KEY MESSAGES:

Insurance is an important component of risk management, and ensuring that poor households have access to insurance services is a high priority in Africa. Given the risk profile in the region, the most important kinds are health, life, and crop insurance. While coverage of all of these types is still relatively low, there have been important innovations in recent years. Several countries, including Rwanda and Ghana, have undertaken ambitious reforms to expand health insurance to cover a significant share of the national population. Micro-insurance is growing rapidly as a result of an expansion in the number of microfinance institutions across the continent. Also several countries have begun offering weather-indexed insurance to protect farmers at a lower cost than traditional crop insurance and with greater reliability. The main challenge will be to encourage poor households to invest in insurance, as one of a menu of social protection instruments. This would not only ensure that a higher share of poor households is covered by the social protection system but would also enable governments to target scarce public resources to the poorest of the poor.

OVERVIEW

Insurance mitigates the economic effects of events like illness, death, disability, fire, theft, and natural disaster on individuals, households, or enterprises. In doing so, insurance helps people to avoid destitution, smooth their consumption, protect their assets, and pursue high-return economic activities and investments. In this way, insurance is one strategy on a continuum of risk management options (see figure on right).

Increasing the access of poor households to insurance mechanisms can prevent them from having to rely on publicly funded support from, for example, a safety net program to cope with the negative consequences of a shock. It can also encourage them to adopt alternative, more productive livelihoods (for example, planting higher-yield crops insured against the risk of drought) that can help to lift them out of poverty.

Therefore, insurance should be regarded as an integral part of a social protection system. The overall insurance agenda is broad, but it relates to social protection in so far as it supports people who are left out of the market to access insurance products and prevents vulnerable families from falling into destitution.

Social Protection-oriented Insurance Programs in Africa

Insurance instruments in Africa are still relatively underdeveloped. There are some historical precedents in the region such as cooperative insurance, community-based health insurance schemes, and informal insurance arrangements through funeral and burial societies. Hardly any private insurance products exist for the rural and urban poor and, even when they do exist, these households cannot afford them. Public social security, which includes not only pensions but also disability and life insurance (survivorship), is limited in Africa, reaching only an estimated 10 percent of the population who are mostly civil.
servants. It is believed that health insurance has similarly limited coverage. A growing area of insurance is micro-insurance, which offers insurance products – most often credit-life and life insurance – to low-income individuals for low premiums. This is largely an outgrowth of microfinance, with the microfinance institutions (MFIs) being the main providers of micro-insurance. A 2009 ILO survey of micro-insurance in Africa estimated that 14.7 million people were covered by these products, equivalent to about 2.6 percent of the population living on less than $2 per day. Despite some recent progress, the vast majority of African households have no insurance against most risks.

Three types of insurance are of particular interest in terms of furthering the social protection of vulnerable populations in Africa in the coming decade:

Life insurance is the most common form of micro-insurance in Africa, facilitated by the extension of the microfinance model into the area of insurance. However, the life insurance provided by MFIs is mainly a way of insuring loans (“credit life insurance”) rather than providing income support in the case of the policyholder’s death.

Agricultural insurance has mainly consisted of crop insurance that covers farmers against multiple shocks and pays out against losses that the insurer assesses by observing harvest yields. Index-based insurance pays out fixed sums to farmers when an independently observed trigger (often rainfall levels, livestock mortality rates, or crop yields) shows that an insured event has occurred. Experiments with index-based insurance are being carried out in various countries, such as Kenya and Malawi, to manage the effects of covariate shocks on rural livelihoods.

Health insurance. Many African countries are developing public, private, and community-based health insurance programs to pool the risks associated with health shocks. The coverage of these programs remains quite low, particularly among the poor, but there is some growth in community health insurance for low-income populations. Several countries (such as Rwanda and Ghana) have recently expanded the coverage of health insurance to a large share of their populations. Gabon, Kenya, Nigeria, and Sudan have begun to scale up their national health insurance schemes to extend coverage. Despite this progress, most health insurance policies cover only a limited amount of the full spectrum of health costs, and few programs anywhere cover loss of earnings for non-formal sector workers, which often dwarfs the out-of-pocket costs incurred by adults.

Key Design Elements

The experience of African countries with insurance has yielded the following operational lessons:

- To deliver insurance in a cost-effective way, investments in existing institutions need to be leveraged. For life insurance, these institutions may include networks of MFIs and community-based organizations. In Senegal, Benin, and Mali, the populations are increasingly being covered by mutuelles de santé - non-profit, membership-based health insurance organizations with funding based on member premiums. This model can be used to expand the coverage of insurance as has happened in Rwanda.

- Setting premiums at the right level is only one aspect of extending insurance to poor households. Experience has shown that how insurance is delivered is crucial to the successful expansion of coverage. This means timely payouts, good technical advice, and regular, credible information (for index-based insurance, this specifically means reliable and timely data on index values).

- It is critical that any insurance products supported by governments should be strictly market-based, including having a design and a rating methodology that are actuarially sound.

