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Financial Protection for the Poor in Malaysia: Role of *Zakah* and Micro-*takaful*

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*Abstract***.** Numerous researches have shown that most of low income and poor do not have financial protection in mitigating their financial losses. The purpose of this paper is to investigate firstly, whether there is any means of financial protection among the poor, and secondly, to determine their financial capacity and perseverance in making monthly contribution for a micro-*takaful* policy. The study was conducted on respondents who fall into the poverty level category in the rural area of Perak, Malaysia. It was found that 97% of the respondents are without financial protection and unable to contribute any amount of money to get the protection. The authors recommend that intervention and support from government is vital in providing the financial capacity for the poor to have the needed protection that principally cover death, medical and savings benefits. The Malaysian government should enforce a policy in providing aid to the poor via micro-*takaful* by providing subsidy and *zakah* forming part of their monthly contribution. With *zakah* fund, these low income and poor could have their own micro-*takaful* schemes which should be able to provide sufficient benefits, preventing them to be trapped into the poverty cycle permanently.

Keyword: micro-*takaful*, micro-insurance, *takaful*, *zakah*, Islamic insurance, poverty.

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1.0 Introduction

The establishment of Islamic microfinance and micro-*takaful* is to allow people to be financially self-sustaining (Bhatty, 2010). According to Billah (2001), Islamic insurance transaction, named *Takaful* is a policy of mutual cooperation, solidarity, and brotherhood against unpredicted risk and catastrophe, where participants contribute (donate) to help one another in times of hardship.

micro-*takaful* is one of the mechanisms to fulfil the needs of the lower income, with the concept of providing affordable protection to the poor. *Takaful* operators should come up with this kind of product, as the alternative to those offered in the conventional market (Swartz and Coetzer 2010). Establishing "micro-*takaful*" schemes enables insurance to become much more acceptable and accessible to the poor whilst still maintaining the benefits (Patel 2002). The needs of the poor in Islamic countries are no different from the poor in other societies except that these are conditioned and influenced by their faith and culture in a significant way (Obaidullah, 2008).

The purpose of the Shari'ah at the highest level is to preserve and protect the five (5) central necessities as stated by famous Persian scholar Al-Ghazali (1413 AH): "The objective of Shari'ah is to promote the welfare of the people, which lies in safeguarding their faith (din), their life *(nafs)*, their intellect *('aql)*, their posterity *(nasl)* and their wealth *(mal)*. Whatever ensures the safeguarding of these five serves public interest and is desirable." The objectives of Shari'ah emphasizes man must fulfil his needs and necessities and the rest will follow suit. Other than basic needs like food and accommodation, it is necessary for an individual, his family and properties to have protection (Frenz & Soualhi, 2010).

Islamic insurance or *takaful* is a noble activity where members of society pool resources in order to compensate one another after sustaining a loss. This in turn provides financial help against unexpected future loss, which ultimately contributes to reduction of poverty, encourages mutual cooperation and the spread of the spirit of brotherhood (Abdul Rahman & Daud 2010).

United Nation Development Program (UNDP) defined extreme poverty is where the gross monthly income of a household is insufficient to purchase certain minimum necessities of life. Therefore, having all types of financial protection in the country to offer to this population will not make any difference, as they could hardly acquire basic necessities such as, food and shelter. Cohen and Sebstad (2006) suggest that providing aid in the form of insurance is far better off in providing security rather than allotment in cash.

This study was conducted to examine the awareness of the poor towards having financial protection and their coping strategies on any risk that could befall them. The study also investigates the ability of the poor in getting this kind of financial protection. It is also to examine how micro-*takaful* and *zakah* can alleviate the burden of the poor.

1.1 Background of Poverty in Malaysia

According to United Nation Development Program, even though, the incidence of poverty is low in Malaysia, poverty continued to exist with high incidences among specific ethnic groups and localities. Specific policies and strategies designed to help eradicate absolute poverty was developed and included in the Ninth Malaysia Plan, 2006-2010 under Malaysia Measuring and Monitoring Poverty and Inequality program. Subsequently, National Key Results Area (NKRA) under the Prime Minister's Department of Malaysia was established to raise the living standards of low income households. (Economic Planning Unit, UNDP, Malaysia 2007).

In September 2010, the central bank namely, Bank Negara Malaysia has urged Takaful operators to design micro-*takaful* policies, medical and retirement products, to penetrate the untapped population; the low income market. Low income and poor who represent the rural and urban poverty groups are the most neglected people in insurance mainstream and are unprotected (Bank Negara Malaysia, 2010). The Tenth Malaysia Plan (2011) stating that a fair and socially just society is where all people, with no exception, have the rights, freedom, and capacity to access services and resources to enhance their well being, and where the most disadvantaged are given extra support to ensure such success. One of the four principles to support Malaysia's growth objectives is a needs-based principle; to alleviate the livelihoods of bottom 40% households and disadvantaged groups.

Terms and Definition

1.2 Categories of Extreme poor, poor and low income household in Malaysia

A common definition of low-income groups based on monthly household income was adopted for use by all ministries and agencies to accelerate coordination in identification are depicted in Table 1 below:

Table 1: Extreme poor, poor and low income household (USD and RM)

Category	Peninsular Malaysia	Sabah	Sarawak
Extreme Poor	USD 138 & below (RM440)	USD 170 & below (RM540)	USD 164 & below (RM520)
Poor	USD 236 & below (RM750)	USD 302 & below (RM960)	USD 261 & below (RM830)
Low Income Households	USD 629 & below (RM2,000)	USD 629 & below (RM2,000)	USD 629 & below (RM2,000)

Source: Performance Management and Delivery Unit (PEMANDU)

1.3 Micro-*takaful* and *Zakah*

Micro-insurance is defined as a protection from specific risks, paid for by regular premiums, specifically designed for low-income individuals (Churchill 2006). According to Khan (2006), **"**micro-*takaful* is defined as a mechanism to provide *Shariah*-based protection to the blue collared, under-privileged individuals at affordable costs. Micro-*takaful* is the *Takaful* scheme for low-income people. All the *Takaful* products like *Takaful* financing, *Takaful* education, fire, pension and so forth can be delivered to poor people with some modification, such as low premium contribution." The micro-insurance and micro-*takaful* movement is one of such innovation strategies in reducing poverty; however, it faces a number of challenges to meet its full potential.

Zakah is defined in Fiqh as "a due right on specific items of assets or properties, in specific percentage with consideration of the passage of a year and satisfaction of the condition of *nisab*." The *nisab* of *zakah* refers to the minimum amount of *zakat*able assets which is subject to paying *zakah* (Ahmed, 2004). The holy Al Quran (verse 9:60) determines that *zakah* can only be paid to eight categories of people, they are *fuqara* (poor), *masakin* (the needy), *'amilun* (funds collectors), *muallafat al-qulub* (those who have been inclined towards Islam), *al-riqab* (freed captives), *al-gharimun* (those in debt) and *ibn al- sabil* (the wayfarer).

Zakah is the pioneer instrument of world welfare system in human history (Khan 2007). As a fiscal mechanism under economic activity, *zakah*, deals with social security, health care, social assistance for childcare, food subsidy, education, housing and public transportation (Qaradawi 1999). Malaysia is one among those countries together with the rest, such as, Saudi Arabia, Libya, Sudan, Pakistan which has enacted laws for government bodies to formally collect and distribute *zakah* (Kahf 1999).

2.0 Problem statement

There are many poverty eradication programs carried out by the Malaysian government that have improved the living of the poor. However, poverty is still in the circle of unfortunate people due to the increase of standard of living and health problems. Therefore, some form of poverty alleviation program needed to be introduced which is a less burdensome financial program, like microinsurance and microcredit (Berma et al 2006). *Zakah* and insurance shall obligate funds to be distributed in order to strengthen the health care system by aggressively targeting the poorest population and rural areas (Mohamed 2008).

3.0 Research objectives

1) To analyze the poor's demographics and their awareness level toward having financial protection.
2) To investigate the poor's vulnerable coping mechanism.
3) To investigate whether the poor have the ability to seek for medical treatment.
4) To explore the ability of the poor to contribute monthly for financial protection.
5) To examine how micro-*takaful* and *zakah* can alleviate the burden of the poor.

4.0 Significance of study

It is a government policy to provide essential aid to low income and the poor, whilst at the same time to have protection by providing subsidy and extending the benefits of financial protection to this population via micro-*takaful*. The integration of micro-*takaful* scheme with *zakah, waqf* and other similar benevolent-activity institutions, are one of the means to alleviate poverty that should be seriously looked into.

Zakah organizations and authorities should expand their wings in contributing financial protection to the extreme poor and the poor in a more innovative manner. This population as explained below, faces substantial risks and is neglected, aside from their inability to get the financial protection needed.

5.0 Review of Literature and Hypotheses

5.1 The Need for Protection

Insurance is a real need, but not a "felt need" by the poor (Patel, 2007). Erlich and Becker (1972) argued that insurance is different from ordinary goods and services because it is not goods per se, but as a means of satisfying basic needs. Brown (2001) stated that vulnerability cannot necessarily be translated into a demand or need for insurance. Matul (2005) confides that rural households are in high need for more risk management options as they are the most vulnerable due to combined effects of health and weather-related agriculture risks. The needs for microinsurance concerned primarily, coverage for basic healthcare costs, death of the main family breadwinner and to a certain extent, coverage of property loss. Less vulnerable people and salaried workers are more willing to buy microinsurance.

Gumber (2002), in his study, reveals that a large proportion of low income households are inclined to participate in any health insurance scheme, both in rural and urban area. They strongly expressed the need for this cover due to the high expenditure in seeking health care. Cohen et al (2005) and Llanto (2005) confided that the need for micro-insurance is high and insurers should produce appropriate products for the poor. Cohen and Sebstad (2005) affirmed that the demand for microinsurance is high, as poor households are aware of their vulnerability to risks. According to McCord (2011) insurance products and services are crucial and forms part of the needs of the poor around the world.

The need and demand for micro-insurance is directly related to vulnerability, risk elimination and risk-management strategies of low-income households (Cohen and Sebstad 2006). Cohen and Sebstad (2006) further stated that research on the impact of risk events and on how poor people cope with shocks are important in illuminating the need for insurance. According to Banthia et. al (2009) women with low level of income and savings have a high desire to purchase insurance. They need to have insurance mostly for their children's health care. Banthia et. al (2009) further indicated that old age people who without retirement fund are the ones in dire need for financial support, health care and living assistance.

5.2 Loss Exposure

Risk is a state of uncertainty where some of the possibilities involve a loss, catastrophe, or other undesirable outcome (Hubbard, 2009). Economic risk is the possibility of losing economic security. Most economic risk is derived from variation from the expected outcome (Anderson and Brown, 2005). Low-income people are vulnerable to numerous perils as they live in risky environments,

however, the poor are more vulnerable to risks than the rest of the population, because they are the least able to cope when a crisis occurred. Poverty and vulnerability are related to each other (Churchill, 2006; Botero et al., 2006; Wiedmaier-Pfister and Chatterjee, 2006).

Instead of being prone to accidents and food poisoning, acccording to Llanto et. al (2006) urban and rural workers often find themselves in poor work facilities, unsanitary and cluttered surroundings, sudden changes in season or climate, calamities, pest infestations, chemical poisoning, and environmental risks. According to Cohen and Sebstad (2006) it is very difficult for the poor to get above the poverty line when there is a minor shock. Cheaply constructed houses in slum areas are prone to be destroyed by fire and natural disasters, where at once, exposed them to a hard life (Morduch 1999). The poor lacked the capacity to cope with the consequences of a shock, largely due to non-existence of significant assets and other risk mitigation mechanisms (Cohen and Sebstad 2006, Patel, 2002).

