the President's Primary Health Care Initiative and now the People's Health Care Initiative. Similarly, the Benazir Income Support Programme (BISP) is a model based on a cash transfer of one thousand rupees per individual. The BISP is geared for distributing Rs. 3.4 million with 19% allocation for health microinsurance. If just 19% of BISP support is carved out to this health microinsurance , coverage can be provided to the entire poor population of this country. In view of the enhanced BISP programme, this money can also come from the development expenditure on health. Another possibility can also be that it comes from Zakat. All that is needed is change at the policy level to implement any number of innovative ideas. For instance, if a 10 paisa surcharge on fuel is implemented, the entire country, including the non-poor, can probably be covered.

RUPALEE RUCHISMITA
Executive Director, Centre for Insurance and Risk Management (CIRM) at IFMR, Chennai, India

Rupalee Ruchismita is the Founding Head of the Centre for Insurance and Risk Management at IFMR; an action research technical group, engaged in providing microinsurance and risk management expertise to the development sector. Ms Ruchismita has been involved in implementing more than five microinsurance experiments in the country. As a graduate of the Tata Institute of Social Sciences, she has worked with the Social Initiatives Group (SIG), a grant and research making group within ICICI Bank. Her work has been in the space of Financial Inclusion. She has also been involved in developing 'Catalytic Infrastructure' and engaging in 'Policy Advocacy' in microfinance.

3. HEALTH INSURANCE - A REGIONAL PERSPECTIVE

Rupalee Ruchismita brought an interesting perspective through a case study from India, highlighting grassroots innovations that have been instrumental in triggering a microinsurance movement in India - a large part, almost 60%, of which represent health microinsurance driven largely by the non-government sector.

India has variety of community-based health insurance models, which are not very scalable ranging from Rs[3]. 3000 - Rs. 30,000. Surprisingly, there are very few examples in India that can compare with the scale that RSPN and Adamjee have demonstrated. While the scale remains small, the interesting part relates to the product and process innovations brought to scale by some of the agencies. This does not mean that they have been able to deliver a whole package as they are still at an infancy stage - but there are processes in product cover that seem to be valuable to take to scale in other areas.

Around the world, if one talks to the insurers, people typically don't buy insurance, but then how come insurance is sold? Why is it that the low income households, who have such a small amount of savings left, are actually keen to pay for health microinsurance? Perhaps, what's specific and interesting is the health part of it. Very similar to Pakistan, the Indian Government has a system of health delivery, which is apparently free, but is marred by absenteeism, lack of consumables and medicines.

Recognising the success of the health microinsurance model, the government of India has launched the first health microinsurance scheme in Andhra Pradesh in Southern India targeting households living below the poverty line. To this end, the public policy has made a huge contribution in expanding the outreach of the health microinsurance in India. There is, however, a parallel argument concerning the prospects of the homegrown community-based health microinsurance models that cover the same set of households as the government.

If one questions as to who gets to finance the delivery of health microinsurance, then the answer is the households themselves. The Indian government pays a very small portion of what is the actual health cost. Almost 83% of what the poor households experience as health, they themselves pay for it and a very small percentage of it is actually planned. There are no savings, and no community-based aggregation. A lot of it comes through selling the family's gold or borrowing from neighbours in that environment. Therefore, it is not surprising that community-based health microinsurance models have become so successful over the past 8-10 years in India.

It all goes back to the existing health infrastructure in India. The irony of the story really is that the poor

3 Indian Rupee

households are unable to access the government's health care subsidy as there are a range of issues which limit accessibility, for instance one could be illiterate and not know how to access it. A large part of the issue relates to the geographical spread of health services. India has a three-tiered structure working at the district level with the tertiary hospital. By the time, one gets to the primary health care which is closest to the household, the kind of care available is extremely poor. Also the ratio of the population to primary health centres is very small. Ms. Ruchismita, agreeing with Dr. Bajwa's analysis, added that similar to the situation in Pakistan, a large part of the Indian government's subsidy in health financing goes back to the economically well-off individuals, who can easily access government care. It is actually the poor who are left to deal with the unlicensed rural medical practitioners and private players. Hence, to a large extent, they get very low back for the money they pay; and are unable to tackle the government's subsidy for health. The third part of the whole health insurance story is the insurance itself. To some extent, Pakistan is an exception where a private insurer has taken an initiative to help health microinsurance grow into a very scalable programme.

In many other countries around the world, for instance the Philippines, where there's a very large programme, or even Indonesia, the initiative has either been taken by the development sector or by the government. Insurers have traditionally not seen a commercial viability in schemes, such as livestock insurance and health microinsurance, for the middle class market or the rural market. Those have been areas where claim incidences have been as high as 125%, which means for every Rs. 100, one collects as premium, there is a spending of Rs. 121. And this is without even taking the transaction cost into account. It is just the actuarial cost of the incidence of health. So, risk carriers don't seem to have an insurer.

There are examples of other countries, where large NGOs and governments have played the role of risk carriers. What are some of the challenges that insurers face? How are five other insurers, beyond Adamjee, taking up health microinsurance? And not as part of corporate social responsibility, but much more as a business that would scale. In India, that has largely been driven by regulation and policy advocacy, where the government has a mandate which binds all those who want to do business, to collect 5% of their annual portfolio premiums from low-income households. So, there is some kind of facilitative regulation, which helps or encourages and mandates the insurers to spend and understand what kind of innovations could work in the low income groups.

One of the challenges that the insurers face is substantiated transaction. To cite an example, a scheme was started in India in 2003 called the Universal Health Insurance Scheme. The government was bringing in the subsidy and the premium was capped at Rs 150 with the hope to get 4-5 million in the pilot. The year closed at Rs 12,000

only and the projections were in millions. When the government and the private insurers looked at the portfolio, it was surprising to know that even with almost 50% subsidy, health microinsurance had not grown. One of the reasons could be that for Rs. 150, the premium was Rs. 300. For every Rs. 100 that the insurer collected from the household, they spent Rs. 170-180 as transaction cost. The other large problem that insurers, around the country, have faced is actual provision of health care. As already highlighted, the government's machinery is marked by non-availability of consumables at times even doctors not being present, which is, at large, a South Asian story. Therefore, insurers have to depend on private hospitals and clinics to provide this service.

The resulting problems include lack of incentive, and quality of care. Insurers are unable to manage provider management. There is a lot of collusion with substantial amount of fraud that has to be dealt with. With respect to risk assessment, there is a very limited amount of credible data on what the experience of low income household is like. This is a virtual cycle because the low income households are unable to access government's health care. So the only data available to the insurer relates to curative care and hospitalisation which shows heart attacks or lifestyle diseases more related to the middle class that do not hold true for what the health microinsurance client really wants. . (So what is available to the insurer is actually data of curative care and hospitalisation which shows heart attacks or lifestyle diseases more related to the middle class that do not hold true for what the health microinsurance client really wants. ??) Therefore, another large challenge that insurers experience in order to price a product is the availability of relevant risk assessment data.

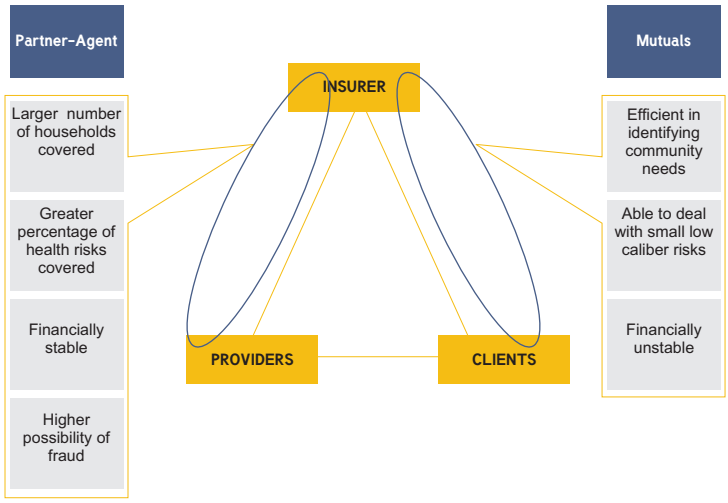
The Adamjee data, therefore, presents a very interesting example, with almost 35% of claims (as Mr. Bajwa highlighted). It's an exceptional scenario since claims for almost 130% would be expected. There may be a couple of reasons for this. First, the health infrastructure may be really far. Second, it is a pilot which is evolving and people still need to know much more about what health insurance is. Once that happens, then the premium at which the product is being offered might have to be reconsidered because with increasing claims, people may want to wind up.