- Achieving high rates of insurance coverage among poor populations will require subsidizing or even entirely covering the cost of premiums for these households in the short term. Determining which groups to subsidize, to what extent, and for how long is ultimately a political question but needs to be informed by a sound understanding of poor populations, including their location and employment status, and of the possible implications of such subsidies for labor markets.
Expanding Access to Micro-insurance in South Africa. The extension of access to financial services to the low-income market is an explicit goal of the Government of South Africa. Under the Financial Sector Charter of 2003, insurers are obliged to fulfill certain access targets for their policies. For example, they are expected to cover a minimum of 6 percent of low-income households with short-term insurance (losses related to property) and 23 percent with long-term insurance (relating to life events) by 2014. The Financial Sector Charter has prompted commercial insurers to offer micro-insurance schemes to the low-income market. These services are offered by a variety of formal and informal institutions, with the majority typically focused on funeral insurance. Low premiums, simplicity, flexible terms, and appropriate mechanisms for paying premiums are prerequisites for achieving success in the low-income market. Cell phones are increasingly used as distribution and payment mechanisms. As an example, in 2006 Hollard Insurance, South Africa’s largest privately owned insurance company, began to issue individual and family funeral insurance sold through a low-income clothing and small appliance retailer, Pep. The product is sold off-the-shelf in packaging similar to cell phone starter packs, with customers paying their monthly premiums in-store in cash. Over 215,000 policies had been sold by 2009.

Malawi’s Weather Insurance Pilot. Because over 90 percent of crops in Malawi are rain-fed, a weather-indexed insurance pilot (IBWI) was initiated in 2005 that has had a positive impact on the incomes of agricultural producers. In the first year, two microfinance institutions (OIBM and MRFC) sold weather-indexed insurance policies to 892 groundnut producers with premiums priced at about 5 percent of payout. In subsequent years, the pilot was expanded to cover an additional 2,225 tobacco and maize farmers. The index provided farmers with coverage against both deficit and excessive rainfall based on historical data for the previous 40 years from five weather stations. Payouts are automatically made when the rainfall index crosses the specified threshold at the end of the contract period. As the crop insurance contracts mitigated the weather risk associated with lending, local banks came forward to offer loans to insured farmers to purchase high-quality seed and fertilizer to greatly increase their crop yield. By 2009, the total value of the crops being insured in Malawi was US$2.4 million. To increase the coverage of the scheme, the government may have to subsidize the premiums for low-income households.

Ghana’s National Health Insurance Scheme (NHIS). In 2005, Ghana rolled out its social health insurance scheme by creating District Mutual Health Insurance Schemes (DMHIS) covering all of the country. The aim of this scheme was to eliminate the system of user fees that was limiting access to health services for the poor. A national health insurance levy of 2.5 percent on selected goods and services funds 63 percent of the scheme’s costs, with the remainder coming from premiums, donors, and the general budget. The minimum annual NHIS premium is set by national regulation at approximately US$5 per person, but each DMHIS decides on the premium amount, which can vary by income level. Almost 16 million Ghanaians are currently covered, representing two-thirds of the population, a rapid increase from the 1.3 million covered in 2005. Evaluations have found that, among those who were recently ill, those enrolled in the NHIS were twice as likely to have sought care at a modern health facility as the uninsured and that the number of births attended by skilled professionals rose significantly. There has also been a substantial reduction in out-of-pocket expenditures for health care. However, participation by the poorest has been lower than policymakers had hoped.

Rwanda’s Community-based Health Insurance. Since 2000, the Government of Rwanda has progressively increased the coverage of health insurance among the population through mutuelles de santé (community health insurance schemes). By 2010, an estimated 92 percent of the population was covered, up from just 7 percent in 2003. About 50 percent of mutuelle funding is comprised of annual member premiums, which average US$2.00 per person per year. The rest of the funding comes from non-mutuelle insurance funds, charitable organizations, NGOs, development partners, and the Government of Rwanda. Specifically, these funds subsidize the annual membership fee for 1.5 million “poorest of the poor,” which covers the minimal package of essential treatments at health centers. Subsidies for another 1.35 million poor citizens, amounting to an additional US$2.00 per person, are channeled to the districts to cover health care at the secondary level. In mid-2011, the government increased the annual membership fee to take into account “capacity to pay,” but the fees for the poorest households continued to be fully subsidized by the government. Independent evaluations have found evidence of increased access to and use of health care among beneficiaries, as well as lower levels of out-of-pocket spending. Catastrophic expenditures have declined by 17 percentage points.

COUNTRY EXAMPLES OF INSURANCE PROGRAMS IN AFRICA
CHALLENGES AND OPPORTUNITIES

The burgeoning experience with insurance instruments in Africa suggests the following priorities:

Promote the access of poor populations to insurance. Increasing the access of the poor to insurance will significantly improve the delivery of social protection and yield important gains in poverty reduction and economic growth.

Build insurance instruments into national social protection systems. National social protection systems aim to provide a continuum of risk management options, and insurance plays an important role in this. Some of the demand for safety nets after a crisis could be handled more effectively by encouraging the purchase of insurance before the shock occurs to mitigate its impact. For example, weather-based crop insurance can help farmers to survive a catastrophic loss of agricultural production due to poor rains, thus reducing their need for emergency food aid or other short-term coping measures. In this way, promoting the uptake of insurance by poor households not only ensures that a higher share of poor households is covered by the social protection system but also enables governments to target scarce public resources to the poorest of the poor.

Bundle insurance with other financial services or with targeted social protection programs. This can be an effective way to reach poor households and to harness the synergies between insurance and other financial services to promote the livelihoods of the poor. For example, life insurance could be bundled with credit, or agricultural input lending could be coupled with a weather insurance policy.

Leverage social protection programs for the outreach, targeting, and delivery of insurance. Many of the constraints to expanding access to insurance to poor households can be addressed cost-effectively, at least in part, by using existing social protection delivery mechanisms. For example, pre-existing targeting mechanisms can be used to identify those poor households who are eligible for subsidized health insurance. Finding these synergies is one of the advantages of building a national social protection system.

Additional Resources and Readings:


