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Making Finance Work for Africa

Microinsurance in Uganda

Country diagnostic report on market and regulations

Abstract

Uganda has a relatively undeveloped insurance market and there is clear potential for expansion, particularly through microinsurance. However, insurers face significant challenges in developing microinsurance beyond credit life. The principal reasons for this are a limited understanding of insurance and its benefits and a very low level of trust amongst the public. A significant reason for the lack of trust is the very low claims ratios, particularly for statutory third party motor claims. Although service levels have improved over the last few years, they are generally considered to be low. Consumer education and market awareness campaigns are widely considered to have strong potential. However, they are likely to fail or be ineffective unless trust can be restored. This in turn requires higher claims ratios, faster claim payment times and improved service standards. These should be the first priority.

One other significant constraint is the lack of suitable delivery channels, especially outside Kampala. The reliance on the traditional broker/agent model is much too expensive for microinsurance. New distribution channels are required. Banks and financial institutions may perhaps provide the most promising distribution channel, but amendments to legislation are required in order to enable their full potential to be achieved.

Heath microinsurance is still a nascent market in Uganda. The development of health insurance faces many challenges, including significant supply-side constraints. The development of health insurance is further complicated by the proposals to create a National Health System. Although the final form of the proposals has not yet been finalised, the new National System is likely to crowd out health microinsurance to some extent.

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The Partners

The Insurance Regulatory Authority (IRA) is charged with the mandate of ensuring effective administration, supervision, regulation and control of the business of insurance in Uganda. Promoting a sound and efficient insurance market in the country is one of its prime functions.

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Acronyms

A2ii	Access to Insurance Initiative
AML	Anti-money laundering
BoU	Bank of Uganda
CFT	Combating the financing of terrorism
CBHIS	Community Based Health Insurance Scheme
CoP	Certificate of Proficiency
EAC	East African Community
FATF	Financial Action Task Force
GDP	Gross Domestic Product
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH
HIO	Health insurance organisation
HMO	Health Maintenance Organisation
IAIS	International Association of Insurance Supervisors
ICD	International Classification of Diseases
ICP	Insurance Core Principles
IMF	International Monetary Fund
IRA	Insurance Regulatory Authority of Uganda
MDI	Microfinance Deposit Taking Institution
MFI	Microfinance Institution
MIO	Microinsurance organisation
MNO	Mobile network operator
MoH	Ministry of Health
NDP	National Development Plan
NHIS	National Health Insurance Scheme
NTD	Neglected Tropical Diseases
PHP	Private for-profit health provider
PNFP	Private not for-profit provider
PPPH	Public-Private Partnership in Health
SACCO	Savings and Credit Cooperative Organisation
UBOS	Uganda Bureau of Statistics
UCBHFA	Uganda Community Based Health Finance Association
UDHS	Uganda Demographic and Health Survey
UGX	Ugandan shillings
UNMHCP	Uganda National Minimum Health Care Package
USD	United States dollars
WHO	World Health Organization

Executive Summary

This Report presents the findings of a study on the microinsurance market in Uganda that was undertaken during the first half of 2013. The primary objective of the study, and this Report, is to make recommendations to the Insurance Regulatory Authority (the Authority) for a policy framework for regulating microinsurance, including health microinsurance. A subsidiary objective is to update a previous study undertaken under the auspices of the Access to Insurance Initiative (A2ii) in 2008.

The primary legislation, the Insurance Act, was amended in 2011 to enable the licensing, regulation and supervision of health membership organisations (HMOs) and health insurance organisations (HIOs). The study therefore included a specific focus on understanding the health financing environment in Uganda, including the public financing of healthcare service as well as the market for and operations of HMOs and HIOs.

Uganda has an undeveloped but growing insurance market. Insurance penetration, at just 0.65% of Gross domestic Product (GDP), is much lower than the penetration in Kenya (3.2%) and the African market taken as a whole (3.6%). On the basis of the figures reported to the Authority, 800,000 individuals (or 2.3% of the population) are covered by an insurance policy. Although the reported figures almost certainly understate the number of individuals covered, in particular by group credit life and health insurance, the outreach is low. There is clear potential for expanding the market, especially given the robust growth in GDP and Uganda's young and rapidly growing population.

The industry and the Authority look to microinsurance as one of the drivers of market growth, and with some 43% of the population being classified (in 2009/10) as "non-poor but insecure" compared with 32.6% classified as middle class, there is some justification for this view as it is likely that only microinsurance will be able to reach a significant portion of the population.

Although Uganda was one of the first countries in which a formal microinsurance product was sold (in 1997), microinsurance has not developed to the extent that it has in other countries within the region. Only 6 of the 21 licensed insurers currently offer policies designed to target the low-income and informal segment of the population. This may be partly explained by the fact that both the life and non-life markets are dominated by just a small number of relatively large insurers. Almost all of the microin-

surance offered is group credit life, mainly sold through microfinance institutions. Despite widespread interest in the development of microinsurance products, very few insurers have developed a specific strategy for growing their microinsurance book. Health and agriculture are seen as areas with particular potential for microinsurance. However, whilst there may be a need and demand for such products, they are also the most difficult products to design and offer, especially at the micro level.

It is clear that insurers face significant challenges in providing microinsurance products, beyond group credit life, that will provide value to their clients. Perhaps the most significant challenge for microinsurance is the very low level of trust in insurers held by the public, together with a general lack of understanding of the concept of insurance and its benefits. Although there are a number of reasons for the lack of trust, one important factor is the very low claims ratio for statutory third party motor liability insurance. Given difficulties in obtaining documentation and bureaucratic hurdles, motor claims usually take a considerable period of time to settle, often as long as a year. Even then, the statutory limits are extremely low. Claimants therefore receive very low payments much too late to meet the costs arising from the accident. Consequently, mandatory motor insurance seems to be viewed by many Ugandans as no more than a tax that is paid to insurers, which provides them with no benefit whatsoever. This view contributes to the lack of trust in other non-mandatory insurance products.

It is generally accepted that service levels are considered by the general public to be low. Although market participants consider that service levels have improved over the last few years, they do not meet accepted best practices. In any case, however good service levels are, it is the perception of the insuring public that counts most.

Many market participants consider that an investment in consumer education and market awareness campaigns and initiatives will help to expand the microinsurance market. Although these efforts may have a valid role, they will be ineffective, and probably counterproductive, unless trust can be restored. This will not happen unless claims ratios, claim payment times (including those under statutory third party motor policies) and service standards have improved.

Although some innovative microinsurance products have been designed, many companies do not have employees with the necessary skills and experience to develop new microinsurance products. Those insurers that belong to a regional or international group have an advantage in this area, as they can tap into their group's pool of expertise.

There are other constraints, perhaps the most significant being the lack of suitable distribution channels for insurance, particularly outside Kampala. Except for group credit life, insurance is primarily sold through the traditional broker/agent model. This is too costly for microinsurance and the traditional brokers and agents have very limited presence outside Kampala. New distribution channels are required. Banks and financial institutions are a promising distribution channel. Although the Insurance Act has been amended to enable bancassurance, the Financial Institutions Act does not permit banks to act as insurance agents. At present, banks and financial institutions are constrained to selling group products, charging an interest rate margin on the loan to cover the premium and what would otherwise be their commission. An amendment to the Financial Institutions Act has been proposed, but it is not clear when it will be enacted. If Tier 1, 2 and 3 banks and financial institutions were permitted to act as agents, they would be able to sell a wider range of individual products. Even without the enactment of the Financial Institutions Act, it is possible for banks to bundle insurance with savings. One promising product that has recently been launched is discussed later in this Report.

Consideration will need to be given to the sale of insurance through other non-traditional methods, such as the agricultural value chain, mobile network operators, and village and community leaders. However, all carry legal and regulatory implications, which are discussed in this Report.

Successful health insurance strategies are those that are flexible enough to manage the ever-changing relationships between access, cost and quality of medical care. However, creating this balance is complicated by many of the factors discussed above, such as lack of trust in the system, which in turn contribute to low uptake of health insurance.

However, the obstacles to developing a solid health microinsurance strategy in Uganda are complicated by supply constraints. Specifically, there is a severe undersupply of medical providers, medical supplies and equipment outside the Kampala area. Additionally, there is a low preventive awareness in the market. These dynamics tacitly encourage sick individuals to wait until their health state is serious before seeking healthcare, rather than addressing the problem in the earlier stages when the cost of treating the ailment would usually be lower and the likelihood of success higher.

Health insurance typically offers protection against multiple types of events, not all of which are insurable in the conventional sense. For example, some healthcare is not accidental (e.g. maternity) and some events are low-cost/high-frequency occurrences (e.g. outpatient care) which would not normally be considered insurable. While these benefits are very important to the target population, they increase product complexity and point to the need for innovative design.

If the goal is to offer a quality health outcome, it is necessary to understand health risks in Uganda. The dearth of providers includes gaps in specialist care and equipment. The marriage of an undersupply of medical providers and increasing life expectancy with the increase of non-communicable disease threats, including cardiovascular and respiratory illnesses, points to the potential for symptoms to be misdiagnosed and/or mistreated, leading to a further erosion of trust in the system.

The private health insurance market in Uganda is dominated by employer-sponsored group business provided by both life and non-life insurers as well as HMOs. Group products enable better pooling of medical risks and, as they are provided by employers, cost is not necessarily a concern to the persons covered.

HMOs are mainly facility-based organisations providing healthcare for a membership fee and referring to specialists or external providers when indicated. There are currently no regulations in place for HMOs, but it is expected that they will be regulated somewhat differently than traditional insurers. Whilst HMOs are positioned to offer health microinsurance products, the premiums would almost certainly be considered too high for the target population. Some insurers are collaborating with microfinance organisations to pilot and test hybrid products which include a health savings component.

The Ministry of Health is working to create a National Health System to provide basic benefits to all residents of Uganda. Though current estimates point to a funding deficit, it is commonly believed that some form of statutory coverage will result. Coverage is expected to begin with those in formal employment and additional funding will be located to subsidise the growth of the medical providers, particularly in rural areas.

In terms of health microinsurance, the core markets served are based outside the Kampala area and are facility-based. Mission-based hospitals form the foundation for healthcare outreach. However, even with the low costs associated with mission-based facilities, the costs of health microinsurance premiums are not always considered affordable, given other financial needs of the family/community. Some informal working communities address healthcare financing risks through Community Based Health Insurance Schemes (CBHIS). There are fewer than 30 CBHIS in Uganda. Their sizes vary from 1,500 to 10,000 members, resulting in an estimated member pool of 108,000 individuals. This represents a very small proportion of the potential market.

Creating a solid foundation for the development of health microinsurance products demands attention to the financial limitations of the target population, innovative solutions addressing provider access gaps as well as incentives to participate. These innovative solutions need to include non-insurance products that will help develop awareness of proactive health management, as well as access to quality medical outcomes. In an effort to balance access, cost and quality of healthcare, important tools to support health microinsurance development include risk sharing, standardisation of medical claims and coding, effective use of evidence-based protocols and the inclusion of patient protections, all of which will increase trust in the general healthcare and insurance environment.

Although amended in 2011, the Insurance Act pre-dates the introduction of international standards for the regulation and supervision of insurance business through the Insurance Core Principles (ICPs) published by the Interna-

tional Association of Insurance Supervisors. It is therefore not surprising that the Act does not enable the Authority to regulate and supervise the insurance market in Uganda in accordance with the ICPs. This also impacts on microinsurance. Furthermore, some provisions in the Act impose constraints on the development of an appropriate regime for supervising microinsurance, which in turn will constrain the growth of the market. Although it is possible to develop a regulatory framework for microinsurance, this will not be optimal. We therefore recommend that consideration be given to amending the Act as soon as possible, particularly as this will also better enable the Authority to regulate and supervise the insurance market as a whole.

1 Project Background

1.1 Introduction and Objectives

This Report presents the findings of a study on the microinsurance market in Uganda that was undertaken during the first half of 2013. The study was commissioned by the Insurance Regulatory Authority of Uganda (the Authority) and implemented with the financial support of the German Federal Ministry for Economic Cooperation and Development through the GIZ Uganda Financial Systems Development Programme and the Partnership "Making Finance Work for Africa".

Although the Insurance Act (Cap. 213) was amended in 2011 to enable microinsurance as a class of insurance business and to provide for the regulation of health membership organisations (HMOs), health insurance organisations (HIOs) and microinsurance organisations (MIOs), Regulations have not yet been issued by the Authority to support these amendments. Without detailed Regulations, the Authority does not have a solid basis for supervising microinsurance, which in turn impedes the development of the market.

The primary objective of the study, and this Report, is to make recommendations to the Authority for a policy framework for regulating microinsurance, including health microinsurance. Once agreed with the Authority, the framework will be used as the policy foundation for drafting new Microinsurance Regulations. The study and this Report are important first steps in the development of an appropriate regulatory framework for microinsurance in Uganda.

A previous study was undertaken under the auspices of the Access to Insurance Initiative (A2ii) in 2008. The findings from the study, which was part of a five-country case study on the role of regulation in the development of microinsurance markets, were presented in a report published in April 2008.[1] A subsidiary objective of this Report is to update that study, although the Report is intended to be a stand-alone document to be read without the need to refer to the previous report.

To that extent, the Report is designed not only for the Authority and stakeholders in Uganda, but also for regulatory authorities in other countries that are considering

1 Making insurance markets work for the poor: microinsurance policy, regulation and supervision Uganda Case Study, http://www.a2ii.org/document-details.html?dam_single=143

the development of their own microinsurance regulatory frameworks, and for the international supervisory and development community generally.

1.2 Methodology

The basis for the study and the Report is the methodology defined by the Access to Insurance Initiative Toolkit 1: "Microinsurance Country Diagnostic Studies: Analytical Framework and Methodology".[2] However, given that the principal objective of the study and Report is more focused than that envisaged by the Toolkit, the Toolkit methodology is not fully appropriate and has been adapted for this study.

In particular, a significantly more thorough legal and regulatory analysis than that envisaged by the Toolkit methodology has been undertaken, given the need to ensure that the recommendations are adequate to support the drafting of Microinsurance Regulations. Furthermore, although a thorough demand-side assessment normally forms part of a Diagnostic Report prepared using the A2ii Toolkit, this was specifically excluded from the terms of reference for this Report, as such an assessment was carried out for the 2008 Report. An updated assessment was not considered to be necessary, as demand for insurance is unlikely to have changed dramatically over the last five years. Finally, the terms of reference specified a specific focus on understanding the health financing environment, including the public financing of health services, as well as the market for and operations of HMOs and HIOs. The Report therefore contains considerably more detail on the health sector and on health insurance than would usually be found in an A2ii Country Diagnostic.