Models of Health Microinsurance:
India has largely seen two kinds of models. A typical model is where a lot of innovations start with mutuals, a community-based health insurance product with the health provider and then makes the transition to a Partner-Agent model[4]. In these two models (mutual or partner-agent), there has been a substantial debate on which one is better. Mutual models have a lot of trust with the community; people come back and re-enroll as theyknow and trust the agency.

4 A partnership is formed between the micro-insurance scheme and an agent (insurance company, microfinance institution, donor, etc.), and in some cases a third-party healthcare provider. The micro-insurance scheme is responsible for the delivery and marketing of products to the clients, while the agent retains all responsibility for design and development.

Responding to the client's needs: There is one programme in Karnataka, in the South West state in India, which has really scaled. They have done some things which are valuable. First, it's a bundled solution. They have not just offered a product which is an insurance cover for catastrophic experiences like heart problems, hospitalisation and surgical care but also for events which the households experience more frequently. So, there is a reason for them to actually pay for insurance premium. The bundled product has savings and insurance covers. The savings component deals with regular events like drug supplies, traveling cost, and diagnostic cost. Since, diagnostics is a big vacuum; the households seem to value that a lot. Additionally, the insurance premium that is collected is passed on to the insurer. The programme also engages in a lot of provider management. It is one of the largest non-government programmes, which has seen a very high enrolment rate. It is a cashless and voluntary cover and isn't tied to the credit programme that a lot of microfinance institutions have. India also has very simple programmes like Karuna Trust which is a Rs. 5000 cover - a floater kind of a product which does not cover a lot of risks.

MODELS OF MICRO HEALTH INSURANCE

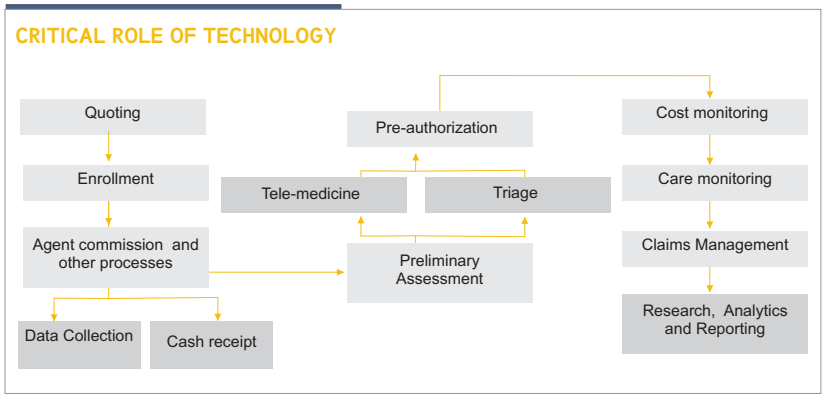


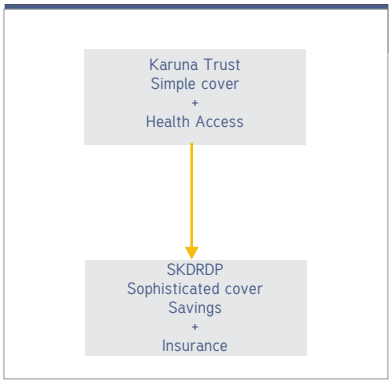
Both models lack scalable Standard Processes for provider engagement

Claims management is much better in a mutual model. The product or the service is covered [including pregnancy cover] - the kind of innovations that RSPN-Adamjee products have shown. The risks covered in a mutual product are more comprehensive, and more customised. It is not really seen in a partner-agent model. However, the partner-agent model is considered to be more financially safe because the risk is retained by a formal insurer [underwriter]. So in case of a systemic risk, or, for example, a waterborne disease that suddenly happens, it is highly probable that a partner-agent model will be able to handle that risk much better. But these are still debates that are open in microinsurance.. There is clearly a lot to learn from the mutual model for the insurance companies and, indeed, the sector.

And who are the real enablers? In some sense, it is the amount of subsidy that comes in [for the mutual model]. Where should it be directed and what should public policy aim at? Managing the triad has been a big problem. Mutuals have been efficient in many ways. But they cover low risks only. The partner-agent model has shown larger scale, covering [far more] health risks. But there is obviously a high possibility of fraud. Both the models lack in demonstrating models of health microinsurance; none have actually shown an approach through which standard processes for provider management can be scaled. They work in their district, in their state but the innovation cannot be taken to another site. That degree of standardisation has not happened (Except with RSPN-Adjamjee - the first partner-agent model demonstrating scale in year one, and rapidly addressing sale of insurance and processing of claims).

One particular example, as a measure of success, is when people come back to buy insurance. Re-enrolment is something that is considered a measure of success because insurance premium is paid by low income households from the very small amount of savings that they have. So, the insurer is really competing with a lot of other very crucial and immediate kind of risks that the household is dealing with. If the household is actually making a choice to come back and pay premium, even when they did not get anything against it then that is a definite signal that they have either understood the product or that they value what they will get through the insurance policy.





Critical role of technology: Technology has been a key factor in controlling frauds, bringing financial efficiency and scale. One such example of technology is the use of hand-held devices which has also brought down fraud and transaction cost in the whole process of claims management. Management Information System is the other area in which data has come in and helped the insurer to work with the other players. There are many ways of doing efficient gate keeping. Efficient referral and dramatic control of transaction cost also seem to be important variables.

Enablers: While governments can do much, private players in the market still remain the drivers of scale and sustainability. So, proper incentives and facilitative infrastructure for private players is a great way to see innovations in a country. The government may be a better player to bring in social security to cover some amount of risks that may not be insurable. But, for a health insurance market, it is time to place our bets on the market and help insurers scale that market. A large part of that should be insurance literacy. Passing on the burden of insurance literacy to the insurer will not make sense and will also not make it commercially viable. Data cost is something that the government should be building in, and by increasing the pool of trained professionals, these products could actually be designed and priced.

Addressing the challenge of claims: Claims and fraud management are major issues. The Yeshaswini Scheme is one of the first, and the largest, pilot programme. In fact, it is not even insurance in some ways, because the risk is not retained by an insurer. It is a mutual model where the risk is retained by the community. A large model that started with a 1.6 million pilot that went up to 3.2 million. What it has shown to the sector are standard treating protocols. It has around 1600 health events with standardised cost. So if a person is suffering from a certain disease, Rs. 30,000 is the cost. Whereas throughout the country, the variation ranged from Rs. 8,000 - 40,000 as insurers didn't know how to price that risk. Yeshaswini Scheme has actually standardised those protocols and were able to manage almost 116 hospital providers. They were able to manage frauds through providing health identity cards and partly co-pay models. Therefore, the amount of fraud dramatically falls. Yeshaswini Scheme also has a health facilitator to smoothen out the process as a large number of people do not know how to access hospital care.

One reason, the Scheme has become commercially successful is because of the huge numbers. With such integrated programmes, commercial viability is always problematic and not experienced in the first year. But with the large numbers that Yeshaswini have been able to bring in, they are almost breaking even, which is not true for a lot of other pilots running in India.


FIRST MICROINSURANCE CONFERE
RSPN

JEANNA HOLTZ,
Senior Grants Officer,
International Labour Organisation,
Switzerland

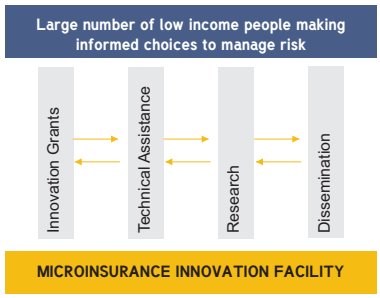
Jeanna Holtz has more than 20 years of experience in health insurance and consulting. Prior to joining the Facility in 2008, Ms. Holtz worked for 5 years for the Allianz Group, based in Munich, Germany, where she led a team of internal consultants to support worldwide health insurance initiatives within Allianz. Earlier, she worked for the US health insurer, Aetna, developing medical provider networks and supporting health plan operations. Her expertise includes medical cost management, provider network development, and health insurance operations. She earned a Masters in Business Administration (MBA) from Northwestern University, Chicago, USA, and holds a Bachelor's degree in human nutrition from Washington State University (USA).

4. INNOVATIONS IN MICROINSURANCE

Jeanna Holtz started with a global perspective on microinsurance taking account of the significant milestones the microinsurance sector has achieved. Looking back, just as recently as ten years ago, the microinsurance sector was truly in an age of infancy. Around the year 2000, there were approximately ten million members globally who were insured with microinsurance products. Most of them were life insurance products that were linked to loans. Recognising the amount of growth in the people who are covered globally with microinsurance products within the last 70 years, there is about a ten-fold increase. Microinsurance now covers approximately a 100 million members and the numbers are growing quickly.

As the momentum of microinsurance members has increased, global dissemination groups and microinsurance organisations are coming together. One such group that came about in the early stages around the year 2001 is the CGAP[5] Working Group on Microinsurance. The CGAP Working Group on microinsurance is a symbolic representation of the change that has come about in the evolution of the microinsurance sector. The Group has been recently renamed and recast in a more formal structure as 'The Microinsurance Network'. The Microinsurance Network is a voice and a global focal point for activity and development within microinsurance. In 2005, the First Global Microinsurance Conference was sponsored by the Munich Re Foundation. The second conference was held in Mumbai, India and then in November, 2008, the fourth international conference was held in Cartagena, Colombia,. Regulators are getting into the act and establishing regulatory environments to enable development of microinsurance. From the donor side, in 2007, a big milestone was reached when the Bill and Melinda

THE FACILITY'S ACTIVITIES



KEY THEMES & LEARNING

Support the development of valuable insurance products for low-income households

Encourage the emergence of institutional models and partnerships that effectively deliver insurance to large numbers of low-income households

Promote market education to help low-income consumers appreciate the utility of insurance in managing risks

Experiment, learn and disseminate

5 Consultative Group to Assist the Poor. CGAP is an independent policy and research center dedicated to advancing financial access for the world's poor. It is supported by over 30 development agencies and private foundations who share a common mission to alleviate poverty. Housed at the World Bank, CGAP provides market intelligence, promotes standards, develops innovative solutions and offers advisory services to governments, microfinance providers, donors, and investors.

TECHNICAL ASSISTANCE

Promote demand for TA	Increase supply and quality of TA	Propagate Microinsurance Successes
Provide TA grants	Designate TA providers	Monitor impact of TA grants
Broker TA	Build a new cadre of qualified TA providers through joint missions and fellowships	Solicit TA providers' insights on trends
	Make tools available and facilitate knowledge sharing	Identify lessons learned and disseminate

Build Capacity

Gates Foundation dedicated some USD 55 This number needs to be checked - it was close to 70m USD??million for microinsurance development activities. The bulk of those funds was actually dedicated to the Microinsurance Innovation Facility[6] (-Ms. Holtz gave a brief introduction to the Microinsurance Innovation Facility (MIF) and its activities, sharing global examples of some of the projects the Facility is supporting. Based in Geneva, Microinsurance Innovation Facility is part of the ILO. The facility is envisioned and funded for a 5 year period, with a funding of USD 34 million . Its mission is to support emerging insurance products for low-income people. It does this through 'Innovation Grants', which are funds that are provided to organisations to test new approaches in microinsurance in real world environments. Microinsurance Innovation Facility is focused on three key activities:

- The first is to the support the development of valuable insurance products, including the entire value chain of sales, distribution, pricing and claims management.
- The second is to develop new partnerships and models that can increase access to and efficiency of insurance.
- The third dimension is to promote market education that will help people ultimately make informed choices about how to manage risks.

The Microinsurance Innovation Facility is also geared towards stimulating demand for technical assistanceto the extent where it can increase the supply and support demand and development of technical assistance fort he sector to become more robust. Technical assistance involves a process of identifying and providing, for the public at large, a list of the qualified technical assistance providers, along with financing in the form of grants to small organisations who can take advantage of the available assistance.

Microinsurance Innovation Facility's 'Innovation Grants' is focused on well-designed action research projects that test new ideas. It intends to offer about 40-50 innovation grants over the course of its 5 year life. Grants are issued twice per year and each time 8-12 organisations get selected for a grant. The average grant amount is USD 350,000.

Microinsurance Innovation Facilityis keen to support all kinds of organisations eager for innovating in microinsurance, including formal insurers, unregulated insurers, labour insurers, cooperatives, people organisations, banks, technology providers - all conceivable types of distribution channels. It conducts a rigorous review process to select projects and evaluates them on four key dimensions. The first is the potential of the market and the impact that the project might have.

6 and to MicroInsurance Agency

The second is the project itself and its viability. Is it well thought out? Is there a financial model and evidence of sustainability? The third area is review of the capabilities of the applicant itself, and then, the fourth is to look at the first three dimensions and consider the extent to which they have strategic relevance and fit with the agenda of the facility.

After two rounds of innovations grants, Microinsurance Innovation Facility has seen applications from more than 200 organisations, coming from more than 40 countries. The selected organisations are geographically dispersed, working in different types of products, including health insurance, life insurance, composite product that includes health, life, asset insurance, and savings product.

Calcutta Kids - Adding value to insurance claim: Calcutta Kids is an organisation committed to the empowerment of the poorest children and expecting mothers in the underserved slums in and around Kolkata India, by increasing their access to health and nutrition services, providing health information, and encouraging positive health-changing behaviors. Calcutta Kids' primary objective is to initiate community-based programmes that advance the promotion and delivery of good health care, medical advocacy, and health education.

Calcutta Kids started out as a small NGO with just 7 employees, focused on maternal and child health. Insurance was not on their minds, when they started about 4-5 years ago. What they realised though, and this is how a lot of organisations come to microinsurance, is that for them to achieve their health objectives, it is critical to find solutions around access to care and financing of care. As a result, Calcutta Kids is planning to launch a health insurance product. They will begin with a fairly simple and limited hospitalisation product. An interesting part of their innovation are some interventions within their membership, for instance when somebody is ill and visits an outpatient clinic, they don't receive any benefit from the insurance because they are not admitted to the hospital.

Calcutta Kids has devised an innovative approach of 'Medical Case Management' - which is a follow up visit after an ill person has been at the outpatient clinic. A trained community worker, known and trusted and having some essential skills, follows up with the patient and discusses the health care encounter and evaluates if s/he is following the doctor's orders, like taking medications they have been prescribed to identify if the member is not recovering and perhaps might need further medical care. If that's the case, the community worker refers them back into the health care system. It's quite interesting typically for those who don't incur claims while holding an insurance policy.

Consequently renewals are a significant challenge and one of the issues to be solved for insurance products to become sustainable. So, the hypothesis

is that the innovation practiced by Calcutta Kids may add additional value for members and encourage them to renew. And there will be a controlled study to actually systematically measure what the rate of renewals is for people who receive this benefit and for people who do not.