Almost all the poor faced some form of vulnerability in their daily life. Vulnerability has been described as the ability of individuals and households to deal with risk. Vulnerability is both a cause and a symptom of poverty (Cohen and Sebstad, 2006). When there is loss of income due to the impact of shock, many households withdraw their savings, borrow money and sell whatever assets they have or even take out their children from school. In many cases, children have to work in low productivity activities to help the family in coping with their lives. Life became more stressful when there are negative effects on the future life of the children and on the earning potential of the household in future. Financial stresses are associated with separation, divorce, school fee payments, and bad debts. Separations and divorce, similar to the death of a spouse, create a high degree of vulnerability and financial stress for women (Ali, 2000; Cohen and Sebstad, 2006).

According to Brown (2001), in many instances, people who have insurance do not understand what they are buying and how to make a claim. Banking with the Poor Network (2008) states that the poor has a low awareness on insurance as they perceived the premium is higher than actual cost. According to Banthia et. al (2009) poor women loathe microinsurance program because they are unaware of the benefits and the coverage which they assume do not fulfil their needs.

Nhu-An and Tan (2004), McCord et. al (2005) and Mechler (2008) confirmed that the poor people are not aware of the basic risk concept and even unaware of insurance at all. Roth and Athreye (2005), Radermacher et. al (2005)

clarified that poor people have low awareness as they do not understand anything about insurance. Roth and Athreye (2005) and Llanto (2006) further commented that, there are some poor people who are aware of insurance, however, their perception towards insurance have been stained due to appalling past experiences.

However, Cohen and Sebstad (2005) stated that the poor are aware of their vulnerability to risk and willing to pay expensively to protect themselves against those risks. McCord (2011) emphasizes that the people should be taught on the importance of having microinsurance as their risk mitigation tools.

Based on the above, the following hypotheses were formulated to assist in this research:

Hypothesis 1: Poor people do not have proper risk coping mechanism.
Hypothesis 2: Poor people have low awareness level on financial protection.
Hypothesis 3: Poor people have a high need for micro-takaful due to their vulnerability.

5.3 Affordability

Ahmad et. al (1991) found that both rural and urban informal worker are illiterate, vulnerable and poor. They could not afford nor do they have access to health care benefits, paid leave for sickness, insurance, old age pension and other benefits due to the low income. However, Brown (2001) argues that verifying affordability can be complex, as people will often say that they are cannot afford the full cost of insurance plan when it is described to them in general, but are willing to pay when they are presented with a product that meets their needs and demonstrates clear value to them. Prekar (2001) highlighted that micro-insurance schemes can help reduce health expenses of poor households and improve their access to health care services

Nyanjom (2006) further elaborated that the poor's lacking in capacity to overcome poverty led to both poor health and disparity in health status. Inability of poor people to access quality and timely healthcare services often increase their poverty (Nyanjom, 2006). According to Das et. al (2008) the health of the poor deteriorate when they choose low quality health care due to insufficient income. A study conducted by Tanuja and Sihare (2008) revealed that the poor did not undergo medical treatment to cure their disease due to financial constraint and the unavailability of health facilities. Gumber (2002) suggested that health protection should be under the component of poverty alleviation program in order to initiate the health coverage to the poor.

Not every poor people can effectively act for themselves (Wood 2003). Matul (2005) confirms that a quarter of rural household do not have any permanent source of income and has very limited saving culture. This indicates that when the resources are inadequate, they are unable to do an effective financial planning. His analysis shows the regularity of saving exist in urban areas where the income flows are more regular, usually on a monthly basis, while in rural area they are much more seasonal. According to Sachs and McArthur (2005) a family that is living at subsistence level are considered as extreme poverty and have no savings.

Hypothesis 4: Medical care is not affordable to the poor people when they fall sick.
Hypotheses 5: Poor people do have any form of savings.

5.4 Financial Capacity

Poor households generally faced difficulty in generating regular and substantial income and are extremely vulnerable to economic, political and physical downturns (Brown and McCord 2000). Poor people are too poor to perform any investment for their living and health care (Woods, 2003). Matul (2005) found that a quarter of households do not have any permanent source of income and nearly half of rural households lived on self-subsistence agriculture. Therefore they do not have the means to contribute to any form of microinsurance scheme.

However, Gumber (2002) confirms that rural and urban respondents are willing to contribute annual premium for protection that covers hospitalization, chronic illness, special consultation and the like. According to Churchill (2002) people may declare that they would purchase the insurance, however, they are not really keen to buy it. Nevertheless, Loster and Reinhard (2010) argued that people on low incomes are perfectly willing to pay for a good product if the insurance product can satisfy three conditions: (1) ability to pay the premium, (2) willing to purchase insurance cover and (3) conclude a contract of insurance. Loster and Reinhard (2010) further stressed that the poor may only afford small premium instalments and may not necessarily make a regular contribution.

Hypothesis 6: Financially poor people do not have the ability to contribute monthly for financial protection.

To put the whole research into perspective, the independent variables also known as the predictors, in this case, which include: demography/profile of the poor, risk coping mechanism, ability to contribute, ability to obtain health care, capacity to support own self and dependents and capacity to save and finally

their awareness levels are determinants for the need for protection. The need for protection is invariably defined as the dependent variable in which this research wishes to investigate. Based on the identification of the variables and the hypotheses above, the following research framework has been designed to execute the research as depicted in Figure 1.