As the Report is intended to serve an audience beyond Uganda, it contains contextual material that would not normally form part of a study designed to support the development of Microinsurance Regulations. This is necessary to ensure that international readers have sufficient background to understand the findings and recommendations.

1.3 Structure of the Report

The Report is divided into 8 sections, including this introduction. **Section 2** describes the Uganda country context, as far as this is relevant to microinsurance and health microinsurance. Section 2 includes information on the financial sector generally, as well as considering the overarching policy and development strategy of the Government. **Section 3** considers the health sector in Uganda. In particular, it examines the principal health risks, which are of critical importance to the development of health insurance products, the health infrastructure, which is necessary to deliver the benefits provided under many health insurance policies, and access to medical care. **Section 4** analyses and describes the insurance market in Uganda, including health and microinsurance. **Section 5** contains a very brief summary of and discussion on the proposed National Health Insurance Scheme. Once the proposed Scheme becomes operational, it is likely to have a significant effect on the demand for health microinsurance. **Section 6** sets out some proposals or strategies for the development of microinsurance and health microinsurance. **Section 7** contains a comprehensive analysis of the current legal and regulatory framework for insurance in Uganda and discusses how the existing framework may constrain the development of microinsurance in the country. This section also contains policy recommendations for the development of the proposed Microinsurance Regulations. Finally, **Section 8** contains a summary of the recommendations made in the Report.

2 See http://www.a2ii.org/knowledge-centre/tools-and-guidance/a2ii-toolkits.html

2 Country Context

Source: www.mapcruzin.com

Uganda is a landlocked country in East Africa. In the north it shares a border with South Sudan, whilst its southern border cuts across Lake Victoria and includes two relatively small stretches of land borders with Tanzania and Rwanda. Uganda is bordered to the east by Kenya and to the west by the Democratic Republic of the Congo.

Covering an area of roughly 241,000 square kilometres and with a population of some 35 million people, Uganda is a relatively small country compared with its larger neighbours, Kenya and Tanzania. It is, however, more densely populated (see Table 1).

2.1 Political and Macroeconomic Situation

Uganda gained independence from the United Kingdom in 1962, but maintained its membership in the Commonwealth. Following a military coup in 1966, a period of political instability, dictatorships and civil wars followed. The current president, Mr Yoweri Kaguta Museveni, has been in power since 1986.

Uganda is a very fertile country and benefits from regular rainfall. In addition, the country has substantial natural resources, including mineral deposits of copper and cobalt, crude oil and natural gas, as well as beautiful landscapes and abundant wildlife. Despite this, the Ugandan economy remains underdeveloped relative to its East African neighbours, mainly because of the devastating effects of political instability and misguided policies in the 1970s and 1980s. Over the last decade, the economy has improved substantially, resulting in robust GDP growth and a decline in poverty rates.

Since 1997, GDP growth rates at market prices have ranged between 6% and 8% annually, with the exception of the 2011/2012 fiscal year, when the growth rate fell to 3.2%.[3] In terms of sectoral contribution to GDP, services account for 50%, industry for 26% and agriculture for 24%.[4] However, the importance of agriculture to the Ugandan economy is higher than these figures may suggest, as agriculture provides a source of income to the majority of the population (see below) and is the basis for most of the industrial activity in the country.[5] Coffee, Uganda's main cash crop for export, represented over 20% of the total value of all exported merchandise in 2011.[6]

Inflation has been volatile in recent years, hovering between 6% and 13% in the period 2006 – 2009, falling to a low of 4% in 2010, and rising to a high of 19% in 2011. The Bank of Uganda's (BoU) target level for inflation is 5%. In a recent press release, the International Monetary Fund (IMF) commended Uganda's authorities "for their successful efforts in bringing inflation down to close to the 5% target level as a result of careful monetary management". The IMF also noted that, "Looking ahead, the macroeconomic outlook is favourable, with growth projected at 6%-7% in the medium term in the context of mid single digit inflation".[7]

Together with Kenya and Tanzania, Uganda is one of the founding countries of the East African Community (EAC). The EAC is an intergovernmental organisation that currently has five member states: Burundi, Kenya, Rwanda, Tanzania and Uganda. The EAC is home to a population of 135 million (2010, estimate) and in 2012 generated a joint GDP of USD 85 billion at current market prices.[8]

Table 1: Some Key Comparative Statistics[9]

Country	Landmass (sq km)	Population (million)	People per sq km	GDP (current market price, million USD)	GDP per capita (current market price, USD)
Tanzania	885,800	48.3	55	23,877	553.1
Kenya	569,140	44.0	77	34,059	862.4
Uganda	197,100	34.8	177	18,089	549.2
Burundi	25,680	10.9	424	2,297	264.0
Rwanda	24,668	12.0	486	6,377	594.8

5 Statistical Abstract 2012; NDP 2010 – 2014.
6 CIA World Factbook.
7 National Development Plan 2010/14.
8 www.ico.org.
9 IMF Press Release No. 13/172; May 15, 2013.
10 EAC Quick Facts, www.eac.int.
11 Landmass and population data from CIA World Factbook, economic data from EAC.
12 4th EAC Development Strategy 2011/12 – 2015/16.

In 2010, the EAC launched a common market for goods, labour and capital. Priority projects to be implemented by 2016 focus on:

1. The consolidation of the Customs Union and the Common Market.
2. The establishment of a monetary union.
3. Laying the foundation of a political federation.
4. The promotion of solid and economic infrastructure to support and spur economic growth.

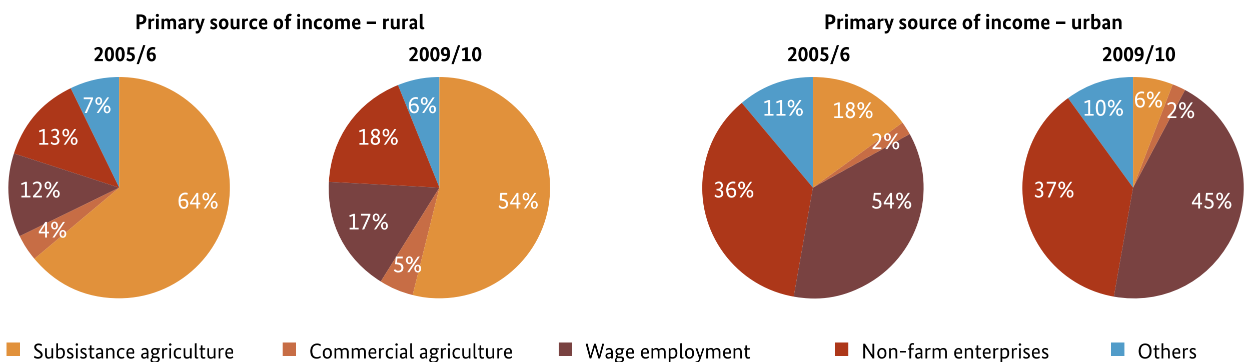
2.2 Socio-economic Background

Uganda is home to a rapidly growing population. According to data from the official census, total population stood at 12.6 million in 1980. The population had increased to 16.7m by 1991 and to 24.2m by 2002.[11] In 2012, the population is estimated at 34.1 million, with 1.72 million living in Kampala and 14.7% considered as urban.[12] Uganda is a predominantly rural country.

Life expectancy at birth is 50 years and the fertility rate in 2011 was 6.2 children per woman.[13] With a median age of 15.5 years, the population pyramid is very flat: 49% of the total population is below 15 years of age and 70% below 25 years of age.[14] Taken together, this results in a rapidly growing, very young population, living mostly outside the big cities.

Agriculture is the largest employer: over 80% of all women are "employed in agriculture as primary producers and contribute 70-75% of agricultural production".[15] The importance of subsistence farming is high, but has declined in recent years. While in 2005 approximately 64% of rural households relied primarily on subsistence farming, this ratio had dropped to 54% by 2010. Non-agricultural wage employment and income from non-farm enterprises have increased significantly and, taken together, are now the primary source of income for 35% and 82% of rural and urban households respectively (see Figure 1).

Figure 1: Primary sources of household income in 2005/6 and 2009/10[16]



According to the Poverty Status Report, Uganda has been able to reduce poverty levels dramatically since 1992, both as a percentage of the population as well as in absolute figures. The Report divides the population into three categories:

1. The absolutely poor: people living on an income below the poverty line.
2. The non-poor, but insecure: people living above the poverty line, but on an income below twice the poverty line.
3. The middle class: people living with incomes above twice the poverty line.

11 Uganda Bureau of Statistics (UBOS), 2006.
12 UBOS Statistical Abstract, 2012.
13 UDHS, 2011.
14 CIA World Factbook.
15 NDP 2010/15.
16 Poverty Status Report, 2012.

The poverty line for Uganda was developed in 1990. It reflects the cost of consuming 3,000 calories per day based on the food basket of the poorest 50% of the population in 1994, including an allowance for some non-food requirements. By adjusting this cost for inflation, the poverty line has been held constant in real terms ever since.

Table 2 gives an overview of the changes in the percentage of the population in each category. This shows a clear trend towards a fast growing middle class and a decline in the number and percentage of the absolutely poor. The dynamics of the 'non-poor but insecure' class is less clear: in absolute numbers, this class increased over the period studied, but as a percentage it has remained relatively stable since 1999.

Table 2: Poverty and Near Poverty Statistics[17]

Year	1992/93	1999/00	2002/03	2005/06	2009/10
Absolutely poor (millions)	9.9	7.4	9.3	8.5	7.5
Below the poverty line (%)	56.4	33.8	38.8	31.1	24.5
Non-poor but insecure (millions)	5.8	9.6	9.6	11.0	13.2
Non-poor but insecure (%)	33.4	43.9	39.9	40.2	42.9
Middle class (millions)	1.8	4.9	5.1	7.8	10.0
Middle class (%)	10.2	22.4	21.2	28.7	32.6

2.3 Financial Sector and Financial Inclusion

Banking clearly dominates Uganda's financial sector. The volumes traded on the Uganda Stock Exchange remain modest and the insurance sector is relatively small, but growing. However, the financial sector has experienced dramatic changes over the last decade.

Mr Kasekende, the Deputy Governor of the BoU, recently listed the following four major achievements of the banking industry during the first decade of this millennium[18]:

1. A dramatic increase in the intermediation of funds:
   - commercial bank credit to private sector: 15% of GDP in 2012 (6% in 2000)
   - lending to private sector: 80% of total deposits (54% in 2000).
2. An impressive expansion of the branch network: 495 branches in 2012 as opposed to 129 in 2000. Over half of all bank branches are now outside Kampala.
3. A phenomenal growth in mobile money services in the last few years. There were 8.9 million registered users at the end of 2012 and the total transaction volume amounted to UGX 11.7 trillion (USD 4.7 billion) in 2012, up by 211% compared with 2011.
4. The maintenance of a very sound financial state despite all challenges: total capital remained at a very healthy 22% of risk-weighted assets.

The volume of customer deposits stood at UGX 9.1 trillion (USD 3.6 billion) at the end of March 2012, compared with UGX 7.1 trillion (USD 2.8 billion) in private sector credit extended by commercial banks. The sector is structured into four tiers, Tiers 1-3 being supervised by the BoU and subject to prudential regulation. A brief description of the tiers is set out below (the number in brackets denoting the number of licensed institutions at the end of 2012):

17 Economic Policy Development and Research Department (2012): Poverty Status Report (Ministry of Finance, Planning and Economic Development, Republic of Uganda).
18 Uganda's financial sector at 50, 2013.

- Tier 1: commercial banks (24) offering full banking services, including cheque accounts and foreign exchange transactions,
- Tier 2: credit institutions (4) which are similar to commercial banks, but cannot perform any foreign exchange transactions,
- Tier 3: Microfinance Deposit Taking Institutions (MDIs) (4) which are allowed to take deposits from the general public and on-lend these, but are unable to operate cheque accounts or to engage in foreign exchange transactions,
- Tier 4: Microfinance Institutions (MFIs), Savings and Credit Cooperative Organisations (SACCOs) and others, classified as "informal" financial institutions.

Tier 4 banks are effectively unsupervised as financial institutions. Although SACCOs are registered under the Cooperative Societies Act, which gives the Registrar of Cooperatives certain supervisory powers, these powers are plainly inadequate for the supervision of financial institutions.

The number of commercial banks present in Uganda has increased steadily over the last decade. In 2006 there were 15. This number rose to 22 in 2009 and reached 24 in 2013.[19] Over the same period, the BoU initiated a programme to increase the minimum capital requirement applicable to commercial banks. It was raised in two stages, from UGX 4 billion (USD 1.6 million) to UGX 10 billion (USD 4 million) by March 2011 and to UGX 25 billion (USD 10 million) by March 2013.

Although the number of licensed insurance companies is similar to the number of licensed commercial banks (21 licensed insurers, 24 commercial banks), the insurance sector is significantly smaller in terms of economic indicators: the gross written premium in 2012 reached UGX 352 billion (USD 140 million), roughly 0.66% of GDP. However, the sector has been growing steadily and quickly over the last decade. Furthermore, the industry is set to witness further important changes in the near future with the separation of composite insurers in 2014.

With regard to mobile money services, Uganda is catching up quickly with its neighbour, Kenya. All of the five major mobile phone operators active in Uganda offer mobile money services: MTN (MTN Mobile Money); Airtel/Warid (Airtel Money/warid pesa); UTL (Msente) and Orange (Orange Money). More importantly, these services now enjoy dramatically increased popularity among the population. The number of active mobile money transfer services tripled during the year 2012, standing at 9 million customers at the end of the year.[20] MTN Uganda has captured the lion's share of the business with over 4 million active users.[21] As a result of Airtel's takeover of Warid, WaridPesa (Warid's mobile money service) is in the process of being merged with Airtel Money.[22]

According to the latest FinScope Report (2010), about 70% of Ugandans aged 16 years and over use some financial services, but mainly through informal institutions: only 21% use banking services. This figure is close to the figure published by the Ugandan newspaper, The Independent, which stated in March 2013 that of the 17 million of Uganda's population aged 16 years or more, 4 million have a bank account, which translates into 23.5% coverage.[23] However, the spectacular growth in mobile money transfer services referred to above completely changes the picture: 9 million of those over 16 years use mobile money transfer services, which translates into a user ratio of over 50%.