The second dimension to this is that additionally this intervention has the potential to reduce the amount of hospitalisation claims. So, if sick people can be identified and treated in the outpatient setting, of course it is much cheaper, it is better for the patient, less time is lost from work, etc.

So, these are some of the types of ideas that can be extremely powerful, if we can demonstrate systematically that they work and come up with models that are generic enough that can be replicated and copied elsewhere.

Hollard Insurance - Making technology work for mciroinsurance: The next example is Hollard Insurance which is based in South Africa. Hollard is experimenting with a new voluntary asset insurance product. This will be distributed to urban poor clients and they have a lot of innovative ideas that they are testing as part of this project. With respect to distribution, they will be distributing this product in the form of partnerships of a diverse group of distributors, such as a retail chain of stores, and a network of community based agents - people who go from door-to-door in the community. They will also be distributing through funeral homes, and banks. So, all kinds of distribution channels are to be applied.

Hollard also have ideas to streamline claims assessment. This is a very costly part of asset insurance and has made it difficult to be financially viable for low income clients who are paying much smaller premiums. Instead of deploying professional claims assessor, Hollard will have lower skilled 'Claims Runners' who are people living in the same communities; who can receive a text message on their cell phone; go to the location that's near where they live and provide preliminary information electronically back to the claims assessor sitting in Hollard's office. That person employs further technology such as Google earth to use satellite images and ultimately the idea is that they can assess a claim without having to physically send a Claims Assessor there. So, it's quite innovative and a great example of how technology can enable new ways to accomplish things thereby reducing cost. Hollard thinks incidentally that they might have 8-9% reduction in the cost of claims assessing by using this technology.

For claims payments, Hollard are also going to experiment with replacing the cash payment for each claim that is processed with access to in-kind payments, e.g. for discounted prices of building replacement material, Hollard is negotiating with building suppliers to build supply stores. They think that not only will this allow more efficient claims processing as one can do a single batch claim for a series of claims, but it will also limit a moral hazard. Somebody will be far less likely to burn down the building, if they are going to receive new building material, as opposed to cash.

CAPTAIN JAMIL AKHTAR KHAN, Chief Executive Officer, Takaful Pakistan Limited

Captain. M. Jamil Akhtar Khan started his career as a Deck Cadet in the Merchant Navy having obtained his academic education from Cadet College, Hasan Abdal and thereafter graduating and passing out from Pakistan Marine Academy with distinction. He progressively rose to the position of Captain after qualifying as Master Mariner and commanded various ships of PNSC before stepping into the insurance arena. Serving in senior positions in reputable general insurance companies, both local and foreign, he was actively involved in all the key operational aspects. In this duration, he also acquired the highest insurance qualification of ACII (UK) achieving 'Distinction' in the subject 'Marine Insurance & World Trade'. In May 2004, he set up the First Takaful Company of Pakistan being the key insurance person designated as 'Head of Operations' of the company. He contributed positively towards finalisation of the legal framework for Takaful in Pakistan that eventually culminated in the form of Takaful Rules – 2005.

5. MICROTAKAFUL BEYOND PHILANTHROPY

Captain Jamil Akhtar Khan descrbed Microtakaful[7] as a mutual arrangement as opposed to separate outsourcing to other companies. That is what makes all the difference. While microfinance can help people improve their lives, MicroTakaful helps them sustain their financial well being. While there are many support schemes and funds launched to help the poor, the idea is to help them sustain themselves and ultimately to bring them above the poverty line. That is where the role of MicroTakaful and microinsurance comes in effect, giving a feeling of well-being and togetherness where basic needs of people are being taken care of. The society, on the whole, benefits from such a system, which is also the concept of an Islamic welfare state.

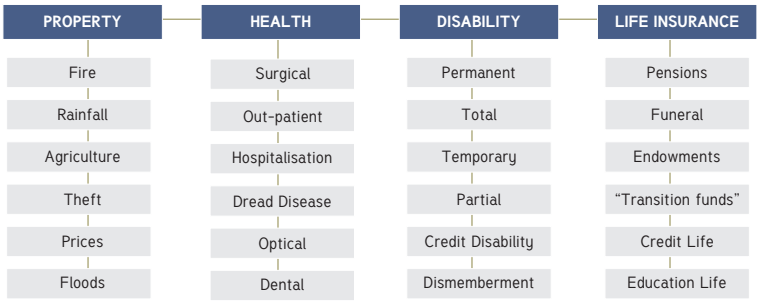
While the government is making its own efforts towards such a state, the various NGOs, programmes and projects, some of which are supported by generous grants from organisations such as the World Bank and ADB, have a collective responsibility to make optimum utilisation of their funds to ensure that this process continues unabated. And eventually, together, we can all contribute to lower the abject poverty, currently hovering at an alarming 40%, in Pakistan. This is the sentiment that forms the basis of the concept of MicroTakaful beyond philanthropy.

The Takaful concept evolved from individual common interest on the basis of mutuality and it has continued to be so over centuries. The industrial era at the turn of the last century shifted the focus to individuals, leading to the Workman Compensation Act, as well as many other legislations which were passed in the developed world to take care of individuals who were busy manufacturing products on mass scale. Starting off at urban level, it later shifted to the rural areas – since that's where most of the world's population resides – introducing cooperative farming and microinsurance.

There are many types of MicroTakaful microinsurance products, available in Pakistan as elsewhere around the world, which include property, health care, life and even education insurance. In Pakistan, serious efforts for microinsurance at the national level only picked up in the last decade with the advent of MFIs and a mushrooming growth of NGOs. However, there is still scope for extensive work in this area. The government has been doing its part by providing support to the RSPsthrough the creation of SMEDA, and recently, by the State Bank of Pakistan's directive to all banks to have at least 20 percent of their branches in the rural areas. This will open up new avenues to infiltrate financing into crops, livestock and other basic requirements for which microtakaful is already actively seeking economies of scale to make them viable ventures.

7 *"a mechanism to provide Shariah-compliant insurance protection to the blue collared, under-privileged individuals at an affordable cost"*

TYPES OF MICROTAKAFUL PRODUCTS



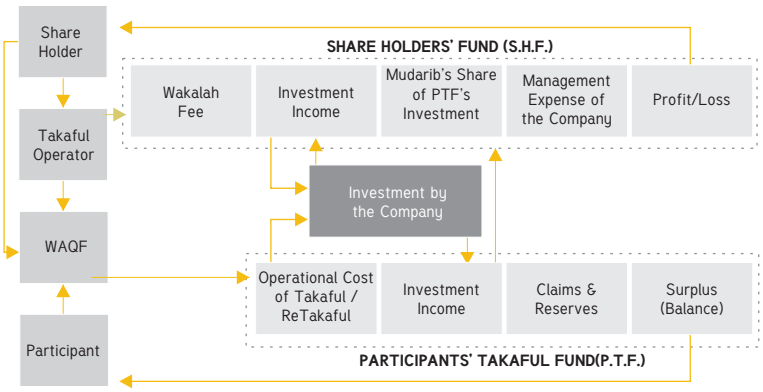
Potential areas of action are already being explored which are based on the immediate concerns of poor families, from the birth of their children to their education, business failure, unemployment, prolonged illnesses and deaths to marriages and construction of houses. Takaful Pakistan has already taken certain initiatives in this regard. It has already provided coverage to over 100,000 low-cost houses against earthquakes and other calamities. It has built synergies with NGOs to work collectively towards a common goal.

Takaful Pakistan 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.

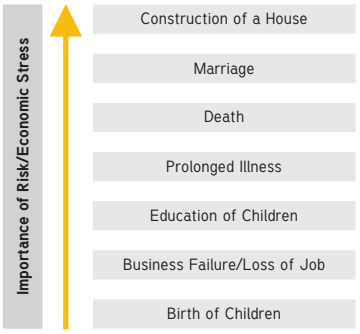
As per the principle behind MicroTakaful, all these are done on a 'no profit basis'. This does not mean that Takaful is in it for charity, but according to the concept of Takaful, the profit is transferred to the individual participant and translated to benefit the customers. Considering the present profitability of microinsurance, one idea can be for all microinsurance/MicroTakaful agencies to save their profits in a reserve fund, which in less profitable times, can be used to cater to losses and provide a cushion. This would not only ensure sustainability, but would also mean less cost at the ultimate grassroots level in order to meet the collective objective of affordability.

The way forward lies in a number of initiatives. The government can give tax incentives to organisations involved in microinsurance and Takaful. All such organisations need to create an atmosphere of goodwill not just with each other, but also

THE TAKAFUL ADVANTAGE



POTENTIAL AREAS OF ACTION



with the government. There is also a need to form strategic alliances, rather than strike out on an individual basis, since a motivated and trained workforce is already available with NGOs and RSPs. This will also make the efforts more effective as well as bring down the overall costs. The idea is not to reinvent the wheel, since all these products are already available in the market, but to tailor them according to local needs, for instance, cash-free arrangements at the grassroots level. Incentives and awards need to be given to acknowledge and reward efforts so that the process continues to benefit. Other innovative means, like the use of technology in monitoring and verification of claims, should be employed to make the process more cost effective.

According to a World Bank study conducted in March 2006, most people seemed satisfied with the policy, but some thought that the premium should be reimbursed if they do not file a claim for the insurance. This advantage is in-built in the Takaful mechanism, where all the premiums are deposited in the Takaful Fund within the overall WAQF Fund. So the surplus from the years, when there are fewer numbers of claims, accrues in the fund. Under the Shariah and under the law prevalent upon Takaful companies, that surplus has to be returned to the participants. Since it is a WAQF for the benefit of the community at large, the same surplus can be utilised to lower down the costs in the future year, instead of returning it to the individual participant. This is an ideal Takaful advantage.

Takaful Pakistan is currently the only rated Takaful company in Pakistan with nationwide presence in 14 cities. In a country where 97% of the population is Muslim, 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.

PETER KNOLL,
Financial Sector Specialist, Asian Development Bank, Manila

Peter Knoll is responsible for administering ADB's microfinance projects in 10 countries in Central and West Asia. Before joining ADB, he provided consulting services to banks, MFIs, and governments on matters including capital markets, banking and insurance, legal and regulatory reform, and institutional structure and governance. Mr. Knoll was previously a Vice President in the investment banking division of Nomura Securities and an attorney in New York representing various parties in syndicated loan, equity, structured finance, and project finance transactions. He also worked on international banking issues at the Federal Reserve Board in Washington, D.C. Mr. Knoll has worked in Afghanistan, Armenia, Azerbaijan, Bosnia, Georgia, Pakistan, Tajikistan, Russia, the United Arab Emirates, and the United States. He is a graduate of Harvard University and the University of Michigan.

6. MICROINSURANCE IN SRI LANKA

An international perspective was presented by Mr. Peter Knoll from the Asian Development Bank, Manila, who, based on his experience of microinsurance in 10 countries in the Asia Pacific region, illustrated many examples from various ADB-funded projects in different countries as parallels to what similar initiatives in Pakistan can be like. Highlighting the role of donor support, particularly the ADB, providing technical support to the governments of Vietnam, the Philippines and Sri Lanka, Mr. Knoll cited the case of Sri Lanka drawing up a close comparative analysis with Pakistan in terms of awareness, outreach and diversity of products and services. Whereas, the case of Sri Lanka offers many best practice examples for understanding the creative evolution of microinsurance in South Asia, Pakistan needs a sustained effort to raise awareness amongst its people with regard to the benefits of insurance, followed by the delivery of insurance products to the poor.

Explaining the role the ADB is playing in the microfinance sector in Pakistan, Mr. Knoll said that from 2001-2008, the ADB had a $ 150 million Microfinance Sector Development Program (MSDP) 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 (IAFS), 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 two decades. He said that this is but one example which illustrates the attention microinsurance has recently been generating and a lot of donors are making grants available for research and other pilot projects.

He went on to extrapolate on three ongoing ADB projects in different countries citing them as examples from which Pakistan can learn in the area of microinsurance. The first project is in Vietnam where the programme is analysing the demand for agricultural microinsurance, to see whether there can be a non-loss making mechanism for protecting farmers from loss in case of damage to crops from natural disasters. The second of these projects is in the Philippines, a more developed microfinance market, where a $ 600,000 grant is being administered to improve the regulatory framework and provide training to government officials and microinsurance providers. A third major component of that programme is financial literacy to educate the potential customers - the clients - to enable them to understand and take advantage of the insurance products being offered.

The third project, called 'Technical Assistance for MI Sector Development Project', financed by the DFID-funded Poverty Reduction Cooperation Fund, is being

administered by the ADB in Sri Lanka. This project also has three components, the first of which was a survey where a consulting firm was hired to interview about a 1000 people, almost three quarters of whom were from the rural areas and about 80% of whom were poor. This was similar to a survey done in Pakistan with the clients of the Adamjee-RSPN venture in 2006 to ascertain their level of satisfaction with the insurance product being offered to them - with even some similar results.

The survey in Sri Lanka found that 39% of the people do not have enough income to pay for any insurance products at all. So, in order for them to get the benefits of insurance, the government will have to provide the funds - a case that is currently being considered in Pakistan also. The second category in the survey was the 33% who were willing to buy insurance and here the problem was of connecting these numerous buyers with sellers who find the relatively small transaction size unfeasible. This is again something which is currently being addressed in Pakistan through the Rural Support Programmes (RSPs) who are essentially using the buying power and aggregating it, so that tens or even hundreds of thousands of people are buying insurance through a single contract. The third category was of the 29% who are able, but not willing to buy insurance for a multitude of reasons. Indeed some of these never will, but a large percentage of those interviewed (75%) had a positive attitude towards microinsurance which can easily be converted into action with a little education.

One thing different about the microinsurance market in Sri Lanka is that since the 90s, commercial insurance companies have been actively selling insurance door-to-door. There are about 15 insurance companies, 7 out of which are very active and around 80% of the surveyed people could name at least one, while two thirds could name at least three insurance companies. Being a relatively better developed market, 77% had heard of life insurance, 30% of funeral insurance, 25% of accident insurance and only 11% of the people were not aware of insurance at all, or like in Pakistan, they might have known about insurance but did not know a lot about its benefits or about how it worked. And so, in order for them to be good consumers of insurance they needed to be educated.

The survey also highlighted the importance of the need for insurance companies to act responsibly in order to sell their products easily by revealing the low level of credibility and trust of the companies in the eyes of the surveyed applicants. This was partially due to the aftermath of the tsunami, where people reported that a large number of death and property claims did not get compensated, or that the insurance companies denied claims over slight differences in the name or birth certificate numbers. Another issue brought out in the survey was the fact that even when insurance products were available and people were interested, sometimes the products themselves were not

suitable, for instance, by being too expensive, so that, for example, the price might have been acceptable if paid on a monthly basis but the insurance company required annual payments, making the product unaffordable. The third observation was that the premium becomes increasingly unaffordable for 50% of the surveyed people who have a limited amount of disposable income to spend on insurance. In Pakistan, that translates to about Rs. 150 a month, which means that it is quite affordable and that the people in Pakistan are not forced to spend every last rupee they have simply to keep up with the insurance.

The second part of the survey in Sri Lanka was to gather people's response to four insurance products. This was done because the third and final part of the project was to run a pilot test on a new insurance product and try to ascertain its response over a period of two years. So, four products were mentioned as part of the survey - property insurance, funeral insurance, health insurance and life insurance - with interesting results.

Although most people said the loss of property due to a natural catastrophe would be the most difficult thing to handle financially, only 9% were interested in buying property insurance. This was due to the fact that not many felt that something on the magnitude of the tsunami was likely again, and even if such a disaster were to occur, financial assistance would be forthcoming from the government and donors, negating the need to buy insurance. The second offered product turned out to be the most popular and that was funeral insurance. 68% of the people were interested in the product which would mean that they pay Rs. 172 annually for Rs. 10,000 worth of coverage. 52% of the people were interested in the third product - life insurance - but at Rs. 200 a month, no one could afford it. The fourth and final product offered was health insurance, which 52% of the people voted for. This product was quite similar to the one being offered by Adamjee-RSPN in Pakistan, covering only in-patient care and the cost for medicines, since the health system is also somewhat similar in that the public hospitals are free. However, the cost in Sri Lanka was much higher, which, according to Mr. Knoll, is cause to be proud of either the generosity or the efficiency of the health products being offered by insurance companies in Pakistan.

The other part of the study looked at the kind of products that were available in Sri Lanka and here, there is a significant difference from Pakistan, since the products being offered there are much more diverse. This might be a result of the fact that there are a lot of insurance companies, so they constantly create new products in order to differentiate themselves. The most successful product in the country, with about 30,000 people, is a compulsory product being offered to women small business borrowers. It combines accident, hospital, funeral and credit insurance to protect the borrower. The price is rather similar to that being offered by Adamjee to NRSP borrowers. The second most successful product is a

similar one for agricultural borrowers which includes a crop insurance component. So, the premium is about the same as the product for other borrowers, but they pay 4% of the amount of the loan for crop insurance. In comparison, there is also voluntary crop insurance, so that any farmer can cover his crop for between 3.5 and 12% of the value of the crop, depending on the crop. So, it is 8% for rice while corn is between 3.5 - 5.5%. In case of a loss, the insurance company pays between 80-90% of the loss depending on the crop. There is also a livestock policy, which costs 3.5 - 5% of the value of the livestock, which is covered if the animal dies or becomes permanently disabled, not just sick. Almost 99% of the clients were people who had taken loans from banks and the premium was deducted from the loan amount.

There are products for self-employed people, farmers, housewives and teachers. All these products are within the range of about Rs. 500 per year and also tend to cover a whole group of risks - death, disablement, and property loss of up to a certain level. A farmer's product covers crop insurance. This is a different type as it is not based on the value of the crop, but limited to the reimbursement of up to Rs. 15,000. Whereas, the teachers' products have little twists; one of the 'if' benefits was if the insured died, then the insurance company paid for the educational expenses of two children. All these examples illustrate the fact that there is a lot of room for creativity in the microinsurance industry.

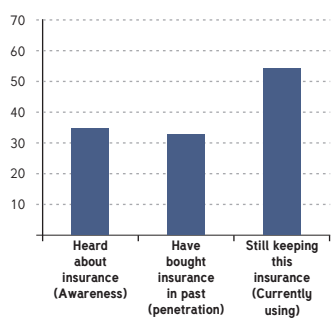
The survey also illustrated the value of having group insurance products in order to keep the costs low while targeting people with small incomes. For example, there is a life insurance product in which the premium for an individual buying the policy on his/her own would cost Rs. 250 per year with a death benefit of Rs. 40,000. Whereas if you are a member of a group, the premium would be only Rs. 90, or about a third of what it would be if you were an individual policy holder, and the death benefit would be not Rs. 40,000 but Rs. 75,000. Then, in addition to that, the group holder also gets hospitalisation benefits and some funeral benefits.

Mr. Knoll concluded his presentation with the hope that the experiences with microinsurance in Sri Lanka would generate interest in diversifying the product portfolio being offered in Pakistan and left the audience with the suggestion that crop insurance and life insurance are two areas which have good potential in Pakistan.

KALEEM ABBAS,
Chief Executive Officer, First Microinsurance Agency

Kaleem Abbas has a Masters in Economics, a B.Com and diploma in Accountancy and various certificate courses in health and life insurance. He has designed Case Management and Customer Loyalty Tools and conducted various training sessions of productivity and life and health marketing management. He has previously worked for the Eastern Federal Union, and New Jubilee Life and Health before joining the Aga Khan Agency for Microfinance (AKAM) in mid 2007. He is also a member of the AKAM Executive Committee.

RESEARCH OBJECTIVES



7. MARKET DEMAND OF MICRO-LIFE AND HEALTH INSURANCE IN PAKISTAN

Mr. Abbas began his presentation with an introduction of the First Microinsurance Agency (FMiA) as the first corporate insurance company in Pakistan. Funded by the Bill and Melinda Gates Foundation, it is part of the Aga Khan Agency for Microfinance, reporting to the AKDN network in Geneva. A new entrant into the challenging world of microinsurance, FMiA started off by thinking of ways to design new innovative products for the people, based on their needs and desires in the long term.

After just one year in the market, today FMiA offers insurance products in three different categories - Life, health and asset insurance - which are being managed and maintained by different microfinance institutions in the country. However, these are not the typical products offered elsewhere. The LI product offers, for the first time in Pakistan, an endowment life insurance. Similarly, the heath component has a hospitalisation product. Finally, in view of the fact that 70% of the population in Pakistan is engaged in agriculture, the asset insurance offers livestock, business asset and crop insurance.

Mr. Abbas went on to explain the results of some surveys and research, which had been conducted for needs assessment before actually offering any new insurance products. These were done to establish the targeted population's priorities for insurance; understand their worries regarding life's unpredictable risks; and, identify possible sales and collection channels that could be used to sell and collect premiums.

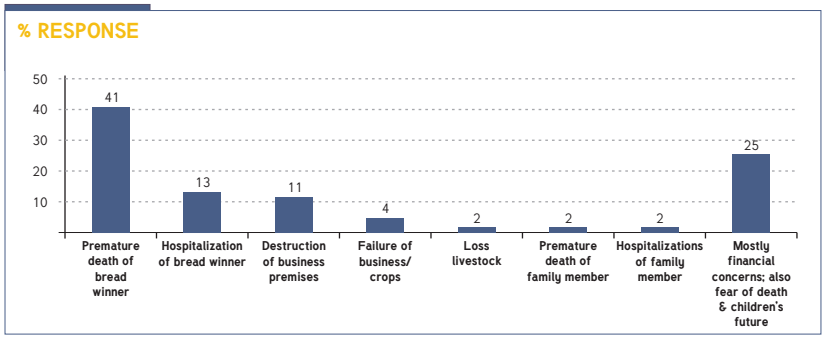
The sample consisted of around 500 field interviews conducted in all four provinces of Pakistan, which gives a fair representation of the needs of the country's general population. The first finding was that 67% of the people had heard of insurance, although they were mostly unaware of its features and benefits, while the awareness level in the male population, at 78%, was higher than the female at 56%. However, only 9% of them had ever bought insurance and only 6% of them had still kept up with their insurance. 90% of these 6% were people who were associated with some MFI, making the insurance, part of the loan. This highlighted the need to not only educate people about the benefits of insurance, but also the challenge of maintaining a consistent client base.