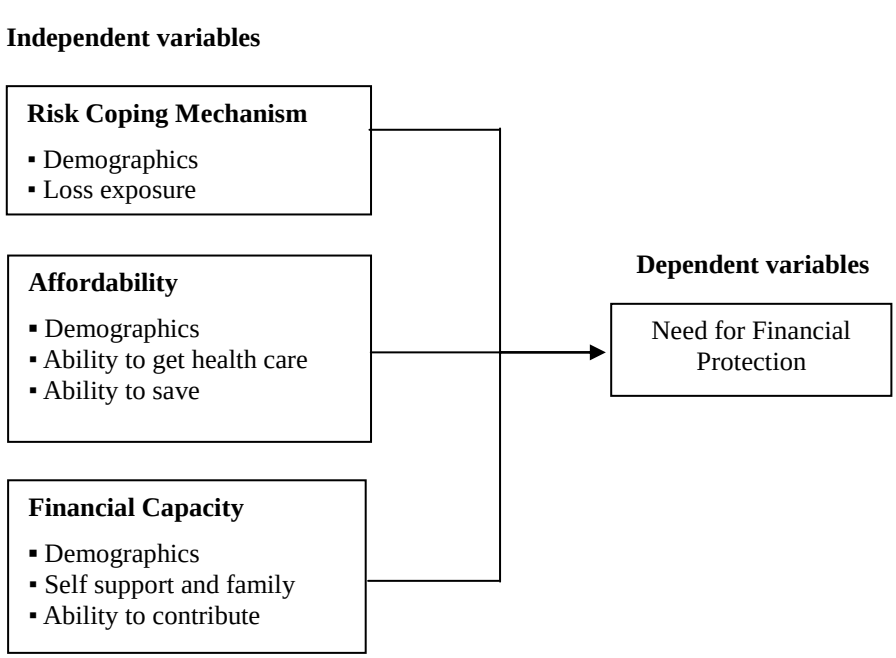
6.0 Research Methodology

6.2 Research Design

This is an exploratory study to determine the poor's risks coping approach, their awareness towards *takaful* and the ability to contribute in order to get the needed financial protection. The study is also meant to investigate the extent to which they are receiving any forms of financial aids, such as, *zakah*, aid from welfare department and the like. Information collected and collated inclusive of the demographics, income range, risk coping mechanism and awareness level of insurance or *takaful* is then analyzed accordingly.

6.3 Research framework

Figure 1: Dependent and Independent Variables



6.1 Data Collection

Questionnaire Design

This is a quantitative study, which is combined with part descriptive and part inferential statistics. The questionnaire consist of three parts, where the first part contained demographic characteristics of respondents such as gender, income range, education level, number of dependents and type of job. The second part is about getting aid or assistance from the government or other quasi agencies or bodies, awareness level of protection plans, savings barriers and whether they possess any form of financial protection plans. The last part focused on three independent variables, namely; loss exposure, financial capacity and affordability which used the Likert scale as a form of measure.

6.3 Sampling

The sample size is determined by using the formula by Cooper and Schindler (2006). The formula for sample size uses Cooper and Schindler (2006) method of calculation and depicted below:

$$n = \frac{\frac{Npq}{z^2}}{\frac{(N-1)\,B^2 + pq}{z^2}}$$

Total Household (N)	491,045 (derived from the Malaysian government documents)
Variance Estimation With Insurance (p)	23%
Without Insurance (q)	77%
Precision Level (B)	3%
Confidence Level (z)	95%
Sample Size (n)	132

The estimation of insurance awareness level in the rural area is 23% based on insurers estimation and a study conducted by the same author (Mohd Rom, 2010). Using the population base of the poor in Malaysia estimated to be 491,045 household in 2007, therefore, the number of household for the sample is 132. Household rather than individual respondents were used for the research as per Matul's (2005) and Ahmed's (2006) study. This research uses 132 household as respondents to ensure the sample could be generalized to the population. The sample choice was Sungai Manik Village, a rural town in the state of Perak of whom the majority are paddy farmers or odd job labourers with income below RM1,000 (USD318). The choice for the state of Perak is in line with the Ministry of Health's survey conducted in the same state as a sample for comparison with the national survey on morbidity rates and general health of

Malaysians, showing the general trend with regards to frequency of physical disabilities, demographics of those prone to this type of loss exposure, the causes of disability and many other issues that were raised (Mustafa and Ismail, 2006).

6.4 Findings

Tables 2, 3, 4, 5 and 6 present the descriptive statistics on demographics, aid from the government and risk coping approach. Tables 7 and 8 present the correlation and regression analysis on the ability to get health care, awareness level and affordability and its relationship to the need for financial protection.

6.4.1 Demographics

Income Range

The respondents comprised of males and females from age 30 to 69 years old. They make a living by paddy farming, rubber tapping, palm oil labourers, unskilled workers and doing odd jobs. Most of them are daily income earners and the expenditure is mainly for food. A few of these poor especially women age above 60 depend on neighbourhoods' kindness to offer them food in order to survive. Some of them are unable to work due to health problem, disability and old age.

Referring to PEMANDU's guide as per Table 1 (Extreme poor, poor and low income household) earlier, 88 respondents are extremely poor, who contributed to the highest proportion of respondents in this study, i.e. 66.6% from the total respondents (Table 2), while, 32 (24.2%) of the respondents are in the poor category. The majority of the extreme poor and poor categories have between 2-5 dependents.

Table 2: Monthly Income of Respondents

Monthly Income	Frequency	Percent
USD94 and below	44	33.3
USD95 – USD157	44	33.3
USD158 – USD251	32	24.2
USD252 – USD314	12	9.1
Total	132	100

Education Level and Savings

The findings showed that only 16 (12% of the total respondents) have savings while 116 (88%) do not have any savings. Respondents who possess

higher education level such as a certificate have a higher percentage (50%) of savings. Respondents who do not posses any formal education do not have any savings (21%). The ultimate barrier for not saving is due to poverty and insufficient income per month to make a living. Besides that, the result also shows that education level played a significant role in determining the attitude of people to save for their old age, children's education and others. Without any form of savings, it is difficult for them to cope with the risks (health problem, natural disaster, death of breadwinner and others) if and when they occur.

Table 3: Education level and Savings

Education Level	**Savings**		
	Yes	**No**	**Total**
Primary	4	36	40
Secondary	8	44	52
Certificate	4	8	12
None of the above	0	28	28
Total	16	116	132

6.4.2 Risk Coping Mechanism

The majority (73%) of the respondents had previously requested for donation in coping with risks like flood, house damage due to storm, accident and illnesses that needed medical treatment and other reasons as well. 9% of respondents used their small savings and borrowed money to cope with these risks. Due to being extremely poor, eight (6%) of respondents do not have any accommodation and are staying with relatives (Table 4).