2.4 Policy and Development Strategy

2.4.1 Institutional landscape

The key Ministries with an interest in insurance are:

- The Ministry of Finance, Planning and Economic Development, which has responsibility for the Insurance Regulatory Authority,
- The Ministry of Health (MoH), which will be regulating and supervising the National Health Insurance Scheme (NHIS) once the NHIS Bill is passed,

19 BTTB 2012-13; BoU.
20 The East African Newspaper, www.eastafrican.co.ke, March 22 2013 (we have not been able to source any statistics from an official body).
21 MTN press release, 8 May 2013.
22 Airtel press release, April 2013.
23 The Independent of Uganda, 22 March 2013.

- The Ministry of Trade, Industry and Cooperatives, which regulates and supervises all cooperatives, including the Community Based Health Insurance Schemes (CBHISs) and has responsibility in Uganda for the COMESA Yellow Card Scheme (the regional third party motor liability scheme),[24]
- The Ministry of Agriculture, which has an interest in developing agricultural insurance.

At the sub-ministerial level, the two most important bodies for the insurance market are:

- The Insurance Regulatory Authority, which licences and supervises insurance companies, insurance brokers, agents, loss assessors/adjustors, HIOs [25] and HMOs,
- The BoU, which is the country's central bank and, as indicated above, is responsible for supervising the Tier 1, Tier 2 and Tier 3 financial institutions.

On the private sector side, there are a number of associations and training institutes relevant to the insurance sector. The most important are:

- The Uganda Insurers Association, the industry association for all licensed insurance companies,
- The Uganda Association of Insurance Brokers, the body that represents Ugandan insurance brokers,
- The Association of Ugandan Insurance Agents, a voluntary association that represents about 40 agents (out of a total of 800) in negotiations with insurance companies,
- The Insurance Institute of Uganda, an independent training body for the insurance industry: membership of the Institute is mandatory for all licensees under the Insurance Act.[26]

The most important private sector organisations concerned with the health sector are:
- The Uganda Medical Association and the Uganda Medical and Dental Practitioners Association which focus on quality in healthcare
- The Uganda Health Care Federation which represents the entire private health sector in Uganda

The Uganda Health Care Federation, which currently has 15 members, was established in 2010. Its mandate is to address common problems in the private sector, to advocate for issues that affect the health sector, to complement the work of the public sector and to monitor progress, including identifying gaps and opportunities for improvement. The structure of the Federation provides for associations and corporations to be represented on the Board, which includes private providers, medical insurance companies, HMOs, medical equipment and laboratory companies and professional bodies, as well as associations representing professional and mission hospitals.

2.4.2 Uganda National Development Plan

The National Planning Authority has developed a framework of plans and strategies called "Vision 2040", to be implemented through six consecutive five-year development plans. The first National Development Plan (NDP) is currently being implemented for the period 2010/11 – 2014/15. The ultimate vision is to "transform Uganda from a predominantly peasant-based economy to a just, peaceful and prosperous middle-income country within 30 years".

For the period of the current NDP, investment priorities will include:

1. Physical infrastructure development, mainly in energy, railway, waterways and air transport
2. Human resources development in the areas of education, skills development, health, water and sanitation
3. Agriculture and industry, facilitating availability and access to critical production inputs
4. Promotion of science, technology and innovation

According to the President, Mr Yoweri Kaguta Museveni, this will be "pursued in a quasi-market environment where the private sector will remain the engine of growth and development. The Government, in addition to undertaking the facilitating role through the provision of conducive policy, institutional and regulatory framework, will also actively promote and encourage public-private partnerships in a rational manner." The NDP aims to eradicate poverty through economic growth and socio-economic transformation.

24 Note that although reference is made to the Scheme for completeness, we have not considered it for the purposes of this Report.
25 HIOs (health insurance organisations) are discussed in section 7.4.1.10.
26 Section 94 of the Insurance Act.

With regards to insurance, the NDP has identified the lack of crop insurance as a major impediment to significantly increased investments in the agriculture sector. Furthermore, it seeks to “develop mechanisms for mobilising pension schemes and insurance deposits to support housing financing.” It also notes that sustainable population growth (i.e. lower fertility rates) is constrained, among other factors, by the lack of appropriate insurance and social safety nets. Finally, the NDP discusses the importance of public and private insurance schemes for adequate health financing, and by way of criticism notes that “several Government policies and bills to promote and regulate health services have been pending on the drawing board for a long time”. [27]

In relation to the health sector, the NDP identifies 8 strategic objectives to be achieved:

1. Strengthen the organisation and management of the national health system.
2. Ensure universal access to the Uganda National Minimum Health Care Package, with emphasis on vulnerable populations.
3. Improve the nutrition status of the Uganda population.
4. Create a culture in which health research plays a significant role in guiding policy formulation and action to improve the health and development of the people of Uganda.
5. Improve the policy, legal and regulatory framework.
6. Build and utilise the full potential of the public and private partnerships in Uganda’s national health development by encouraging and supporting participation in all aspects of the National Health Policy at all levels and according to the National Policy on the Public-Private Partnership in Health (PPPH).
7. Strengthen collaboration between the health sector and other government ministries and departments, and various public and private institutions (universities, professional councils, etc.) on health and related issues.
8. Ensure that communities, households and individuals are empowered to play their role and take responsibility for their own health and well-being and to participate actively in the management of their local health services.

27 Source: National Development Plan (2010/11 – 2014/15), Republic of Uganda.

3 Health Sector

Health insurance and health microinsurance sustainability requires maintaining a balance in terms of access to healthcare (sufficient provider supply and geographically close to customers), cost of healthcare (affordability and efficient delivery of services), and quality of healthcare (effectiveness of the medical treatments).

When evaluating the potential for health microinsurance products, it is important to understand the health needs of low-income households, the capacity of the health system to deliver and manage the health services to be provided, and the extent to which health risks can be mitigated by proactively controlling these risks through preventive healthcare.

In this section we first discuss the health risks that need to be managed and then consider the supply side constraints, i.e. the facilities and health personnel and the importance of correct diagnosis for a quality medical outcome.

3.1 Health Risks

Understanding Uganda's specific health risks is an important component of health microinsurance development because it identifies those risks that increase the vulnerability of the poor to an adverse health event. When the health risks are understood, policies to encourage adequate services to prevent and manage them and appropriate health microinsurance products can be developed. For example, malaria is an important risk in Uganda, so it is important to ensure that there is adequate access not only to financing, but also to providers and medication if a quality outcome is to be obtained. While the Authority should have the remit of regulating the insurance component, regulations to manage the quality of providers and medications must be in place and an appropriate body charged with the task of enforcing them. This would not be the Authority.

Health risks change over time. For example, as the life expectancy of the population increases, different healthcare risks can be expected to emerge. Uganda has made progress in improving the health of its population. HIV prevalence has been reduced from 30% in the 1980s to 6%-7% in 2008 and polio and guinea worm were eradicated, although there is a re-emergence of polio due to cross-border migration.[28] Partly as a result of this, life expectancy increased from 45 years in 2003 to 52 years in 2008.

28 National Development Plan (2010/11 – 2014/15): May 2010
International Monetary Fund Country Report No 10/141 "Uganda: Poverty Reduction Strategy Paper"

Table 3: Trends in Health-related Outcomes (1995-2006) and Planning Targets (Ministry of Health, Sector Performance Report 2008)

Indicator	1995	2001	2006	PEAP[31] Target (2007/2008)	NDP Target (2014/2015)	MDG Target (2015/2016)
Infant mortality rate (per 1,000 live births)	81	88	76	68	41	41
Under 5 Mortality rate (per 1,000 live births)	156	152	137	N/A	60	60
Maternal Mortality ratio (per 1,000 live births)	527	505	435	354	131	131
Total Fertility Rate	6.9	6.9	6.5	5.4	6	N/A

The under-five mortality rate improved from 156 deaths per 1,000 live births in 1995 to 137 per 1,000 live births in 2005. Under-weight prevalence was reduced from 23% to 16% over the same period; stunted growth from 41% to 38.5%, and wasting increased from 4% to 6%. [29] The new-born mortality rate was 33 per 1,000 live births in 2000 and decreased to 29 in 2006, accounting for 40% of infant mortality. As regards overall child mortality, 70% is due to malaria, acute respiratory infections, bacterial diarrhoea, pneumonia and malnutrition. The prevalence of vaccine-preventable diseases has declined sharply. [30]

The leading causes of overall morbidity and mortality remain malaria, malnutrition, respiratory tract infections, HIV/AIDS and tuberculosis. The high burden of disease due to these conditions continues to undermine efforts and investments made for social and economic development. However, non-communicable diseases are an emerging problem and include hypertension, cardiovascular diseases, diabetes, chronic respiratory diseases, mental illness, cancer conditions, injuries from road accidents and oral diseases. Certain types of cancer are on the increase in Uganda, some of them being linked to sexually transmitted diseases such as HIV/AIDS and Human Papilloma Virus. The increase in non-communicable diseases is due to multiple factors such as the adoption of unhealthy lifestyles, increases in life expectancy and metabolic side effects resulting from lifelong antiretroviral treatment.[32]

Although communicable, maternal, perinatal and nutritional conditions account for 65% of total mortality, non-communicable diseases account for 25%.[33] Non-communicable diseases can be partly addressed proactively through lifestyle and behavioural changes. For example, diabetes can partly be addressed through nutritional modification. To help manage non-communicable diseases, and some communicable diseases, lifestyle education is required.

In the above paragraph we consider general healthcare risks. But there remain other risks including Neglected Tropical Diseases (NTDs). These risks have an important effect on healthcare outcomes as they can be mis-diagnosed and therefore incorrectly treated, leading to higher medical costs and low quality outcomes. NTDs are a group of tropical infections that are especially endemic in low-income populations in developing regions of Africa, Asia and the Americas. The most important of these in Uganda are soil-transmitted helminths, schistosomiasis, lymphatic filariasis, trypanosomiasis and onchocerciasis. NTDs are still common, even though many are targeted for elimination. In Uganda, control programmes for NTDs are housed in the Vector Control Division of the MoH and, with external funding, these programmes have achieved considerable success over the years.

NTDs are more difficult to manage if medical providers cannot correctly diagnose them. For example, in the case of trypanosomiasis, diagnosis depends on a blood smear or serological testing. In the areas where provider access is limited, health providers may not be able to correctly diagnose and treat NTDs or, if the costs of the appropri-

29 UDHS, 2006.
30 National Development Plan (2010/11 – 2014/15): May 2010 International Monetary Fund Country Report No 10/141 "Uganda: Poverty Reduction Strategy Paper".
31 Poverty Eradication and Action Plan.
32 Ibid.
33 World Health Organization, Uganda: http://www.who.int/nmh/countries/uga_en.pdf

ate tests are not covered under the health policy, health providers may not even undertake them. As noted above, incorrectly diagnosed ailments may be treated incorrectly, leading to even higher medical costs and a lower quality outcome. If not correctly diagnosed and treated, patients will return for re-diagnosis and care, resulting in a loss of trust in the healthcare system and higher healthcare costs.

Mortality rates in Uganda also include accidents. Uganda has one of the highest road accident fatality rates in Africa. In 2010 there were 2,954 road traffic fatalities.[34] This is important for a number of reasons. First, it represents a high death risk, but it also indicates the likelihood of significant road accidents requiring emergency care. Ambulances are in rare supply outside the Kampala area and the extent to which informal communities that live in these areas can reach a medical facility and receive appropriate treatment is therefore unclear.

The implications of the health risks in Uganda and the relationship to the health microinsurance sector are significant. The major determinants of health in Uganda include levels of income and education, housing conditions, access to sanitation and safe water, cultural beliefs, social behaviour and access to quality health services.[35] Studies indicate that there is a correlation between the education of the individual and ability to manage healthcare risks. Specifically, the 2006 Demographic and Health Survey (UDHS) generally shows that the level of education attained constitutes one of the major determinants of health, e.g. prevalence of diarrhoea, acute respiratory infections and fever among under-five children decreases based on the education of the mother.[36]

As already indicated, the proportion of people living below the poverty line has significantly decreased from 52% in 1992 to 25% in 2010. However, Uganda is still a low-income country with significant income disparities. A direct relationship exists between poverty and prevalence of diseases such as malaria, malnutrition and diarrhoea, as these diseases are more prevalent among the poor than the rich households.[37]

3.2 Health Infrastructure

Healthcare in Uganda is provided through a mix of public and private facilities. There are important shortages in both sectors. Healthcare provision is mainly focused in the Kampala area, where there are large public hospitals as well as private facilities. Outside the Kampala area, which is home to 88% of the population, healthcare is mainly delivered by non-profit mission-based and public facilities. Health infrastructure is important because financing alone will not ensure access to medical care, particularly when economically developed countries recruit health workers from overseas to fill domestic shortages.[38] International organisations, such as the World Health Organization, are concerned about the outflow of skilled medical professionals (particularly physicians) from the developing to the developed world.[39] It is estimated that between 18% and 23% of practicing physicians in the US, the UK, Canada and Australia are physicians trained in other countries, between 40-75% of these coming from lower-income countries.[40]

Physician migration is significant. An estimated 61% of all doctors educated in Ghana between 1985 and 1994 were in the US or the UK by 1998, and about 20% of Uganda's doctors and 43% of Liberia's doctors were working in the US or Canada by 2002. More recent data present a more pessimistic picture.[41] Surveys of migrating professionals indicate myriad reasons for leaving their home country, including economic conditions, poor working conditions, low salaries, political instability and poor governance.[42] In 2004, 385 physicians migrated from Uganda to the

34 Global Status Report on Road Safety 2013 – WHO.
35 The Second National Health Policy, The Republic of Uganda Ministry of Health; July 2010.
36 Uganda Demographic and Health Survey 2006: Uganda Bureau of Statistics, Kampala, Uganda; Macro International Inc., Calverton, Maryland, USA: August 2007 http://www.measuredhs.com/pubs/pdf/FR194/FR194.pdf
37 "The Second National Health Policy: Promoting People's Health to Enhance Socio-economic development" July 2010: The Republic of Uganda Ministry of Health.
38 Human Resources for Health: "Effect of UK Policy on medical migration: a time series analysis of physician registration data", Clare Blacklock, Carl Heneghan, David Mant, and Alison M Ward. 25 September 2012 doi: 10.1186/1478-4491-10-35.
39 WHO, 2006.
40 An Empirical Investigation of Why Doctors Migrate and Women Fail to Go for Screening by Edward Nwabugwu Okeke (University of Michigan, 2009).
41 Ibid.
42 Ibid.

US and UK. Data on the migration to other countries is not available, nor is data regarding other skilled medical personnel including nurses and midwives. [43]

In addition to medical personnel gaps, it should be noted that there are certain types of specialist procedures (e.g. complex cardiovascular surgery[44]) that are not currently available in Uganda. Therefore, private insurers evacuate certain patients to other countries if there is insufficient local expertise or capacity.

3.2.1 Health facilities

The public healthcare system in Uganda was designed in 1962 to follow a referral structure, meaning that health-care access begins at simple levels and is referred to specialist care based on the presenting conditions and the referral provider. Over time, the concept of referral has been replaced by individuals seeking the care that they can locate.

The number of health facilities in Uganda is estimated at more than 4,000 of which about 46% are private health providers. Most of these providers are located in the Central Region, the Kampala district alone accounting for 45% of the total private health providers.[45]

Public facilities are located across the country, but there are important gaps in terms of medical practitioners as well as supplies. Not for profit hospitals are also limited in terms of donations and availability of medical staff, and these hospitals are a critical health channel in rural areas.

Private for-profit facilities are not currently investing heavily in the rural areas, as there is insufficient economic

Table 4: Categories of Public Healthcare Facilities in Uganda

Type of Provider	Description
National Referral Hospital	There are two national referral hospitals, Butabika and Mulago.[46] These facilities provide an increased availability of specialists including neurology, cardiology, urology, ophthalmology, dentistry, radiology, and intensive care unit care.
Regional Referral Hospital	There are 12 [47] regional referral hospitals that provide specialist services such as psychiatric, ear, nose and throat, radiology, pathology, ophthalmology, high level surgical, paediatrics, obstetrics and gynaecology, and other medical services not available at the general hospitals.
District Hospital	General hospitals with about 150 beds; obstetrics/ gynaecological services, medical/surgical bed availability and paediatric capabilities.
Health Centre 4	County level, sub-district health centres with a general practitioner and a larger number of beds.
Health Centre 3	Sub-county level health centres, with a midwife and clinical officer, having a few beds
Health Centre 2	Structures within the localities (about 10 villages) with a nurse and medical assistant, outpatient care.
Health Centre 1	This is a village health team with community medicine distributors. The village health team is voluntary but cannot be guaranteed to be in place.

43 Ibid.
44 Interview with Mulago Hospital March 2013; confirmed in interviews with private sector providers/HMOs
45 "Survey of private health facilities in Uganda, September 2005: USAID: Andrea Mandelli, MA, Lennie Bazira Kyomuhangi, Susan Scribner - Abt Associates.
46 "The Republic of Uganda Ministry of Health Statistical Abstract 1020" Ministry of Health http://www.ubos.org/onlinefiles/uploads/ubos/pdf%20documents/PNSD/2010MOHStatAbst.pdf
47 "The Republic of Uganda Ministry of Health Statistical Abstract 1020" Ministry of Health http://www.ubos.org/onlinefiles/uploads/ubos/pdf%20documents/PNSD/2010MOHStatAbst.pdf

Table 5: Health Facilities 2004 - 2010 [48]

Year	2004				2006				2010				% of total
Type	Govt	PNFP	Private	Total	Govt	PNFP	Private	Total	Govt	PNFP	Private	Total	
Hospitals	55	42	4	101	59	46	8	114	64	56	9	129	3%
Health Centre IV	151	12	2	165	148	12	1	161	164	12	1	177	4%
Health Centre III	718	164	22	904	762	186	7	955	832	226	24	1082	25%
Health Centre II	1055	388	830	2273	1332	415	261	2008	1562	480	964	3006	68%
TOTAL	1979	606	858	3443	2301	659	277	3237	2662	774	998	4394	

growth to support the costs associated with the investment. As indicated, rural areas therefore have to rely primarily on public, as well as not-for-profit, mission-based facilities.

The private system includes private not for-profit providers (PNFPs), private health practitioners and the traditional and complementary medicine practitioners. The PNFPs are more organised and structured than the other sub-sectors in terms of collaboration with the MoH. Although the private sector provides a significant proportion of health services, it is not well integrated with the public sector and the sectors do not, therefore, work well with each other. This is a common issue in many countries, where there are fragmented access points to healthcare and sharing patient information may not take place effectively. For example, in many countries this leads to medical tests being performed more than once (as the results are not shared with other providers), and diagnoses not being shared across sectors (if an individual is diagnosed and treated by one doctor, and sees another doctor for the same issue).

In the public system there are four health centre classifications and three types of hospital classifications.[49] These are set out in Table 4.

Hospitals have been unable to keep pace with the growing population. For example, Mulago Hospital, a National Referral Hospital in Kampala, was designed with 1,200 beds, but at times the occupancy is so stretched that it is expanded to hold 1,500 patients.
As demonstrated in Table 5, there was an increase in facilities from 2006 to 2010, primarily with the growth of Level II Health Centres.

3.2.2 Medical personnel

The size of the private health sector in Uganda has been at the centre of recent discussions on human resources for health and public–private partnerships that increase access to health services. The number of facilities in, and the volume of services produced and delivered by, this sector have been the subject of broad estimates, but no reliable figures have been available. This information is important, however, because it underlies the vision of the PPPH as outlined in the draft national policy and the Health Sector Strategic Plan II. Effective partnership between government and private for-profit health providers (PHPs) needs information on how many facilities exist, where they are located, what staff they employ, what services are offered, what equipment and infrastructure are available and how they currently relate to the public sector (e.g. registration with professional councils, submission of health management information). Ideally, this information should be available to both public and private sector stakeholders.

To address this information gap, Partners for Health Reformplus (PHRplus), in collaboration with the PPPH Desk of the MoH, created a comprehensive database for

48 Ministry of Health, Infrastructure Division, 2004 and 2006 and 2010.
49 Based on an interview at Mulago Hospital on 11 March 2013.

PHPs. From the database, PHRplus selected a nationally representative sample of health facilities run by PHPs and surveyed them to provide a more in-depth picture of their number and distribution, the human resources they employ, and the services they offer. More specific objectives of the study were to:

- establish a comprehensive database of the PHP facilities in Uganda,
- assess the types of ownership of the PHP facilities in Uganda,
- gather information about human resources employed in the private health sector,
- assess the scope of services offered by the PHP facilities, and obtain information on their equipment and information systems.

The information is intended to inform policy and programmatic decision making, especially to enable an informed debate on the potential scope and merit of public-private partnerships for health.

The estimated number of staff employed in the PHP sector nationwide is 12,775. Of the doctors working in the private sector, 54% also work in the government sector, whereas more than 90% of private sector nurses, midwives, and nursing aides work full-time in the private sector. A total of 9,500 health professionals are estimated to be working exclusively within the private sector, including more than 1,500 doctors and 3,500 nurses. More than 80% of the doctors are employed within the Central Region. [50]

Uganda suffers from an undersupply of general providers, specialists, hospital beds and even pharmaceuticals. While 95% of women visited antenatal clinics, only 4% of births are assisted by a skilled provider, and 63% of women in rural areas give birth at home, compared with 20% of women in urban areas. [51]

Progress has been made in increasing the number of health workers and in producing a multi-purpose nursing cadre that is able to perform both nursing and midwifery tasks. Availability of data on the public sector health workforce has also improved. A comprehensive human resources policy and strategy to address priority human resource constraints is in place, although implementation needs to be improved. However, the shortage of human healthcare resources and the pro-urban distribution of health workers (doctors, pharmacists, and other cadres) remain major obstacles to access to quality healthcare in remote and hard-to-reach areas.

The wage bill limits the ability of the public sector to fill its vacant positions and to absorb the increasing numbers of health workers produced. This is therefore a major bottleneck to the performance of the entire health system. In addition, the quality of pre-service education is low. Attracting and retaining health workers in the public sector is another key challenge. For example, wages are currently higher in HIV facilities and in neighbouring countries. There is evidence that these wage disparities contribute to attrition among public sector health workers, particularly in rural areas, where the shortage of human healthcare resources is most acute. [52]

In an ideal case, healthcare workers should go where the people are and the needs are greatest. As with most countries worldwide, the distribution of healthcare workers in Uganda does not follow this logic. While only 13% of Uganda's population is urban, human healthcare resource distribution, particularly among higher-level professional cadres, is skewed toward urban areas. Likewise, regional distribution is skewed towards the central region including Kampala. For example, staffing levels in Kampala are 123% of posts, while in Namayingo District in Eastern Uganda, they are less than 20%. The skewed distribution of human healthcare resources poses major barriers to access to quality healthcare in rural, remote, and hard-to-reach areas.

This maldistribution is a result of the failure of the health system to attract healthcare workers to these posts, and to retain them once there. Table 6 details the urban distribution and population ratio for health workers cadres. More up-to-date data were not available during the data collection, analysis and writing of this Report. [53]

50 "Survey of private health facilities in Uganda, September 2005: USAID: Andrea Mandelli, MA, Lennie Bazira Kyomuhangi, Susan Scribner - Abt Associates.
51 http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/AFR/2012/12/26/090224b08183fb34/1_0/Rendered/PDF/Uganda000Ugand0Report000Sequence006.pdf
52 "Uganda Health System Assessment 2011" Ministry of Health http://health.go.ug/docs/hsa.pdf
53 "Uganda Health System Assessment 2011" Ministry of Health http://health.go.ug/docs/hsa.pdf

Table 6: Health Worker Cadres, Urban Distribution and Population Ratio, 2002 [54]

Health Cadres	Total (2002)	Urban (%)	Population per Health Worker	Self-employed (%)
Medical doctors	664	70	7,272	14.0
Nurses and midwifery professionals	3,361	58	36,810	17.5
Dentists	98	75	249,409	23.5
Pharmacists	162	80	150,877	22.8
Other health professionals	3,572	68	6,843	10.2
Allied health clinical	4,378	39	5,583	14.0
Nurses and midwives associate professionals	20,340	41	1,202	14.4
Allied health dental	342	52	71,468	19.3
Allied health pharmacy	600	45	40,737	28.5
Allied health diagnostic	1,622	28	15,069	12.0
Other allied health professionals	5,828	34	4,194	18.0
Nurse assistant/aid	16,621	30	1,471	29.6
Traditional medical practitioners	5,430	30	4,501	85.4

There are a significant number of open positions in the Ugandan healthcare system. According to a report from the MoH in 2010, in November 2008, 51% of approved positions at the national level were filled. There were, however, variations among districts, with some in northern Uganda only having 35% of posts filled. Shortage of critical staff, especially midwives, doctors, nutritionists, anaesthetists, pharmacists, pharmacy assistants and laboratory staff, has greatly compromised the quality of health services.[55]

There is a shortage of health workers related to low motivation, labour migration and retention of professional workers, both in the Government and PNFP subsectors,

54 Analysis on health workers from the Uganda 2002 Population and Housing Census (taken from "Uganda Health System Assessment 2011").
55 "The Second National Health Policy: Promoting People's Health to Enhance Socio-Economic Development July 2010" The Republic of Uganda Ministry of Health: http://apps.who.int/medicinedocs/documents/s18426en/s18426en.pdf
56 National Development Plan p 253.
57 Uganda Poverty Reduction Strategy Paper; May 2010. International Monetary Fund Country Report 10/141. May 2010.
58 National Development Plan (2010/11 – 2014/15): May 2010 International Monetary Fund Country Report No 10/141 "Uganda: Poverty Reduction Strategy Paper".

as both employers have been unable to offer attractive employment packages.[56] Despite the existing four Medical Schools in Uganda, there is a very low doctor to patient ratio of 1:24,725 and nurse/midwife to patient ratio of 1:11,000.[57] The World Health Organization (WHO) recommended doctor-patient ratio norm is 1:800. The health worker to population ratio of 1:1,298 must be seen against the WHO standard of 1:439. [58]

At regional and international levels, the remuneration of health workers in Uganda is much lower than that of their counterparts abroad. On average a doctor (medical officer) in Kenya earns four times more than his counterpart in Uganda (MoH 2009 Motivation and Retention Strategy). In rural areas, a doctor earns about 600,000 a month (source Bishop Wasili Hospital). There are significant differences in wages between Kampala and rural areas. As discussed in the opening paragraphs of this section, it may be difficult to encourage medical personnel to stay in Uganda when there are other countries (including Kenya and the UK) which offer higher salaries and stable professional careers.

Only 56% of all positions in the staff establishment are currently filed by qualified staff. However, it should be noted that the standards changed in 2006/07 to reflect the higher need for human resources for healthcare. Workloads increased, resulting in the sudden "drop" from 75% in 2005/06 to 38% 2006/07. The steady increase in 2008/09 was directly related to the recruitment drive that was instituted in 2008. [59]

3.3 Access to Medical Care

The Constitution of Uganda obliges the State to ensure that all Ugandans enjoy equal rights and opportunities and have access to education, health services and clean and safe water, among many other things.[60] The State is also obliged to "encourage and promote proper nutrition through mass education .... ".[61] Investing in the promotion of people's health and nutrition ensures that they remain productive and contribute to national development. [62]

Adequate quantities of affordable, good quality essential medicines and health supplies should, therefore, be accessible to all. However, 72% of government health units have monthly medicine deficits. Costs of medicines are 3 – 5 times more expensive in the private sector than in the public sector, making them unaffordable to many. Only one third of facilities offering delivery services have basic equipment and supplies for conducting normal deliveries.[63] Less than one quarter of health facilities have all essential equipment and supplies for basic antenatal care.

New outpatient attendance improved from 0.60 visits per capita in the fiscal year 2001/02 to 0.80 visits per capita in fiscal year 2008/09. Similarly, deliveries in health facilities increased from about 23% in the fiscal year 2001/02 to 40% in 2007/08. However, the vaccination coverage remained largely stable between 2002/03 and 2008/09, and the percentage of health centres without medicine stock outs throughout the year actually decreased from 33% to 26%.