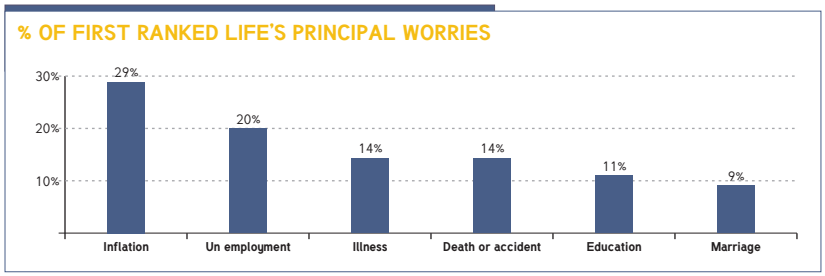
In terms of people's worries regarding life's unpredictable risks, the findings showed some interesting facts. A large majority (41%) is worried about the premature death of the breadwinner, while the second largest group (25%) is worried about the future of their children in case of the accidental death of the breadwinner. The third fear was the hospitalisation of the family's breadwinner, leading to a loss in regular income, followed by the loss of business, crop failure and lastly, around 2% considered the loss of

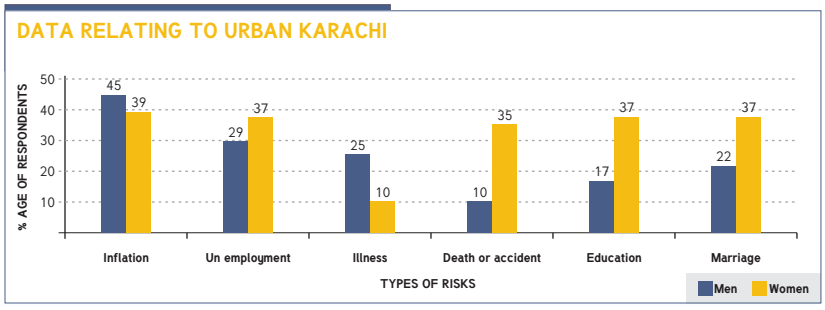
livestock or other business as a major catastrophe.

In terms of life's principal worries, economic issues like inflation (29%) and unemployment (20%) topped the list. Next to disability and illness (14%), unemployment posed the biggest concern. These were followed by other social concerns like education and marriage. While an insurance service provider cannot offer protection against concerns such as inflation and unemployment, it can offer a product which offers the cushion of protection based on these needs. The findings also emphasised the fact that the needs of the people differ both culturally and socially across Pakistan and the products being offered need to be tailored accordingly. Another big issue, that the FMiA is considering, is how to offer a savings product to the poor, who need not just life or health insurance, but also a proper savings plan for their short, mid and long term needs. Designing such a product, however, is a challenging task due to the simple reason that the dearth of disposal funds make a savings cycle short and unpredictable. However, target saving is not only a real need, it is also a demand of the market, a fact which is clearly illustrated by the conventional method of saving with committees (short term savings schemes) employed by a large number of people. There is an opportunity to replace this committee system by offering a short term microinsurance product along the same lines. Another big need, which is very important, is that of a cashless insurance policy which works on a reinvestment basis.

The main crux lies in designing products based on the needs of the people and making them realise that these needs can be catered to with the right product. It must also be done through low cost selling techniques keeping in mind the actual affordability level of the market. More consumer education is also required which should be done through meetings, role plays, etc. Special areas, like transportation cost for hospital visits or attendant's costs, also need to be addressed through creative ways in insurance products due to rising







inflation. Cashless health insurance is also a great need which should be addressed, like for instance, the FMiA offers its customers a health card that gives a 20% discount on pharmacies. The possibility to exit without penalty or emergency encashment is also a feature which needs to be incorporated in product design.

Mr. Abbas ended his presentation by highlighting some operational details of the FMiA. It offers a mixed category of products to its clients all over Pakistan, which include a voluntary village based enrollment scheme in the Northern Areas with a basic cover of Rs. 25,000. 50% of the village has to be insured in this scheme and the whole family has to be insured for risk control. Another pilot scheme, with the Kashf Foundation, provides cover to around 80,000 around Lahore where it is mandatory for the borrowers and their spouses. A third savings project is being implemented with the Tameer Savings Plan, and the final fourth voluntary plan is being implemented with FMFB Savings.

KAZI ABDUL MUKTADIR, Managing Director, National Institute of Banking and Finance

Mr. Kazi Abdul Muktadir is the senior-most Executive Director of the State Bank of Pakistan. Currently, he is the Managing Director of NIBAF and is a lead trainer in the area of banking. He has specialised knowledge of banking supervision & inspection, agriculture credit, banking policy and change management. He holds an MSc degree in Rural Development, from Sindh University & Wye College, University of London and a BSc degree in Agricultural Engineering from McGill University, Canada. He has experience of working for both commercial banking and the Central bank.

8. CROP LOAN INSURANCE SCHEME

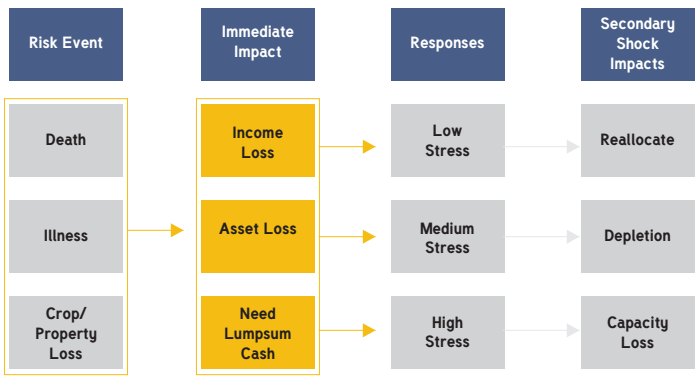
Kazi Abdul Muktadir's presentation stressed on the need for agricultural insurance in relation to the Crop Loan Insurance Scheme that has recently been promulgated by the government in collaboration with the State Bank of Pakistan. Agriculture is a sector completely vulnerable to the unpredictability of nature, while being the only source of livelihood for many resource-constrained farmers. In case of a natural calamity, the farmer is dealt a double blow faced with the loss of a productive crop and the default on a bank loan. There is a dire need to cover such risks and investments of marginalised farmers and protect them from what can mean total economic collapse. And for a country like Pakistan, where the quantum of agricultural credit increased from Rs. 39 billion in 1999-2000 to Rs. 212 billion in 2007-2008, the need, for a scheme such as the Crop Loan Insurance, becomes crucial.

Mr. Muktadir went on to explain the risk events and their immediate impact on borrowers through a graphic representation which starts off with death and illness. When it comes to the productive cycle, the borrower looks at the crop and property loss. The immediate impact would be income loss from the production or even a total loss of the assets. In order to break through, he needs lump sum cash to offset these costs and to be sustainable. The responses can be in three different areas: low, medium or high stress.

It can be low stress, where he basically needs to modify his consumption, call in small debts that he may have given out to other people and also draw in on informal and formal sources. In the rural areas, people normally do give out presents, which are collectible when certain events happen in their own family. So that is one area where he could go out and collect.

The medium stress basically demands the use of savings which the borrower may have kept for a longer period of time and also looks into sources of borrowing from the

RISK EVENTS AND IMPACTS



formal sector. And then the person also looks into striving and doing labour and working hard to mobilise resources. And last, but not the least, under medium stress he will try to migrate from the region in order to offset his losses.

Under high stress, he would end up selling his assets, and eventually, he will also sell his productive assets. Once he sells his productive assets, he is no longer a productive person. He would then have no option but to become a labourer.

Looking at the relative complexity to different insurance products, the easiest product would be a Credit Life Insurance where debt is paid on the death of the borrower, the lowest and simplest form it can be. The second option would be a Term Life Insurance where payment is given to the beneficiaries on death.

There can be many products when it comes to this option like property insurance, annuities and endowments which are basically retirement insurances. The equation becomes highly complex when looking at health and disability insurance, and crop insurance.

To highlight the importance of crop insurance in a global perspective, the presentation included a slide which showed the initiatives different countries around the world have taken in this regard.

Highlighting the complexity of crop insurance, he explained that there are different product types. One is a damage-based product which looks into the perils of hail, drought, frost, excessive rain, fire, etc. These are based on a percentage value of damage, are localised, and have a low degree of risk if covering a large

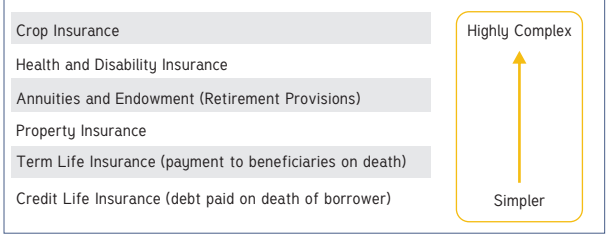
CROP INSURANCE - GLOBAL PERSPECTIVE

COUNTRY	INITIATIVE
Argentina	25% crop area covered against hail. Market rates and products
Brazil	Govt subsidized covering too much risk too quickly - problem
Cyprus	Govt. agency covering drought, hail and rust
India	Developed private sector for products on commercial lines. 50% subsidy to small and marginal growers under Government programme
Malaysia	Crop insurance for large and small plantation enterprises - mixed
Mauritius	Parastatal agency cover sugarcane against cyclones
Philippines	Cyclone cover by parastatal agencies - maize and rice. Subsidized
Syria	In process to cover drought with Government subsidy

CROP INSURANCE - GLOBAL PERSPECTIVE

PRODUCTS	PERILS
Damage based products	Hail, Frost, Fire
Yield Based Products	Multi peril geared to expected yield
NEW PRODUCTS	**COVERAGE**
Crop-revenue insurance product	Production-price risk leading to gross revenues
Whole farm insurance	Introduced in US in 1999 as adjusted gross revenues
Index based insurance	Based on coupon/index policy triggered by meteorological measurements

RELATIVE COMPLEXITY TO DIFFERENT INSURANCE PRODUCTS



given area and they seem to be insured to a certain extent. The second product is a yield-based product which is basically a multi-peril product geared to expected yields, depending on the nature of risks, difficulties faced and yield in the same area from past periods.

Different number of products can be created in a crop-to-crop basis of insurance. There are three different new products that have been seen in this part of the world and not in the developed world. The first is a crop revenue insurance product basically looking on the production price list that leads to gross revenues. With a lower production, the prices go up, so the farmer does not lose that much and is still sustainable. The second is whole farm insurance where the whole farm is insured and the adjusted gross revenues that could come in from the annual returns on the farm are considered. The third is index based insurance, basically a policy-triggered mechanism which looks into the meteorological measurements, excessive rain, wind speeds, droughts, based on 5 and 10 year predictions. For instance, the world has witnessed the La Nina and El Nino effect, and even in Pakistan, the rainfall increases one year, while the next might bring drought. So, with better information and better methodologies, we are more and more in a position to predict events. And once you can predict, then you can take calculated risks - and that's where insurance comes in.

A look back at the global perspective shows us that different countries have different forms and mechanisms of crop insurance and most of them have subsidised insurance covers that are given to marginalised farmers. Argentina makes a very good case study where almost 25% of the crop areas are covered against hail and they are looking at market-based rates and products. This is something that should be tried in Pakistan where insurance runs on market-based rates and products, for once you come into subsidies, you are looking for hand-outs and that is an area which has been avoided for a number of years.

Some crop loan insurance proposals have been considered in Pakistan since 1947. In 1986, there was an ADBP pilot project in collaboration with a private insurer. Then ADBP, and the Insurance Association of Pakistan have presented different proposals. The IAP had proposals for crops and catastrophe in 1990, and following the floods in 1996, a crop insurance proposal for only floods and rain. Then there is the National Insurance Corporation's Compulsory Crop Insurance Scheme of 1996. And finally, the State Bank set up the Task Force on Crop Loan Insurance Framework in 2006.

The Task Force comprises of representatives of the State Bank of Pakistan, leading banks, insurance companies, Ministry of Food and Agriculture, PARC and the Provincial Chambers of Agriculture. The report put up by the Task Force in July 2008 has been approved by the Cabinet. It has also been negotiated with Hannover Re and it is mandatory for all crop loans formally launched for Rabi 2008. All banks involved in agricultural lending and all insurance companies dealing in

general insurance can participate in this scheme, while all borrowers availing production loans from banks are eligible. All production loans disbursed by the banks for major crops (wheat, rice, sugarcane, maize, cotton) are to be insured compulsorily.

The name of the farmer and his crop must be entered in the land revenue record. The scheme will also be applicable to tenants, lessees, etc. The insurance cover would be for the period from sowing to harvesting (9-18 months depending on the crop) and would cover perils like natural calamities - excessive rain, hail storm, frost, flood, and drought crop related viral and bacterial diseases, or any other damage caused to the crop like locust attacks, etc.

Sums insured will be based on the per acre borrowing limits prescribed by the banks subject to a maximum amount agreed between the banks and the insurance company. The amount of claim is restricted up to 300% of the total premium received by the insurance company during the year or repayment period of the production loan. The premium will be a maximum 2% of the loan amount per crop per season inclusive of standard levies. The banks will collect the premium from the farmers on behalf of the insurance companies upfront. For this purpose, the insurance company will open a collection account with the bank which will then deposit all premiums so collected. Claims shall be payable to the banks by the insurers for credit to the insured borrowers bank account. The banks will make all the necessary arrangements to facilitate the insurance companies by providing them all the relevant data - making data sharing an area of prime importance for the future.

Based on the scheme that was presented to the Cabinet, the Cabinet came about with a number of important decisions, which include (i) the banks may also share the insurance premium along with the government (ii) the Ministry of Finance will obtain a copy of the bank's agreement with the insurance companies, containing the details of scheme, including the rate of premium (iii) the bank will pay the agreed premium on account of its subsistence borrower farmers that will be forwarded to the government on a half yearly basis, and (iv) before making payments to insurance companies through banks for premium subsidy, the State Bank will verify the amount claimed. All these decisions are deemed to be necessary based on past experience where miscreants have taken advantage of the situation in calamity-affected areas resulting in excessive claims which have to be curtailed in order to make the crop loan insurance scheme a success.

CONCLUSION AND THE WAY FORWARD

The panel discussion in the end offered an opportunity to stakeholders to arrive at a common vision to drive the evolution and growth of a vibrant and sustainable microinsurance sector. The panelists mutually agreed that the prospects of growth in microinsurance are enormous. The sector is expanding rapidly. While there are visible benefits promised by microinsurance, there are also many challenges that need to be addressed. A few of the recommendations made by the panel are:

- **Market-driven approach:** A lot more work needs to be done in tailoring and innovating product designs to the needs and demands of the poor
- **Enabling policy and regulatory environment:** Governance for ensuring sound regulation, supervision, facilitation and risk management for the development of an effective and efficient microinsurance sector
- **Building trust and awareness:** Spreading awareness and building trust among the poor to encourage participation and insurance claims
- **Achieving competence:** Maximising efficiencies of the distribution systems to ensure sustainability and market discipline
- **Ensuring affordability:** Reducing transaction costs to make the insurance products accessible to the poor
- **Simplifying procedures:** Simple and understandable processes for obtaining insurance by the poor, who lack awareness and are often not literate
- **Protecting consumer:** A mechanism must be developed for consumer protection in terms of risk management, disclosure and timely payment against claims
- **Effective use of technology:** Improved technology and information management systems to reduce the operational costs and increase performance, efficiency and transparency
- **Seeking appropriate business models:** Acceptable business and operational models that take into account the social and financial realities and context of the target group as well as the market.

Addressing these important issues through continuous learning and sharing, and adoption of best practices is important for the future of microinsurance sector in Pakistan. A sound regulatory environment must be sought to ensure trust among policyholders along with developing awareness and reliability of the microinsurance products and services. As the microinsurance sector evolves, both the regulators and practitioners will need to proactively engage with each other and to learn from the national and international best practices for achieving a balance between effective supervision and efficient delivery of the microinsurance products and services.


RSPN
Rural Support Programmes Network


DFID
Department for
International
Development


adamjee
insurance
Leadership from strength


ADB


Pakistan Microfinance Network
Licenced under Section 42 of Companies Ordinance 1984