Table 4: Risk Coping Approach

Risk Coping Mechanism	**Frequency**	**Percentage**
Withdrawal of Savings	12	9
Sell personal belongings	4	3
Borrow money	12	9
Request for donation	96	73
Staying with relatives	8	6

Assistance from Government and *zakah* Organization

Referring to Table 5 below, only 8 (6%) respondents from 120 (91% of 132 respondents) who are under extreme poor and poor category received *zakah*,

while 20 (15%) respondents and 12 (6%) others received aid from welfare department (monthly) and school aid (yearly) for children respectively.

27% out of the total respondents are single mothers, who have dependents of between 2 to 5 children with a monthly income below USD94. Eight of them are receiving *zakah* between USD31-USD47 per month. Four of them are receiving school aid from the government for their children (Table 5).

Table 5: Monthly Income and Financial Aid

	Aid				
Monthly Income	***Zakah***	**Welfare Department**	**School Aid for Children**	**None**	**Total**
USD94 and below	4	8	0	32	44
USD95 – USD157	4	4	8	28	44
USD158 – USD251	0	8	4	20	32
USD252 – USD314	0	0	0	12	12
Total	8	20	12	92	132

6.4.3 Awareness Level and Affordability to Contribute for Financial Protection

Of the total, 97% of respondents are not aware of Islamic insurance (*takaful*) or insurance protection. None of these respondents have the capacity to contribute a minimum amount or monthly contribution to get financial protection. Only 3% of respondents are aware and at the same time own Islamic insurance (*takaful*) policy and they are those with monthly income ranging from USD 252 to USD314 (RM800 to RM1,000).

Table 6: Monthly Income and Awareness

Monthly Income	**Awareness**		
	Yes	**No**	**Total**
USD94 and below	0	44	44
USD95 – USD157	0	44	44
USD158 – USD251	0	32	32
USD252 – USD314	4	8	12
Total	4	128	132

6.5 Relationship between Independent and Dependent Variables

Table 7 indicates that there is a positive correlation between affordability in getting health care when sick and the need for financial protection, since the r-value = 0.205 and p-value= 0.18 (p-value <0.05). From the survey, 97% of

respondents hardly received any form of medical treatment when they fall sick and 67% cannot afford to pay for medical treatment, while 43% of the respondents borrowed money to get the medical treatment when needed. It indicates that these respondents obviously do not have the financial capacity to pay for health care. Some of them are bedridden and hardly get the medical treatment due to unavailability of transportation to the nearest hospital.

There is a positive relationship between financial capacity and the need for financial protection as the r-value = 0.271 and p-value = 0.002 (p-value < 0.01). The higher correlation denote the importance of the independent variable to the dependent variable, i.e. to have financial protection and that a few of the respondents have capacity in only fulfilling their family needs. In addition, the Pearson Correlation test also indicates the ability to save for children's education, emergency and old age (Savings) and have a positive relationship with the need for financial protection. Since there are 88% respondents who do not have savings, the need for financial protection is pertinent during emergency and when risks occur. Of the three variables, affordability measured by income or ability to support oneself and dependence seemed to be the determinant factor that could predict the need for financial protection due to the relatively high coefficient value (.270) and significant as p-value = .002 (Table 7).

Table 7: Correlations

		Affordability	**Financial Capacity**	**Loss Exposure**	**Need for Protection**
Affordability	Pearson Correlation	1.000	-0.094	-0.284**	0.205*
	Sig. (2-tailed)		0.283	0.001	0.018
	N	132	132	132	132
Financial Capacity	Pearson Correlation	-0.094	1.000	-0.180*	0.271**
	Sig. (2-tailed)	0.283		0.039	0.002
	N	132	132	132	132
Loss Exposure	Pearson Correlation	-0.284**	-0.180*	1.000	0.270**
	Sig. (2-tailed)	0.001	0.039		0.002
	N	132	132	132	132
Need for Protection	Pearson Correlation	0.205*	0.271**	0.270**	1.000
	Sig. (2-tailed)	0.018	0.002	0.002	
	N	132	132	132	132

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

6.6 Multiple Regression Analysis

Table 8 below indicates that the tested variables, namely; risk coping mechanism, affordability, financial capacity and the need for financial protection are highly significant at $p<0.01$ at a 99% confidence level.

Table 8: Linear Regression of Dependent Variable vs. Independent Variables

ANOVA[b]

Model	Sum of Squares	Df	Mean square	F	Sig.
Regression	10.224	3	3.408	18.335	.000[a]
Residual	23.792	128	.186		
Total	34.015	131			

Coefficients[a]

Model	B	t	Sig.
(Constant)	-.073	-.146	.884
Risk coping mechanism	.396	4.715	.000
Affordability	.422	5.077	.000
Financial capacity	.291	5.628	.000

Dependent Variable: Need for financial protection

7.0 Discussion of the Results

From the findings, the researchers accepted all six (6) hypotheses. Hypotheses 1 was accepted and concluded that poor people do not have appropriate risk coping mechanism. This is aligned to that of Matul's (2005) and Ahmed's (2006) studies which confirmed that the needs for microinsurance among the poor and vulnerable households are very high as they do not have appropriate risk management strategies and have to borrow from many sources to cope with the expenses that unfolded. Matul (2005) further demonstrated that there is a strong correlation between household indebtedness and impact of risks. In addition, Ahmed (2006) identified that most respondents use their own savings and relinquish their assets to cope with the risks.

Hypothesis 2 is also accepted. The study has confirmed that the awareness levels on any form of financial protection techniques are very low. They are also not aware of financial protection products like *takaful* and insurance. The study is supported by Ahmed (2006) who confirms that low awareness of insurance is due to being uneducated, having low income household and they do not believe in insurance. Matul (2005) stated that insurance knowledge depended on income and location of the individual. However, Link and Wirz (2008) confirmed that there is no correlation with income in their study on poor women.

Hypothesis 3 is also accepted, as the findings indicated that they needed some form of financial protection through *takaful* (95% said 'yes' to *takaful* policy). The correlation test and regression further confirmed this findings as the results indicated high significant level between the Dependent Variable (need for financial protection) and Independent Variables (affordability and financial capacity). Hypothesis 4 is similarly accepted as the findings confirmed that do not have access to health care when they fall sick. Also the results depicted that, 97% of the respondents were not getting medical treatment when they fall sick due to financial constraints. Dror et. al (2009) further confirmed that most of the insured are respondents who seek medical treatment in hospital compared to the uninsured. From the findings on poor households, surprisingly both insured and uninsured preferred to seek medical treatment from private clinics, hospitals and pharmacies rather than government hospitals.

Hypotheses 5 is not rejected, because only 12% have savings while the rest (88%) are unable to save for the future, and at the time they may need most, such as risk of natural disaster (flood), death of a bread winner, sickness, accident and many more, they are ill-prepared. Since most of them are daily income earners and working in the agricultural sector, hence, the possibility to be unemployed is higher than falling sick, meeting with an accident, bad weather such as prolonged raining, dependents falling sick and so forth.

Hypothesis 6 is accepted in conjunction with the result which confirmed that the rural poor have no ability and capacity in contributing even with the minimum amount of payment, for as low as USD3.18 (RM10) per month. This is in contrast to the earlier exploratory study carried out by the researcher on the low income and poor from the urban area, where most of the respondents are willing to participate in micro-*takaful* and willing to part with a minimum of USD11 (RM35) monthly. This finding is supported by Matul's (2005) who found a quarter of rural household who do not have any permanent source of income and has very limited saving culture, thus they are unable to do an effective financial planning. Loster and Reinhard (2010) confirmed that the annual insurance premium is not the only matter poor people may not afford small premium instalments, but, they may not be able to make a regular monthly contribution too, due to financial constraints.

8.0 Recommendation

The study demonstrates that the poor is in dire need of financial support when they fall sick, need for children education, coping with other daily risks and during old age. The government should urge Islamic insurance or *takaful* operators to design micro-*takaful* products to offer to this potential market. In order to ensure the population is covered, *zakah* bodies and the government may

get involved in providing financial support to enable these poor and extreme poor have financial capabilities to participate in a micro-*takaful* scheme.

One possible way is to explore a global *takaful* alliance that leverage on the wealthy, including *zakah* collections into a structured micro-*takaful* arrangement that is professionally and efficiently run by tapping into the appropriate delivery channels to deliver this product to the needy. Ahmed's (2004) study revealed that *zakah* and *waqf* institutions are not being used to their full potential in Malaysia, Pakistan and South Africa. Due to this fact, the government needs to integrate the role of these institutions in an overall development plan of the country. The Malaysian government can enforce the policy to help the poor via micro-*takaful* by providing subsidy and *zakah* as part of their monthly contribution. In terms of *zakah*, only the needy and poor can benefit from this policy.

The government and the relevant authorities should revise the existing *takaful* products, in order to make it accessible to the poor and extreme poor. According to Mohamed (2008), *Takaful-ta'wuni* is ideal since it is a not-for-profit scheme and takes the form of mutual guarantee by members in a cooperative venture. Islamic approach to alleviate poverty involves a charity based intervention inherent in the institutions of *zakah* and *sadaqa* to take care of consumption needs of the extremely poor and the destitute and create a social safety net.

There is a large number of household under the poverty category. They can be grouped into the pool for micro-*takaful* policyholders, undertaken by *zakah* bodies. Biener and Eling (2011) stated that the group policies may overcome the adverse selection and moral hazard problems under micro-insurance markets and can be applied similarly for micro-*takaful*.

To provide relevant aid to the poor, the government should enforce every eligible working Muslims to pay *zakah* by monthly deduction from their eligible income, similar to the compulsory monthly deduction for taxation. Dogarawa (2009) commented that *zakah* is an ad hoc practice and an irregular contribution from Muslims around the world. The absence of trustworthy and credible z*akah* administration and voluntary organisations in many Muslim minority countries has made the socio-economic role of z*akah* almost a thing of the past. Thus there is a need to bring *zakah* to the economic fold and ensure its role in poverty eradication is substantiated.

The government should provide effective and comprehensive financial protection to the poor by creating additional fund via using subsidy and *zakah* to

complement this need (Bhatty 2010). The government of China spent higher amounts on insurance financing for its rural and urban population. Their health care system under various schemes is designed according to local economic situation and public view. China's insurance financing system is definitely better off than some of its Asian counterparts, like Indonesia and India (Gumber 2002).

Reference

Abdul Rahman, Z. and **Mohd Daud, N.** (2010) *Adverse selection and its consequences on medical and health insurance and takaful in Malaysia*. Humanomics, 26(4), pp. 264-283. Emerald Group Publishing Limited.

Ahmad, E., Drèze, J., Hills, J. and **Sen, Amartya** (1991) *Social Security in Developing Countries*. Clarendon Press, Oxford, pp: 423-424.

Ahmed, H. (2004) "Role of *Zakah* and *Awqaf* in Poverty Alleviation." Occasional paper No.8. Islamic Development Bank Group, Islamic Research & Training Institute. Available at http://www.irti.org/irj/go/km/docs/documents/IDBDevelopments

Ahmed, M. (2006) "Market Research on Microinsurance Demand." Technical Assistance Consultant's Report-Market Research on Microinsurance Demand. Project Number: 4761-SRI (2006) Sri Lanka: Microinsurance Sector Development for Ministry of Finance and Planning. Asian Development Bank (ADB).

Ali, Mortuza M.K. (2000) *Provision of Microinsurance for Microfinance Clients.* Microfinance Newsletter Issue No. 7, pp: 2-5 January-March 2000.

Al Quran (verse 9:60)

Anderson, J.F. and **Brown, R.L.** (2005) "Risk and Insurance." (Second Printing). Society of Actuaries (SOA Study Note).