3.4 Uganda National Minimum Health Care Package

To ensure cost-effective service delivery and those interventions that address the highest disease burden, the National Health Policy defined the Uganda National Minimum Health Care Package (UNMHCP), which is being developed through the World Bank's Uganda Health Systems Strengthening Project.[64] The objective of this project is to deliver the UNMHCP, which includes a focus on maternal health, newborn care and family planning. This will be accomplished by improving human resources

59 National Development Plan (2010/11 – 2014/15): May 2010, International Monetary Fund Country Report No 10/141 "Uganda: Poverty Reduction Strategy Paper".
60 The Constitution of the Republic of Uganda, article XIV (b).
61 Constitution, article XXII(c).
62 "The Second National Health Policy: Promoting People's Health to Enhance Socio-Economic Development July 2010" The Republic of Uganda Ministry of Health: http://apps.who.int/medicinedocs/documents/s18426en/s18426en.pdf
63 Uganda MoH, 2008.
64 This World Bank project (P115563) was approved on 25 May 2010 and the closing date is 31 July 2015. Total project cost and total commitment cost is USD144.31 million. The team leader is Peter Okwero (http://www.worldbank.org/projects/P115563/uganda-health-systems-strengthening-project?lang=en).

for health, physical health infrastructure, and management, leadership and accountability for health service delivery. As of December 2012, the project reported overall ratings in terms of progress towards achieving the goal as satisfactory, overall implementation progress as moderately satisfactory and overall risk rating as substantial.[65]

The UNMHCP includes (1) health promotion, environmental health, disease prevention, and community health initiatives, including epidemic and disaster preparedness and response; (2) maternal and child health; (3) prevention, management and control of communicable diseases; and (4) prevention, management, and control of non-communicable diseases. [66]

The use of such a package presumes that:

- the government has a good estimate of the resources that are going to be available for health service delivery,
- the delivery system has the capacity to deliver the package of services, and
- the costs of the services to be delivered are available. [67]

The UNMHCP has, however, been consistently underfinanced throughout the years, and receives only about 30% of the total funding required for its full provision.[68] At the operational level, the delivery of the minimum package has been rendered ineffective and inefficient, by trying to attain universal access with a sum of USD 8 per capita instead of USD 28. System capacity issues do not support the intention.[69]

65 http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/AFR/2012/12/26/090224b08183fb34/1_0/Rendered/PDF/Uganda000Ugand0Report000Sequence006.pdf
66 MoH, 2010f.
67 "Uganda's Minimum Health Care Package: Rationing within the Minimum?" Freddie Ssengooba, Lecturer, Institute of Public Health, Makerere Medical School, Uganda.
68 "Uganda Health System Assessment 2011" Uganda Ministry of Health http://health.go.ug/docs/hsa.pdf
69 "Uganda's Minimum Health Care Package: Rationing within the Minimum?" Freddie Ssengooba, Lecturer, Institute of Public Health, Makerere Medical School, Uganda.

4 The Insurance Market

This section provides an overview and analysis of the private insurance sector in Uganda. Social security schemes and the pensions sector are not discussed. As explained in section 1 of this Report, a demand-side analysis was excluded from the in-country work, even though it is usually part of an A2ii Country Diagnostic. However, Ugandan households' perception of key risks, which could translate into insurance demand, is discussed based on the work done in 2008 and other secondary sources. In other words, the focus is on insurance companies and other entities supervised by the Authority. Special emphasis is given to microinsurance products and companies involved in providing them. Health insurance will be discussed to some extent here, but in more detail in section 6.

4.1 Key Industry Players and Statistics

As at the date of this Report, the number of licensed insurers in Uganda stands at 22. This number has been more or less constant over the past five years, although it is likely to rise in 2014 when composite insurers are required to split. Furthermore, it is noteworthy that since 2008 three insurance companies have exited the market (2009: Micro-Care; 2010: East Africa General Insurance, Paramount Insurance) and five new insurance companies have been licensed (2008: Pax; 2009: APA; 2010: Britam, Sanlam Life; 2011: Nova).

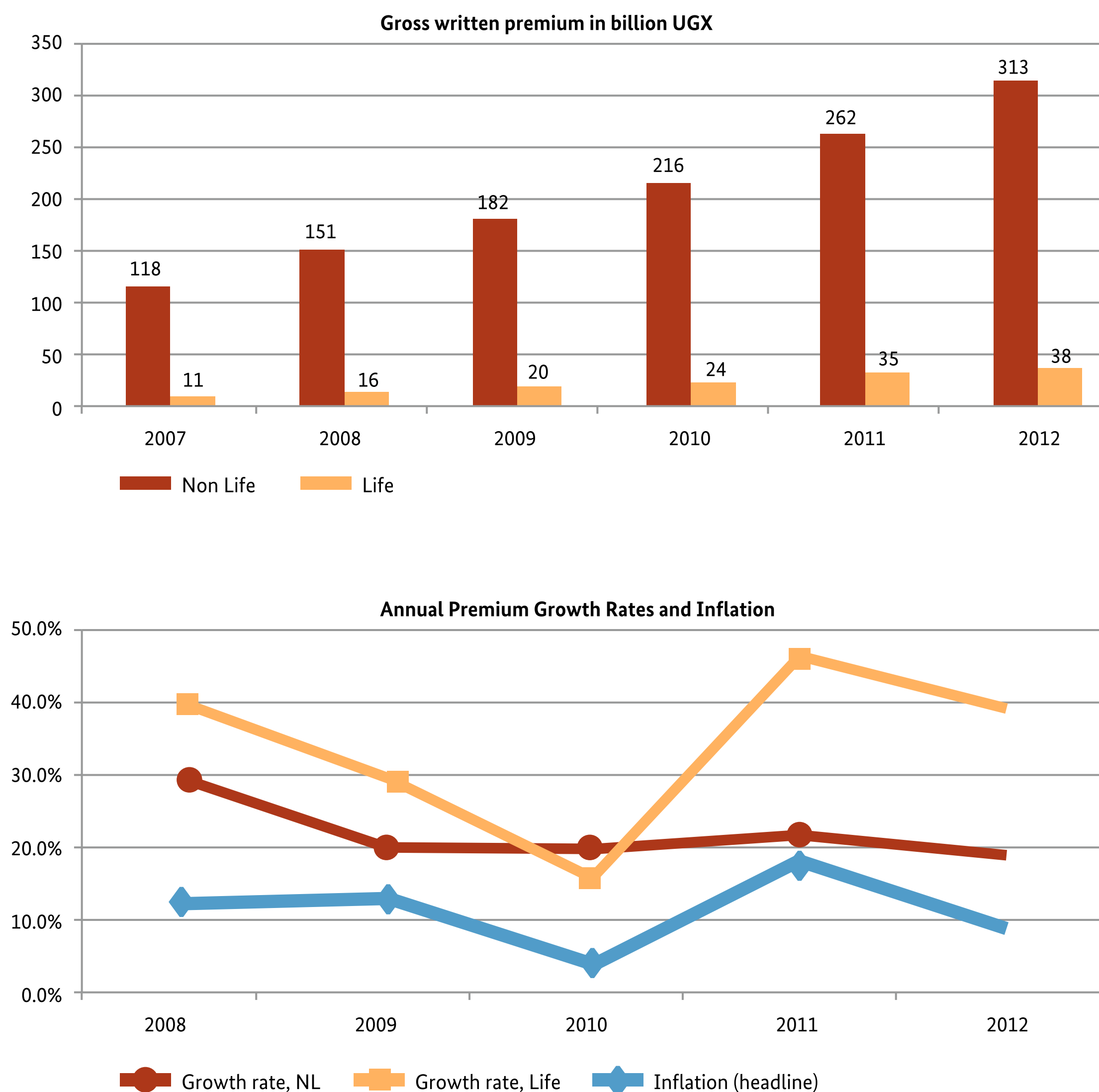
In 2012, the Ugandan insurance market was served by: [70]

- 14 non-life insurers
- 6 composite insurers
- 2 life insurers
- 1 reinsurance broker
- 30 insurance brokers
- 828 licensed agents
- 18 loss adjusters.

The insurance market is dominated by general business, which accounts for roughly 89% of total insurance premium generated in 2012. Due to significantly higher growth rates in the life insurance sector, its share of total premium written increased from 9.6% in 2007 to 11.7% in 2011, but fell back to 10.7% in 2012.

70 IRA annual report, 2013.

Figure 2: Evolution of gross written premium for Life and Non-life insurance (upper chart) and annual growth rates (lower chart)



The annualised growth rate of gross written premium for the entire industry stands at 22% for the period 2007 – 2012. The average growth over the same period for the non-life sector stands at 21.6% (close to the industry average, as the whole industry is dominated by non-life), while the life sector reported average annual growth rates of 27.2%.

Underdeveloped, but fast growing: The insurance market in Uganda is less developed than the markets of other countries in the region. Insurance penetration currently stands at approximately 0.66% of GDP in Uganda,[71] whilst the equivalent ratio for Kenya is 3.2% and for the African market taken as a whole 3.6%.[72] The insurance penetration rate has increased, but only slowly, from 0.59% in 2008 to 0.65% in 2011. Despite high nominal growth rates in gross written premium, penetration grew modestly due to relatively high inflation rates. Gross written premium reached UGX 352 billion (USD 140.8 million) in 2012.

With an estimated minimum of 2 million individuals covered (see table 7) and an estimated population size of 35 million people, the outreach ratio stands at approximately 5.7% of the population. The number of policy holders and thus people who made an active decision to

71 IRA annual report, 2012.
72 SwissRe, 2012.

buy insurance is much lower, as a large proportion of the 2 million individuals are covered through group policies. According to the Authority's data, almost 300,000 individual policies have been issued or renewed in 2013. [73]

The estimate of individuals covered is based on various sources: the IRA Insurance Market Report (2013), interviews with key stakeholders, especially for formal and informal health coverage, as well as our own estimations. Table 7 provides an overview of those figures reported to the Authority:

Table 7: Individuals Covered by Policy Type (2012)[74]

Type of policy	Individuals covered, IRA market statistics
Workers' compensation	75,390
Group personal accident	55,425
Individual personal accident	8,406
Microinsurance	90,105
Group credit	311,933
Comprehensive insurance package	55,836
Life, group and individual	62,961
Health insurance (formal, group)	39,065
HMOs	100,847
Total	**799,968**

The reported figure of nearly 800,000 individuals covered is the sum of all covered by various products. This figure is therefore probably overestimated, as there is certainly some overlap of people covered by multiple products (e.g. employees benefiting from workers compensation, group personal accident and health insurance). Industry representatives estimate the number of people covered by formal health insurance at 460,000, roughly half of them through licensed insurers and half through HMOs. HMOs only recently started to report figures to the Authority, which almost certainly explains the difference in the HMO data. In fact, the IRA Market Report contains data from four out of seven licensed HMOs only: AAR Health Services Limited, International Air Ambulance Limited, KADIC Health Foundation and International Health Network. The remaining licensed HMOs that did not provide data are International Medical Link Ltd, Case Med Care Limited and Kampala International Medical Centre.

The number of people covered by group credit life is most likely a significant underestimation. The top five MFIs alone (Equity Bank, Finca, Opportunity, Pride and Finance Trust) reported a combined borrower-base of 227,000 clients to Mix-Market (www.mixmarket.org). All five organisations have a credit-life product that covers up to six persons (borrower, spouse and four children). Hence these five institutions alone account for roughly 1.3 million covered people. In addition numerous other financial institutions, including SACCOs, cover their portfolio and clients through credit-life insurance. It is probable that the number of covered people reported to the Authority account for the borrower only and do not include those family members who are also covered under the same policy. Taken altogether, we estimate there are at least 2 million people covered by some formal insurance services.

A few players dominate a fragmented market: Despite the comparatively high number of insurers active in Uganda, the market remains dominated by a small number of relatively large players. Over 53% of total gross premium written in the non-life sector is generated by three companies, while the smallest five players account for less than 4% of total premium. On the life insurance side, the top three players capture over 72% of total gross premium (see Table 8).

As a result of the numerous companies sharing the rest of the business, the market is highly fragmented. So far, there are no signs of market consolidation, as evidenced by the higher number of new entrants compared with those exiting the market. Geographically, large parts of the insurance market are focused on Kampala, with just a few branch offices located in other towns. Competition is fierce and focused on price, but this has not yet led to significant product innovation.

The insurance broking business in Uganda mirrors to some extent the situation found among the insurers. Although there are 30 licensed brokers, the broker market is dominated by two large brokers: Marsh and AON. These two brokers account for almost 58% of total intermediated

73 IRA annual report, 2013.
74 IRA Market Report, 2013.

Table 8: Uganda Insurance Market Statistics (USD exchange rates at mid-2012)

Company	Type of business	Ownership	Gross premium written 2012				Market share	
			Non-life (m UGX)	Non-life (m USD)	Life (m UGX)	Life (m USD)	Non-life	Life
AIG	General	Foreign	45,437,763	18,075	-	-	14.5%	-
APA	General	Foreign	11,039,378	4,391	-	-	3.5%	-
Britam	Composite	Foreign	2,881,112	1,146	406,922	162	0.9%	1.0%
E.A. Underwriters	General	Domestic	12,001,041	4,774	-	-	3.8%	-
Excel	General	Domestic	8,172,864	3,251	-	-	2.6%	-
FICO	General	Domestic	5,413,870	2,154	-	-	1.7%	-
Goldstar	Composite	Foreign	19,777,587	7,867	337,392	134	6.3%	0.9%
ICEA	Composite	Foreign	16,989,241	6,758	9,288,423	3,695	5.4%	23.7%
Jubilee	Composite	Foreign	81,457,240	32,403	3,464,836	1,378	26.0%	8.8%
Leads	General	Domestic	4,847,840	1,928	-	-	1.5%	-
Liberty Life	Life	Foreign	-	13,153,595	5,232		33.5%	
Lion	General	Foreign	17,178,417	6,833	-	-	5.5%	-
National Insurance	Composite	Foreign	7,179,018	2,856	1,689,723	672	2.3%	4.3%
NIKO	General	Foreign	7,130,568	2,836	-	-	2.3%	-
NOVA	General	Foreign	154,746	62	-	-	0.0%	-
PAX	General	Domestic	2,519,534	1,002	-	-	0.8%	-
Phoenix of Uganda	General	Foreign	13,108,225	5,214	-	-	4.2%	-
Rio	General	Domestic	803,054	319	-	-	0.3%	-
Sanlam	Life	Foreign	-	5,070,170	2,017		12.9%	
Swico	General	Domestic	9,665,017	3,845	-	-	3.1%	-
TransAfrica	General	Foreign	6,304,075	2,508	-	-	2.0%	-
UAP	Composite	Foreign	40,913,515	16,275	5,846,263	2,326	13.1%	14.9%
Total			**312,974,105**	**124,498**	**39,257,324**	**15,616**	**100%**	**100%**

gross premium, while the number 3, Liaison, captures some 4% of the total broking business. As a whole, the Ugandan insurance brokers intermediate less than 40% of total insurance premium. Still, some insurers perceive them as controlling or 'owning' the market, even though the share of brokered insurance business gradually declined from 40% in 2007 to 36% in 2012.