Banking with the Poor Network (2008) "Microfinance Industry Report-Vietnam." Available at http://www.bwtp.org/files/MF_Industry_Report_Vietnam

Bank Negara Malaysia website. Available at www.bnm.gov.my/ -

Banthia, A., Johnson, S., McCord, M. J. and **Mathews, B.** (2009) "Microinsurance that works for women: Making gender-sensitive microinsurance programs." Microinsurance Paper No. 3. International Labor Organization.

Berma, M., Shahadan, F. and **Abdul Ghapor, S.** (2006) "Alleviating Bumiputera Poverty in Sarawak: Reflections and Proposal." Paper presented in The Malaysian Research Conference 4th International Conference, 19-21 June 2006, Salford, England.

Bhatty, A. (2010) *Protecting the Forgotten Through Micro-takaful*. Middle East Insurance Review, July 2010, pp. 60-61.

Billah, M.M. (2001) "Takaful (Islamic Insurance): An Economic Paradigm." International Cooperative and Mutual Insurance Federation (ICMIF Takaful). Available at http://www.takaful.coop/index

Brown, W. and **McCord, M.J.** (2000) "Virtual Conference on Micro-insurance." Oct 9th–Oct 27th, 2000'. USAID Microenterprise Best Practices (MBP) Project, Development Alternatives /USAID 2000.

Brown, W. (2001) *Micro-insurance-the risks, perils and opportunities*. Small Enterprise Development, Volume 12, Number 1, 1 March 2001, pp. 11-24(14)

Churchill, C. (2002) *Trying to understand the demand for microinsurance*. Journal of International Development. Volume 14, pp. 381–387.

Churchill, C. (2006*) What is insurance for the poor? Protecting the Poor: A Microinsurance Compendium.* International Labor Organisation, pp. 12-22.

Cohen, M., McCord, M.J. and **Sebstad, J.** (2005) *Reducing vulnerability: demand for and supply of microinsurance in East Africa.* Journal of International Development. Volume 17, Issue 3, pp. 319–325, April 2005.

Cohen, M. and **Sebstad, J.** (2005) *Reducing vulnerability: The demand for microinsurance.* Journal of International Development. Volume 17, Issue 3, pp. 397-474, April 2005.

Cohen, M. and **Sebstad, J.** (2006). *The Demand for Microinsurance*, in C. Churchill (ed.), *Protecting the Poor, A Microinsurance Compendium*, International Labor Organisation, pp. 25-44.

Cooper D.R. and **Schindler, P.S.** (2006) *Business Research Methods*. 9th Ed. New York: McGraw-Hill.

Das J., Hammer J., Leonard, K. (2008) *The Quality of Medical Advice in Low-Income Countries*. Journal of Economic Perspectives, American Economic Association. 2008; 22(2), pp: 93-114.

Dogarawa, A.B. (2009) "Poverty Alleviation through *Zakah* and *Waqf* Institutions: A Case for the Muslim *Ummah* in Ghana." Munich Personal RePEc Archive (MPRA) Paper 23191. Available at http://mpra.ub.uni-muenchen.de/23191/

Dror, D. M., Radermacher, R., Khadilkar, S. B., Schout, P., Hay, F-X., Singh, A., and **Koren, R.** (2009) *Microinsurance: Innovations In Low-Cost Health Insurance*. Health Aff (Millwood). 2009;28(6):1788–98.

Economic Planning Unit, United Nations Development Programme (UNDP), Malaysia (2007) Available at www.epu.gov.my/

Erlich, I. and **Becker, G.S.** (1972) *Market Insurance, Self Insurance and Self Protection.* The Journal of Political Economy, **80**(4), pp: 623-648.

Frenz, T. and **Soualhi, Y.** (2010) *Takaful & Retakaful, Advanced Principles & Practices*. Munich Re 2010, pp. 23.

Gumber, A. (2002) "Health Insurance for the Informal Sector: Problems and Prospects." ICRIER Working Paper No. 90. Indian Council for Research on International Economic Relations, New Delhi.

Hubbard, D.W. (2010) *How to Measure Anything: Finding the Value of Intangibles in Business.* 2nd Ed. New Jersey: John Wiley & Sons, pp. 49.

Kahf, M. (1999) "The Performance of the Institution of *Zakah* in Theory and Practice", Paper Presented at the International Conference on Islamic Economics towards the 21st Century, Kuala Lumpur.

Khan, M.F. (2007) "Integrating Faith-based Institutions (*Zakah and Awqaf*) in Poverty Reductions Strategies (PRS)" Available at http://ctool.gdnet.org/conf_docs/Khan paper_BRP_wk.doc.

Khan, M.J.A. (2006) "Micro-*takaful*, the way forward." Academy for International Modern Studies. Available at www.LearnIslamicFinance.com

Link. B., and **Wirz, M.** (2008) "Why the poor are underinsured - a case study on Micro-insurance in Southeast India." Available at http://arc.hhs.se/download.aspx

Llanto, G.M., Almario, J and **Llanto-Gamboa, M.G.** (2006) "Microinsurance: Issues, Challenges and Policy Reforms." Discussion Paper Series No. 2006-25. Philippine Institute for Development Studies. Available at http://www.pids.gov.ph

Loster, T. and **Reinhard, D.** (2010) *Micro-insurance and Climate Change*, in Morelli E., Onnis G.A., Ammann W.J., Sutter C. (Eds.) (2010), *Micro-insurance - an Innovative Tool for Risk and Disaster Management.* Global Risk Forum GRF Davos, Switzerland, pp. 39-42.

Matul, M. (2005) "Demand for Micro-insurance in Georgia. Quantitative Study Results." Microfinance Centre for Central and Eastern Europe and the New Independent State. Available at http://www.mfc.org.pl/sites/mfc.org.pl/files/Demand_for_ Micro-insurance _in_Georgia.pdf

McCord, M.J. (2011) "Micro-insurance Product Development for Microfinance Providers. A Manual for Facilitating Widespread Access to Micro-insurance Services (IFAD)." Micro-insurance Centre. Available at www.microinsurancecentre.org/

Mohamed, G.K. (2008) *Financing health care in Sudan: Is it a time for the abolishing of user charges?* Sudanese Journal of Public Health: January 2007, 2(1), pp. 38-47.

Mohd Rom, N.A. (2010) The development of Micro-*takaful* for low income and poor. Paper presented in 3rd International Conference on Business and Management Education, Bangkok, Thailand, 24-27th January 2011. **3**, pp. 82.

Morduch, J. (1999) *Between the State and the Market: Can Informal Insurance Patch the Safety Net?*. The World Bank Research Observer, **14**(2), (August 1999), pp: 187-207.

Mustaffa, R. and **Ismail, L.** (2006) "The Third National Health and Morbidity Survey 2006: Physical Disability in Perak." Hilir Perak District Health Office, web documents files. Retrieved October 15, 2009 from www.jknperak.moh.gov.my.

Nhu-An, T. and **Tan S.Y.** (2004) "TYM's Mutual Assistance Fund Vietnam." CGAP Working Group on Microinsurance. Good and Bad Practices Case Study No. 3. Available at www.ilo.org/publns

Nyanjom, E. (2006) "Inequality in Kenya's Health Sector." Readings on Inequality in Kenya: Sectoral Dynamics and Perspectives. Available at http://www.hennet.or.ke/downloads/humanrights/InequalityKenya.pdf

Obaidullah, M. and **Khan Tariqullah** (2008) "Islamic Microfinance Development: Challenges and Initiatives." Islamic Research & Training institute, Policy Dialogue Paper No. 2.

Patel, S. (2002). "Insurance and Poverty Alleviation. The Cooperative Advantage." Available at http://www.ocdc.coop/Sector/Insurance/InsuranceAndPoverty.pdf

Patel, S (2007) *Opportunities and Challenges of Micro-insurance. Providing an alternative risk pooling mechanism for the poor.* The International Cooperative and Mutual Insurance Federation (ICMIF). Prosper. Issue 1, 2007.

Performance Management and **Delivery Unit** (PEMANDU), Malaysia. Available at www.pemandu.org.my

Preker, A.S., Carrin, G., Dror. D.M., Jakab, M., Hsiao, W. and **Arhin, D.** (2001) *The Role of Community in Resource Mobilization and Risk Sharing: A Synthesis Report*. The International Bank for Reconstruction and Development / The World Bank, Washington.

Qaradawi, Y. (1999) "*Fiqh al-zakah*: A Comparative Study." Translated by Monzer Kahf London: Dar AI-Taqwa Ltd. Research Strategy Macro-insurance Innovation Facility 2008-2012.

Radermacher, R., Putten-Rademaker, O.V., Müller, V., Wig, N. and **Dror, D.** (2005) "Karuna Trust, Karnataka India CGAP Working Group on Microinsurance." Good and Bad Practices Case Study No. 19. Available at www.ilo.org/publns.

Roth, J. and **Athreye, V.** (2005) "TATA-AIG Life Insurance Company Ltd. India. CGAP Working Group on Microinsurance." Good and Bad Practices. Case Study No. 14. Available at www.ilo.org/publns

Sachs, J.D. and **McArthur, J.W.** (2005) *The Millennium Project: a plan for meeting the Millennium Development Goals.* Lancet Vol. 365 January 22, 2005. Available at www.thelancet.com.

Swartz. N.P. and **Coetzer P.** (2010) *Takaful*: *An Islamic insurance instrument.* Journal of Development and Agricultural Economics, **2**(10), pp. 333-339, October, 2010.
Available at http://www.academicjournals.org/JDAE

Tanuja, P.K. and **Sihare, H.** (2011) *Pros & cons of micro health insurance to eradicate health problems in the Below Poverty Line (BPL) population: empirical evidence from India.* Italian Journal of Public Health. IJPH - Year 9, **8**(4).

Tenth Malaysian Plan. Available at www.epu.gov.my/.../rmke10_english.html

United Nation Development Program, Malaysia. Available at www.undp.org.my

Wood, G. (2003) *Staying Secure, Staying Poor: The ''Faustian Bargain.''* World Development, **31**(3), pp: 455-471, 2003. World Development Report 2010. The World Bank.

الحماية المالية للفقراء في ماليزيا: دور الزكاة والتكافل المصغّر

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المستخلص. العديد من البحوث أظهرت أن معظم ذوي الدخل المحدود والفقراء ليس لديهم الحماية المالية للحد من الخسارة. إن الغرض من ورقة البحث هذه هو للتحقيق في: أولاً: فيما إذا كان هناك وسيلة لحماية المال بين الفقراء، وثانياً، لتحديد قابليتهم المالية والمواظبة على تقديم دفعات شهرية لبوليصة التكافل المصغّر. الدراسة جاءت استجابة للذين سقطوا تحت خط الفقر في المناطق النائية من "فيراق" ماليزيا. لقد تبين أن (٩٧٪) من المجيبين بدون حماية مالية وغير قادرين على المساهمة بأي مبلغ من أعمال للحصول على الحماية. الباحثون يوصون بأن تدخل ودعم الحكومة حيوي من أجل توفير القابلية المالية للفقراء من أجل الحصول على الحماية التي في الأساس ستغطي مصاريف الوفاة والعلاج والاستفادة من الادخار على الحكومة الماليزية أن تفرض سياسة لتوفير المساعدة للفقراء من خلال "التكافل المصغّر" عن طريق تقديم الدعم والزكاة كجزء من مساهمتهم الشهرية. بأموال الزكاة، ذوي الدخل المحدود هؤلاء سيحصلون على نموذج التكافل المصغر خاصتهم الذي يفترض أن يكون قادرا على توفير المساعدة الكافية، مانعا إياهم أن يحتجزوا في دائرة الفقر بصورة دائمة.

الكلمات الرئيسية: التكافل المصغر microtakaful ، *التأمين المصغر* microinsurance، *تكافل takaful* ، *زكاة zakah* ، *التأمين الإسلامي* Islamic insurance ، *الفقر* poverty.