Limited skills and low trust levels: The Ugandan insurance industry faces a number of severely limiting constraints. A relatively limited pool of skilled insurance professionals is supplemented by a significant number of foreign professionals (particularly from Kenya and Zimbabwe[75]. Whilst these professionals provide essential experience and skills, which are necessary to grow the sector, the companies are exposed to the risk that these professionals leave before there is sufficient local expertise to replace them. This influx of foreign resources is probably connected to the fact that more and more insurance companies are owned or controlled by foreign groups. Out of the 21 insurance companies licensed in 2013, 15 were foreign-owned (see Table 8). By market share, the situation is even more pronounced: foreign-owned companies write 86% of gross written premium in the non-life sector and 100% of the premium in the life sector.

Given that 21% of the working population is formally employed[76] and an equal percentage use bank accounts,[77] it is perhaps not surprising that many insurance companies state that premium collection is one of their major concerns. Over the same time, mobile money has gained momentum in Uganda, with 9 million active users (see above). These new services should also allow for convenient and cost-effective premium collection. In fact, several insurance companies stated that they are interested in partnerships with mobile money companies for doing exactly this. In one case, premium is collected exclusively through mobile money (see Box 2 on MCash).

Perhaps the biggest challenges in the short term are the very low levels of trust held by the public in insurers and insurance as a product, a general lack of understanding of insurance and its benefits as well as the absence of adequate distribution models for extending insurance services outside Kampala. Although there appear to be a number of reasons for the lack of trust, one likely factor is the very low claims ratio for statutory third party motor liability insurance (37.6% in 2012). Mandatory motor insurance seems to be viewed by many Ugandans as no more than a tax that is paid to insurers, which provides them with no benefit whatsoever. This view contributes to the lack of trust in other non-mandatory insurance products. Many countries in the region and elsewhere face this problem.

Many insurance professionals involved in motor business concede that a major issue with the claims experience for clients is related to the difficulties in obtaining the documentation required to support a motor claim. Insurers typically insist on receiving numerous official documents, which in the Ugandan context are time-consuming and costly to acquire. The cost of procuring the documentation can often exceed the value of the claim. Bribing officials is believed to contribute substantially to the high cost of securing the required documents. The absence of a national identification system is another reason for relatively complex claims requirements and lengthy processes, as the identity of a client has to be verified through other means.

Several market participants consider that service levels have improved over the last couple of years, although it is clear from a number of the interviews that service levels do not yet meet best practice. Although many industry representatives concede that the general public is dissatisfied with the level of service provided, most interviewees consider this opinion to be ill-founded. However, what ultimately counts in a free market environment is the impression that clients have of a service provider. As long as clients perceive service levels to be lower than expected, they will be reluctant to do business with the provider if they don't have to. There are two areas of major concern to most market participants, delayed premium remittance from brokers to insurers and the time required for claims adjustment and settlement. The first issue not only impacts on an insurer's financial performance and flexibility, but may also leave policyholders uninsured at worst, or the status of their cover uncertain. The latter has a direct impact on client value as well as the public's perception of the entire industry. Swift claims payment is critical, especially for microinsurance products.

75 Impression gained from meetings in Kampala.
76 UBOS, 2012.
77 FinScope, 2010.

Table 9: Annualised Growth Rates and Retention Ratios 2007 - 2012 by Line of Business

Line of Business	Gross written premium 2012	Gross written premium 2012	Gross written premium share	Annualised growth rate (2007 - 2012)	Reinsurance Premium ceded (bn UGX)	Reinsurance Premium ceded (m USD)	Retention Ratio	Retained premium share
(bn UGX)	90.052	(m USD)	29%	20%	8.719	3.488	90%	47%
Misc. Accident	56.934	22.774	18%	25%	42.547	17.019	25%	8%
Fire	55.268	22.107	18%	29%	28.945	11.578	48%	15%
Personal Accident	29.647	11.859	9%	23%	13.830	5.532	53%	9%
Marine & Aviation	22.970	9.188	7%	16%	18.663	7.465	19%	3%
Engineering	21.760	8.704	7%	25%	14.497	5.799	33%	4%
Workers' Compensation	13.174	5.270	4%	12%	3.296	1.318	75%	6%
Public Liability	9.869	3.947	3%	22%	6.462	2.585	35%	2%
Burglary	7.401	2.960	2%	8%	1.054	0.422	86%	4%
Bonds	5.898	2.359	2%	23%	3.361	1.345	43%	1%
Total	312,974	125,190	100%	22%	141,374	56.550	55%	100%

4.1.1 Non-life insurance

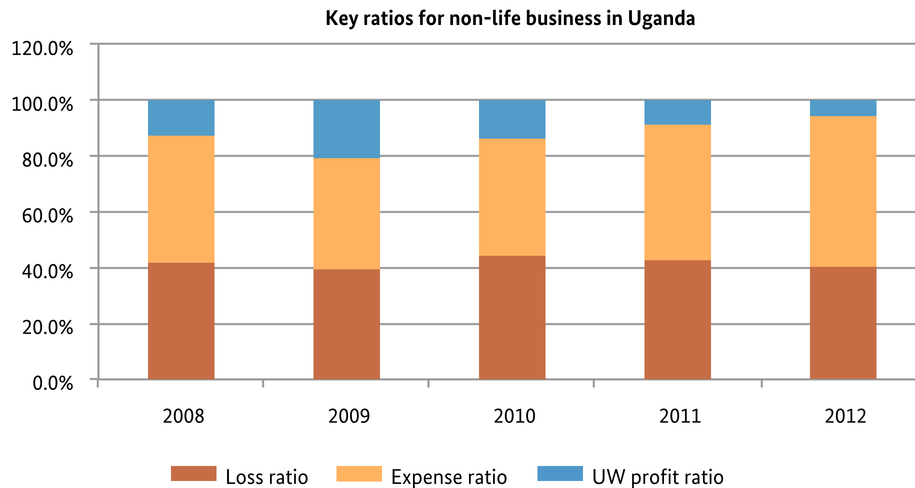
The non-life insurance sector, which with 89% of total gross written premium clearly dominates the whole industry, reported healthy annualised growth rates of 22% for the period 2007 – 2012. Considered by line of business, the picture is more nuanced. At the high end, fire insurance recorded annualised growth rates of 29% over the period, while burglary insurance has the lowest annualised growth rate (8%). See Table 9.

Measured by gross written premium, motor is the largest line of business with a 29% share, followed by fire and miscellaneous (both at 18%). On a net earned premium basis, the share of motor business increases to 49%, followed by miscellaneous (14%) and personal accident (9%). Reinsurance cessions are of varying importance, depending on the line of business. At the lower end, 10% of the motor business is ceded to reinsurers, while over 80% of all premium written in marine & aviation is ceded to reinsurers. Across all lines of business, 55% is retained on the books of the insurers.

The sector produced an underwriting profit of UGX 9.2 billion (USD 3.7 million) in 2012. Underwriting results have steadily declined over the past four years and are now less than half the amount reported in 2009 (UGX 19.4 billion; USD 7.8 million), though close to the amount reported in 2008 (UGX 10.0 billion; USD 4 million). This development is even more dramatic when the growth of net earned premium over the same period is taken into account: non-life underwriting profit amounted to almost 21% of net earned premium in 2009 and now stands at 5.6%.

Taking net earned premium as the basis for calculating key industry ratios, the non-life sector as a whole shows relatively low but stable loss ratios, rather high and rising

Figure 3: Loss ratio, expense ratio and underwriting profit ratio for non-life insurance (expressed as percentage of net earned premium) [78]



expense ratios and declining profitability over the last five years (see Figure 3). Worryingly, insurance customers pay more to the industry to keep the business running than covers what they can expect to receive back in the form of claims paid.

Despite the socio-economic importance of the agrarian sector, there is hardly any agriculture insurance available. The insurance industry has yet to come up with products specifically tailored to the realities of smallholder farming. On the positive side, many insurance representatives acknowledge the urgent need to find solutions and have stated their interest in exploring ways to serve the millions of smallholders in the country. Some have just started to experiment with crop and livestock insurance, as illustrated by Box 3 below.

The non-life sector is set to grow with further economic development in Uganda and could see a tremendous boost from the emerging oil and gas industry. However, only a few players currently have the technical and financial resources to exploit this opportunity.

4.1.2 Life insurance

In five out of the last six years, the growth (in %) of the life insurance sector has outpaced the non-life sector. Gross written premium grew on average by 27% for the period 2007 – 2012. However, it started from a very low level and currently captures just 11% of gross written premium. The sector still suffers from a lack of trust among the general public due to a series of currency devaluations in the 1980s, which wiped out a whole generation's savings held in endowment policies. Life insurance business also took an immediate hit from high inflation rates in the first nine months of 2012 and the subsequent tight macroeconomic measures implemented by the BoU.

The life insurance business is currently dominated by Liberty Life (the oldest pure life insurer in Uganda) with a market share of 33.5% on a gross written premium basis. Liberty Life is followed by ICEA with a market share of approximately 23%. However, with the entry of a second life insurance company into the market in 2010 (Sanlam) and the expected split of composite insurers by 2014, the life sector is set to see significant change in the near future.

4.2 Health Insurance

Health insurance is a mixture of insurance and pre-paid healthcare and covers some non-insurable events. Table 10 highlights some of the core differences between general and health insurance.

Per capita health expenditure in Uganda is estimated at USD 33, of which the public sector contributes 14.4%, development partners contribute 35.6%, and households pay 50%. More than 9% of household expenditure is spent

78 IRA, 2013.

Table 10: Some Core Differences between General & Health Insurance

General Insurance	Health Insurance
Large number of similar exposure units	Small pool, and high risk of adverse selection
Covers a clear event (e.g. car accident)	Individuals define when they feel sick
Accidental loss	Not all health events are accidental (e.g. pregnancy)
Low frequency, high loss	High frequency, low loss
Affordable premium	Healthcare is expensive

on out-of-pocket health expenses. [79] As demonstrated, health insurance is just one way to finance healthcare costs. In Uganda, out-of-pocket payments make up the largest part of health financing, followed by public expenditure for healthcare. Formal and informal health insurance accounts for only a relatively small part of total healthcare financing.

The current private health insurance market in Uganda consists of three different types of organisations:

- those insurance companies, both non-life and life, that offer health insurance;
- HMOs, primarily hospital-based membership organisations managed by facilities offering primarily in-kind services (currently the HMOs and insurers operate under different requirements);
- CBHIS, organisations set up and managed by the community to pool resources and sometimes to negotiate with the service provider (currently CBHIS are unregulated and unsupervised).

Currently, few insurers offer health packages, possibly due to the complexity of the product line. Additionally, few Ugandans purchase health insurance products, except those that are funded by employers. This leaves the greater portion of the population (unemployed and low wage earners) unable to purchase coverage as it is considered too expensive.[80]

Additionally, health insurance products in Uganda are largely curative, meaning that they do not proactively address issues regarding healthcare risks. Rather, they indemnify the risk of an adverse healthcare event. As already stated, not all residents of Uganda have access to basic healthcare, due to provider access issues that are more strongly felt in the rural areas.

Formal health insurance products are primarily bought on a group basis by employers for their employees and cover an estimated 460,000 lives.[81] Insurers and HMOs have almost equal shares in terms of persons covered. Both offer their services predominantly in the wider Kampala area.

Current health insurance penetration in Uganda is very low, even though households are spending out of pocket income on healthcare events. This suggests that there is vulnerability to a catastrophic healthcare event, but that residents of Uganda are unwilling or unable to afford the premiums associated with health insurance. Therefore, there is a potential market for microinsurance if the premium is affordable and the product is considered valuable.

An affordable premium is one that does not interfere with daily life expenses. From a demand perspective, the potential health microinsurance population typically has minimal financial means. And individuals who do not think they will need healthcare will probably not want

79 "The Republic of Uganda Ministry of Health Statistical Abstract 2010" Ministry of Health http://www.ubos.org/onlinefiles/uploads/ubos/pdf%20documents/PNSD/2010MOHStatAbst.pdf
80 "Uganda: National Health Insurance Scheme to Spur Sector Growth" 26 January 2012, Ghana MMA News, http://www.ghanamma.com/news/1/uganda-national-health-insurance-scheme-to-spur-sector-growth/
81 This is based on informal conversations with the main HMOs in Uganda.

to purchase insurance because they do not expect to use it. From the health microinsurer perspective, affordable products are not adversely selective and ideally are comprised of a community of individuals to ensure pooling (including low risks).

A valuable health insurance product is one that ensures a quality outcome. This means that there are quality providers in place and that there are both tools and expertise for correct diagnosis. For a health microinsurance policy to be successful the product should have broad appeal and the premium must be competitive and affordable. Specifically:

- the cover must be something people are willing to pay for (a low loss ratio suggests that the product is not being used and likely will not be renewed);
- outpatient coverage is very important (high frequency, low cost);
- the product is purchased by both low and high risk groups;
- there are sufficient providers in the market;
- there are reliable and correct diagnoses (to make the product worth purchasing);
- to keep premiums low and ensure quality medical outcomes, the insurance company must proactively manage medical costs (often through pre-authorisation, cost control, standard provider fees, etc.) and administrative costs.

As health insurance is typically renewable on an annual basis, if the product does not provide quality outcomes or customer service, or is too expensive, policyholders may not renew. This is not efficient for an insurer, which may have incurred significant acquisition costs in obtaining the policyholder as a customer. Additionally, health insurance usually provides cover for multiple claims, in some markets up to seven claims per person per year, and these include low-cost, high-frequency claims like a surgery visit or a prescription.[82] This is different from vehicle and property insurance where there are few, high-cost claims. From this information we see that the risks and skills required to manage health microinsurance are different from other lines of business. Specifically, the health microinsurers must be able to manage the volume of claims as well as the medical expenses, and maintain low administrative expenses. If an insurer just indemnifies claims and does not understand what is driving the cost increases, then it may simply respond to increasing medical costs by increasing the premium rates, rather than understanding and managing the healthcare costs.

In general, health insurance in mature markets is usually provided by specialist insurers dedicated to managing what is a very complex business separately from other insurance products. Insurers focusing solely on health tend to develop products and processes that aim to understand and manage the local drivers of medical claims trends. These products are typically supported by a dedicated claims system that is populated by detailed claims line items, including diagnosis and procedure codes. This is what we can expect to see develop in Uganda over time.

4.2.1 Standardised claims forms and coding to lower administrative costs

Only a few insurers and HMOs offer health insurance in Uganda. And as there are a finite number of employers purchasing insurance, there is competition for this business. If these insurers and HMOs decide to enter the health microinsurance business, they will also need to provide low-cost, high-value products. But this can be expensive. In emerging health insurance markets, the administrative costs can average 25-35% of the premium. To reduce these costs, companies typically try to standardise as much as possible so that processes can be performed quickly and efficiently. Standardised claims forms and coding are two important tools that can help streamline administrative processes. From a health microinsurance perspective, managing administrative expenses is even more critical to sustainability.

Standardised claims forms

In many global markets, providers and hospitals have their own bills and formats. This means that as claims are received by the insurer, the claims handler has to look at the claim and search for the data that he/she needs to adjudicate. This adds time to the process and the forms submitted may not include the data that the claims handler requires.

Introducing standard claims forms can be a difficult process if the regulator does not require it. However, it is

82 This estimate is based on full health insurance coverage for inpatient, outpatient and pharmacy expenses. Country estimates for Uganda may be above or below this figure. It is intended to demonstrate the high volume of claims associated with the line of business.

possible to move in this direction if at least some foundational issues exist, including:

- the insurer requiring completion of standard claims forms is an important claims source for the providers;
- there are multiple insurers who will require completion of standard claims forms;
- the insurer will support those providers in learning how to complete the claims forms correctly, and provide support when they are incorrectly completed;
- there is some penalty (that can be enforced) for not completing the claims forms correctly (e.g. claim will not be paid).

In some markets,[83] insurers began this process by creating "super bills." A super bill is a precursor to a standard claim form. It typically includes very basic information on the most commonly occurring claims types. Instead of asking the provider to code, it will include the common codes (and descriptors) so that providers only check boxes. If the treatment is not on the list, the provider can enter it. Super bills can be organised per field of specialisation, so that, for example, cardiology claims are included separately from obstetric and gynaecological claims.
As this process is occurring, the providers are being trained in terms of coding requirements and the claim form organisation. Over time, the super bills are phased out and standard claims forms are phased in.

Coding

Coding is also important as it provides a foundation for the collection of data to help study medical utilisation and cost trends. Typically there are both diagnosis and procedure codes.

International coding is a good option because there are comparable data from other countries to study. However, if there is a home-grown set of codes (such as the AMB Codes in Brazil), they can be used as long as the market recognises and uses them consistently.

The most common international coding is the International Classification of Diseases (ICD). The ICD is used to classify diseases and other health problems recorded on many types of health and vital records globally. It serves to classify diseases, symptoms, and other signs.[84] These codes could be used in Uganda to create fee schedules from which providers are reimbursed, as well as to help the Government track morbidity and mortality trends.

4.2.2 Key success factors for health insurance in general

In summary, key success factors for health insurance include:

- Correct product and pricing
  - Products must be of value (unless the premium is negligible, low loss ratio products in health suggest that the product is not meeting market needs);
  - If premiums are under-priced to "buy" the business in a competitive market, it is almost impossible to recover that money unless you cost shift to another group or product line.
- Correct distribution channels
  - Health insurance is "sold"; it is not "bought." This mean that the distribution channel not only needs to understand the complexity of the products, networks, and claims management channels, but must have the incentive to sell it and address questions as they arise. Simple products and processes have the best chance of success.
- Ability to manage medical and administrative costs
  - This can be achieved in many ways, including capitation (as seen in Nigeria, capitation is the core method used to manage high-frequency, low-cost medical claims); the development of fee schedules (standard rates that an insurer reimburses for procedures); pre-authorisation and medical management processes (making sure that the treatment is medically necessary and a quality outcome is achieved); cost containment plans (including administrative, medical, and fraud management).

However, insurers can only manage if they can measure. Insurers therefore need to know what the actual costs are in detail (e.g. how many office visits occurred, how many CT scans were carried out and how much was paid to which providers). To do that, an insurer requires a detailed claims system and standard coding, as described above. Again, as indicated, for the adjudication of claims to be timely and accurate, standardised claims forms are needed.

83 For example, Panama and the Republic of Georgia.
84 World Health Organization Classifications: http://www.who.int/classifications/icd/en/

4.2.3 Insurance companies

Both non-life and life insurance companies offer health insurance, with Jubilee (a non-life insurer) covering the most significant portion of the group business.

In the non-life category, the following insurers reported health results in 2011:[85]

Table 11: Non-life Insurers Reporting Health Results 2011[86]

Company	New group health – number of individuals covered by group policies	Renewed group health – number of individuals covered by group policies	Total new and renewed health number of individuals under group policies	TOTAL individuals covered by group policies	Percentage of total number of insured individuals that have health insurance cover
Jubilee	5,556	23,474	29,030	52,582	55%
UAP	1,100		1,100	88,400	<1%
E.A. Underwriters	704		704	13,436	5%
ICEA	1,212	680	1,892	1,892	100%
TOTAL	8,572	24,154			

Jubilee, ICEA and E.A. Underwriters demonstrate a substantial interest in the health insurance space. Therefore, these companies may be aware of the growing risks associated with health insurance, and support the development of a standardised infrastructure including coding and claims forms.

Life insurers offering health products are Sanlam and Liberty. The results for health are grouped under miscellaneous and therefore cannot be isolated.

Health insurance in Uganda is reportedly often loss-making for many reasons, including the potential under-pricing of the risk (possibly due to competition), inexperience in the market, absence of fee schedules and lack of standardised coding and claims forms.

4.2.4 Health Membership Organisations (HMOs)

The Health Membership Organisations (HMOs) in Uganda are primarily hospitals that provide medical services to "members" in return for a monthly premium payment.

The HMO market is said to cover about 200,000 total lives,[87] with AAR Health Services Limited and International Air Ambulance being the top two players.

HMOs are primarily headquartered in Kampala and are considered membership organisations in which health-care is provided "in kind". However, a few of the HMOs interviewed indicated that they provide healthcare across the country, typically through non-owned facilities on a fee-for-service basis.

4.2.5 Community Based Health Insurance Schemes (CBHIS)

Some informal working communities address healthcare financing risks through Community Based Health Insurance Schemes (CBHIS). There are fewer than 30 CBHIS in Uganda. Their sizes vary from 1,500 to 10,000 members, resulting in an estimated membership pool of 108,000 individuals. The CBHIS are loosely affiliated under the Uganda Community Based Health Finance Association (UCBHFA).

The UCBHFA was established in 1998 to create a forum for the different schemes to share information and ideas. The group is not well funded, but works to increase the

85 Insurance Regulatory Authority of Uganda, Annual Insurance Market Report, 2011 http://www.ira.go.ug/2011_annual_market_report.pdf
86 Insurance Regulatory Authority of Uganda, Annual Insurance Market Report, 2011 http://www.ira.go.ug/2011_annual_market_report.pdf
87 Based on informal group discussions with different HMOs in Uganda.

transparency and lessons learned from various health insurance trials. There are three categories of members:

1. Schemes owned by a clinic: typically the clinic is the fund manager that mobilises the community and assumes risk.
2. Pure community based health schemes: these are self-mobilised communities that open bank accounts and contract with facilities. These schemes are self-managed and register at the Community Development Offices, which is not a formal registration, rather an informal recognition).
3. Community service providers: MicroCare, which served as an intermediary managing the fund, was the only player in this segment and closed down its operations in 2009.

While there are CBHIS in different parts of Uganda, the core issue of sustainable pricing remains unresolved.

4.2.6 Efficiency, cost and quality of healthcare

Efficiency, cost and quality of healthcare measurements are important for health insurance because these metrics create a healthcare system that is safe, offers optimised processes, and is trusted by the population. This is even more important for the micro-health insurance market, because there is less disposable income to spend on healthcare. Efficient, low cost and high quality services are critical to health microinsurance sustainability.

In Uganda, attention is paid to the supply of providers in the market, but limited attention is given to the way healthcare resources are mobilised, allocated and used.[88] Going forward, attention to standardised data collection in terms of utilisation and cost of services will lay the groundwork for movement towards effective management of medical costs. If medical costs and utilisation trends are not measured, it will be difficult to manage them. Currently, individual hospitals measure quality and manage risk internally. It may be helpful to create standard quality metrics that hospitals provide to the MoH.

Table 13 indicates wide variation in the costs of two different procedures in the Kampala area. The difference in these costs demonstrates the potential risk that private providers may cost shift to private paying or privately insured patients.

Table 12: Selected costs of two common procedures

Procedure	Estimated Public Cost	Estimated Private cost
C-section	1,800,000	2,500,000
CT scan	80,000	150,000

Without some standard scoring of the unit value of work associated with procedures from a professional and facility perspective, providers may cost a procedure based on their overall fixed and variable costs.

BOX 1: Community Based Schemes vary in terms of coverage, experience and focus

One example of a community based health scheme is "Save for Health" based in Luwero. The group offers three types of health insurance to its members: zero deductible, a mid-range deductible, and a high deductible plan. With each deductible increase, the premium is reduced. Premiums must be paid a year in advance.

The goal is to offer members an option to borrow money to pay for the cost of healthcare above a certain price point. However, the burden of the premiums seems to point to adverse selection as well as difficulty in seeing the loans repaid. Core issues in the rural areas are the lack of providers and the cost of transportation to see a provider. As an example, an individual may prefer not to pay the 20,000 shillings to travel to receive treatment costing 4,000 shillings. This could lead to untreated situations that could become more serious and cost more in the long run.

Save for Health has worked well in the community to help sensitise individuals to the burden of an unexpected healthcare event, but has not been able to fully manage the provider supply and transportation issue.

Results of the Save for Health scheme suggest that the cost of health insurance premiums is high and the plan has seen a 21% loss of membership in the last year. Reasons for non-renewal include financial issues, low levels of satisfaction, or moving to another area.

88 National Health Policy: Reducing poverty through promoting people's health. May 2009 version, p 7.

4.3 Microinsurance

As we note later in this Report, there is no clear, legal definition of microinsurance in Uganda. For the purposes of this Report, we consider as microinsurance all those products which have been designed to serve the low-income and informal market either directly or indirectly through group policies. Uganda is one of the early adopters of formal microinsurance delivered by an MFI and underwritten by a regulated insurer. As early as 1997, AIG and Finca introduced a group personal accident policy to cover Finca's borrowers. Two years later, the product evolved and covered in addition the spouse and up to four children. [89]

Some 15 years later, the situation has changed, but only at the margin. Most microinsurance in Uganda is still provided through group policies sold to financial institutions such as MDIs, MFIs, SACCOs and commercial banks serving the lower and lower middle-income segment. The standard product heavily resembles the improved version of 1999, covering borrower, spouse and up to four children. Encouragingly, additional covers have been added such as catastrophic property loss. AIG is still a major player in this market segment, though other insurers such as UAP, NIC and Lion insurance have made some inroads into the business.

The Ugandan credit-life microinsurance market is notably different from most others as it is non-life insurers that write most of the business, rather than life insurers. This surprising fact is due to the history of this market segment in Uganda. Formal credit life business started as personal accident written by non-life insurers. Over time, additional covers, including life and property for business premises or goods purchased with the loan have been added, which makes it very difficult for life insurers to compete in this segment, as they cannot offer the property covers.

4.3.1 Current players and products

A growing number of players: the number of insurers actively serving the low-income segment has steadily increased over time. The following companies offer policies designed to target the low-income and informal segment:

- AIG (mainly credit-life)
- UAP (mainly credit-life)
- National (credit-life and school-fee protection
- Lion (credit-life, agriculture)
- Liberty Life (PA and hospital cash)
- ICEA (savings-linked life and PA).

In addition to these, a growing number of health insurers are developing and offering products for the lower income segment.

However, the microinsurance sector has also seen the two dedicated players exit the microinsurance market over the last couple of years: MicroCare (a specialised health insurer) and MicroEnsure (formerly Micro Insurance Agency, a specialised microinsurance broker). MicroCare ceased trading on becoming insolvent in 2009 and MicroEnsure withdrew from the market in 2010.

On the distribution side, almost all bigger financial institutions catering to the low-income segment cover their clients through at least a basic credit-life product, often extended to the family and including additional covers. However, most of these products are group policies and end clients may not be aware of the extent of their cover or, in some cases, even that they are covered at all, as they do not usually receive a summary of their cover. As a consequence, even those who are covered may not be well aware of this fact and hence not really appreciate the service.

Microinsurance, mainly credit life products: Activity in microinsurance is generally low and few insurers offer more than credit life policies. Where credit life policies cover more than the outstanding loan amount, the players seem to have developed their policies from a common template, limiting innovation. It is noteworthy that many of the extended credit life policies being sold offer fairly comprehensive coverage, including against natural and man-made disasters as well as a funeral benefit for family members. While the cover is fairly comprehensive, several insurers noted with concern that MFIs do not reliably transfer the claims payments to their end-clients. This is rightly a concern to insurers, as late or non-payment is a clear reputational risk to them, even if they are not directly responsible.

A number of insurers indicated a high level of interest in microinsurance and state that they are considering how they can best penetrate the market. However, very few

89 CGAP Case Study No 9, 2005.

BOX 2:
MyLife: a personal accident and hospital cash product
In February 2013, Liberty Life and MCash jointly launched a new microinsurance product for the urban lower-income class under the name MyLife. The product offers compensation in case of personal accidents and hospitalisation and comes with three benefit options:

Option	Max. cover (UGX)	Monthly Premium (UGX)
Silver:	1 million	2,500
Gold:	2.5 million	6,250
Platinum:	5 million	12,500

The events covered are accidental death and permanent disability, as well as hospitalisation exceeding 72 hours. The hospital cash benefit is one-third of the accidental benefit cover option and an insured is entitled to a maximum of two claims per calendar year.

The product is sold exclusively through MCash agents, fully trained and licensed by the Authority as insurance agents for Liberty Life. At the beginning of the pilot, Liberty Life trained 40 agents on the product, all recruited from within the boda-boda community, the primary target market for this product.

Premium collection is monthly, premiums being paid exclusively through the mobile money service MCash, a provider-agnostic service. MCash's range of services includes money transfer, e-payments (both push and pull), as well as cash deposits and withdrawals. MCash complies with "know your customer" and other anti-money laundering (AML) requirements for banking services set by the BoU.

of them seem to have developed a specific strategy for growing their microinsurance book. When asked which products they are most likely to develop for the low-income market, health micro and agricultural insurance were frequently mentioned. Whilst appropriate products in these two lines of business should meet significant demand, they are also the most difficult products to offer, especially at the micro level. Additional challenges in the micro-health segment include the deficit of providers in rural areas, as well as the high cost of transportation.
Microinsurance expertise and product innovation: Invariably, those players that state an interest in microinsurance indicate a need for technical assistance and exposure to international examples of best practice. Those insurers that belong to regional or international insurance groups will be able to tap into their respective group's pool of expertise. For example, Jubilee Insurance recently hired a full-time microinsurance champion in order to drive innovation and grow its respective book. Microinsurance is a key topic at Jubilee's board level and country operations can tap into the group's resources and experience. Jubilee has conducted a series of pilot tests for life and funeral insurance products, targeting families that participate in village savings & loan associations and have benefited from financial education programmes delivered by non-governmental organisations. The products typically provide cover for the parents as well as for up to six children, with the benefit level for the parents double that for children. The primary goal of Jubilee at this stage is not to make an immediate profit, but to better understand the low-income market in Uganda before developing an upscaling strategy.

Identifying suitable distribution options, market and demand research, product design and rating are areas where most insurers will require assistance in order to make quick progress. Some innovation is already taking place. A combined accident and hospital cash product has recently been launched for boda-boda drivers (see Box 2). Opportunity Bank International (Uganda) introduced a life and school fee insurance linked to savings (see Box 3). Finally, there are proposals for a number of insurers to create a

BOX 3:
Opportunity Legacy: a savings linked life and personal accident product.
In April 2013, Opportunity Bank International (Uganda) launched its newest insurance product called 'Opportunity Legacy'. The policy is automatically attached to the bank's regular savings accounts and covers the account holder against death (any cause) and permanent disability. Opportunity Bank offers this policy free of charge to customers who maintain a minimum balance in their savings accounts of UGX 50,000 over a 3-month period.

Opportunity Bank introduced this new service in partnership with the Insurance Company of East Africa (ICEA) and with a double goal in mind: providing an incentive to its customers to increase their deposits and securing their families, including their children, in the case of death or permanent disability. With this objective, the benefit package has two components:
i) a death and disability benefit proportional to the savings balance
ii) a fixed benefit aimed at securing the child's school fees

A one-year tuition fee for an average public school is estimated at UGX 200,000

Benefits (in 1,000 UGX):

Average balance	proportional benefit (death & disability)	fixed benefit (school fees)
50 – 100	3.5x average savings balance	200
101 – 200	5x average savings balance	500
201 – 250	7x average savings balance	750
>250	10x average savings balance	1,000

Out of the current 80,000+ savings account holders, over 14,000 qualify from the start:
- 5,000 for the lowest benefit level
- 3,000 for the second benefit level
- 1,000 for the third benefit level
- 5,000 for the highest benefit level

Opportunity Bank (Uganda) plans to evaluate the 6-month pilot carefully to better understand whether this product acts as a strong incentive to increase deposits and how customers perceive its value.

co-insurance pool for the purpose of offering agricultural insurance (see Box 4).

4.3.2 Current and potential distribution channels

Microinsurance distribution and bancassurance: Except for credit life, insurance is sold primarily through the traditional broker/agent model. In 2012, there were 30 brokers and over 800 agents. In the past, brokers have helped the Ugandan insurance industry to develop group products targeting the lower-income segment. However, as previously noted, the specialist microinsurance broker MicroEnsure withdrew from Uganda in 2010, stating limited business potential as its reason. The sale of individual policies to the low-income market through agents and brokers is too costly for most microinsurance products, particularly outside Kampala. It will therefore be necessary to identify different distribution channels. Currently one insurer, Liberty Life, is experimenting with direct sales to the informal sector (see Box 1) in partnership with MCash, a mobile money operator.

Most insurers view banks and financial institutions as a promising distribution channel, both for microinsurance and for insurance products more generally. Whilst the Insurance Act has been amended to enable bancassurance (although see our concerns in relation to how this has been done in section 7.4.1.5), the Financial Institutions Act

BOX 4:
Kungula Agrinsurance: crop and livestock insurance
In June 2013, a group of six insurance companies launched both crop and livestock insurance in Uganda under the name Kungula Agrinsurance. The six companies APA, FICO, Lion, NIC, NIKO and UAP formed an underwriting pool under the lead of Lion Insurance. Each company retains 5% of the pool business; 5% is ceded to Uganda Re and 65% to SwissRe.

For livestock, two complementary products are on offer: a mortality all risk as well as a catastrophic cover, which is index-based. Premium rates range from 2%-5%, depending on the area and are sub-additive for those buying both products. A minimum of 50 heads of livestock have to be insured, though farmers are encouraged to form groups in order to reach that limit.

Crop insurance is based on a Normalised Difference Vegetation Index (NDVI) provided by EARS (Netherlands) and is available for coffee, maize, beans and banana. The minimum size to qualify for insurance is 5 acres, and again farmers are encouraged to form groups. Premium rates range equally from 2%-5%, depending on the agricultural district and the crop grown. The trigger points of the indices are set at a recurrence period of once every five years and total losses are expected every 10 years. Participating farmers have to insure all their area under cultivation with the same, eligible crop. Beyond primary producers, all entities with an insurable interest can buy this policy.

The pre-underwritten policies are distributed primarily through Centenary Bank and Pride. The underwriting consortium is targeting a premium volume of USD 250-500,000 in the first year and aims to break even by year 3. This initiative received financial support from aBi Trust, which will be extended over the next three years.

prohibits it. The necessary amendments to the Financial Institutions Act have been drafted and sent to Parliament, but it is not clear when they will be enacted. Banks and MFIs have, through the use of group policies, been able to act as a channel for the delivery of credit life products to their borrowers. Technically speaking, these banks and MFIs don't sell credit life to their customers, but buy it on their behalf. However, they usually charge their clients for this service, for example by charging a higher interest rate, including a mark up against the premium that they are paying the insurer. The absence of provisions enabling full bancassurance is a significant constraint to further market development, as it is not lawful for banks and MFIs to be paid commission for the sale of insurance products.

Yet, banks and deposit taking institutions can still become active in promoting and extending insurance services. One recent example is described in Box 3: the bundling of insurance with savings, financing the premium through reduced interest rates paid to the clients and gains made in refinancing costs. This can be seen as a creative way of providing value to both the clients and the lending institution.

wAlthough the introduction of bancassurance would enable banks and financial institutions to sell microinsurance and insurance products to their clients, other distribution methods are needed to reach those who do not have a relationship with a bank or a financial institution. Most insurers consider that in the more remote areas it is necessary for microinsurance to be sold by people who are trusted in the community, such as village chiefs and community leaders. However, an insurance agent is currently required to obtain a Certificate of Proficiency (CoP) in order to obtain a licence and the insurers consider that it is unrealistic and impracticable to expect village chiefs and community leaders to obtain a CoP.

Insurance distribution through the agriculture value chains: surprisingly little use is made of the various existing value chains in agriculture. With a predominantly rural population, these value chains could hold the key to reaching unserved customers. However, even the recently launched agriculture insurance pool (see Box 4) works primarily through banks for distributing policies, not other companies along the agriculture value chain.

Table 13: Ex-post coping mechanisms counted on by Ugandans for selected events (source: FinScope Uganda, 2010)

Coping Mechanism	Serious illness of household member	Crop failure	Serious sickness of breadwinner	Loss of family member
Ask neighbours, relatives and friends for donations	33	19	29	37
Sell assets (e.g. land, livestock)	24	13	29	19
Withdraw savings	19	10	18	8
Take a loan from family or friends	15	7	12	12
Don't know what to do	8	12	10	21
Ask for government assistance	7	23	6	4
Look for more work	6	15	9	5
Take a loan from an informal organisation	4	7	5	6

Farmer cooperatives are numerous, but relatively small in size (interview with Mr Msekaweli, General Secretary of Uganda Co-operative Alliance): primary cooperatives have between 150 – 200 members and those at the secondary level between 700 – 1,000. Despite their small size, working through these producer organisations could open up new avenues for rural distribution.

Mobile Network Operators (MNOs) have, without doubt, the largest outreach and penetrate deeply into the low-income and informal sector, in Uganda as in any other countries. The first attempts to distribute microinsurance through MNOs to their mobile phone customers took place a few years ago and since 2010 this has spread rapidly across Africa and Asia. Though the use of MNOs has allowed insurers to reach large numbers of clients very quickly, a whole set of new issues arises and should be considered carefully, from a regulatory perspective too (see section 7.5.5.2).

4.3.3 Summary of the constraints to further market development

The general market sentiment is that the potential for microinsurance in Uganda is very significant, but growth is currently limited by a number of constraints, including the following:

- limited local expertise in designing and implementing microinsurance programmes, combined with low awareness levels of advances in microinsurance outside Uganda;
- severely limited options for microinsurance delivery, service and collection of premium, especially for products that are not linked to the extension of credit;
- very low levels of awareness of and appreciation for the benefits of having insurance among the general public;
- absence of regulations allowing financial institutions under the supervision of BoU to actively sell insurance products (though this should, a priori, be solved in the near future).

We would add a fifth constraint: product development without thorough demand assessment. Ugandan insurers seem to invest very few resources into researching specific

market segments, conditions and habits of target populations before developing new products.

4.4 Households' Risk Perception and Management

The Uganda Country Diagnostic (2008) identified costs related to health events as the primary concern to Ugandans. This finding is also supported by the FinScope Study (2010), which found that the three most important risks in terms of financial consequences for a Ugandan family are related to health and agriculture. Serious illness of a household member ranked first (39% of respondents indicated this as a serious risk), followed by crop failure (33%) and serious sickness of the main income earner (28%). Not surprisingly, crop failure is a much bigger concern for rural than urban respondents: rural respondents indicated this as a key risk three times more often than urban interviewees.

The loss of a family member, which ranked fourth in terms of importance, appears to be a more serious risk for rural households (24%) compared with their urban counterparts (16%), whereas the loss of household items owing to fire, flood, destruction or theft (16%, ranked 6th) is a bigger concern for urban households (23%) than for rural ones (14%).

Informal insurance schemes exist in Uganda mainly through the form of burial groups: 17% of all respondents indicated adherence to such groups. However, it should be noted that burial groups exist in many forms in Uganda, ranging from loose schemes under which villagers come together and basically promise each other mutual assistance (in-kind or cash) to those where members make regular payments into a common fund, which serves to compensate those suffering a bereavement in the family.

In the light of very low outreach ratios for formal and informal insurance schemes (with the exception of burial societies, which attract decent numbers of members), it is no surprise that most people indicated that they rely on family and neighbours, sell assets and draw upon accumulated savings, where existent. Details of ex-post coping mechanisms are provided in Table 13.

5 Proposed National Health Insurance Scheme

Over the long term, a sustainable healthcare marketplace will include economic development that will bring investment into the country and provide residents with the opportunity to afford health insurance that not only covers the curative aspects of their health, but also provides preventive care. Preventive healthcare is a critical aspect of healthcare, as it aims to reduce the onset or exacerbation of illnesses. To that end, as the Ugandan economy develops, one can expect a parallel development of the private sector health insurance market and an increasing focus on prevention versus curative care.

However, economic development is a long-term phenomenon that relies on a myriad of stakeholders, economic factors, and resources. To help protect the health of Ugandan residents, the MoH has undertaken the task of designing a National Health Insurance Scheme that has the ambitious aim of providing healthcare resources and financing to all Ugandan residents. The National Health Insurance Bill has been drafted to implement the scheme.

The plan[90] is to initially cover an estimated 2 million Ugandans (6% of the population), including 300,000 government workers. Employees are scheduled to contribute 4% of their gross salary, which employers will match. The challenge in getting the Bill passed includes resistance from unions and employers. Currently, employers already contribute 10% of gross salary to the national pension plan.

To reduce employer reluctance to support the NHIS Bill, informal conversations with the MoH suggest a willingness to allow employers to opt out of the social coverage, as long as they are able to demonstrate provision of a comparable benefit. However, while this may benefit the employers in terms of reduced health insurance contributions, it is unclear how those remaining in the system will be able to support this long-term initiative without additional external funding.

While the Bill is still being considered, it is clear from our interviews that both the MoH as well as many in the health industry itself expect that the Bill will be enacted in some form that will provide coverage for the entire population, considered likely by 2040. This section addresses some core components of the coverage, as well as the impact on development of health micro-insurance.

90 CMAJ, February 3, 2009 vol. 180 no. 3 foi: 10.1.1503/cmaj.082039: Rosebell Kagumire, “Public health insurance in Uganda still only a dream”.

5.1. Potential of the proposed NHIS Scheme

The sustainability of the proposed model is critical to the potential health microinsurance population. If the NHIS is rolled out to the potential health microinsurance population, there will be limited need for health microinsurance products. However, if it is not successful in attaining universal coverage, then the impact on the potential health microinsurance population will be felt deeply. Three issues related to the NHIS Bill are discussed: (1) achieving sustainable funding – will it happen?; (2) unclear lag time before the health microinsurance community is added – when will it happen -- and (3) creating an entirely new public health insurance system that manages itself may present operational, competition and governance conflicts – *will it sustain itself?*

Achieving sustainable funding:

- The current benefits are comprehensive and the proposed pricing is being reviewed.
- The cost of covering all residents of Uganda is high and there is currently insufficient funding available. There are efforts underway to locate funding.
- It is unclear whether additional external funding is required for long-term sustainability or only as an interim measure.
- In addition to insufficient funding at present, the current proposed funding also depends on subsidisation from the government and private sector. It is unclear whether this subsidisation is affordable.

CONCLUSION: Insufficient funding and comprehensive benefits represent an important obstacle to sustainability. While the goal of total coverage is important, it is often easier to begin with basic benefits and scale up, rather than offer extensive benefits that cannot be supported and must be retracted later. If there is insufficient funding of the NHIS, this diminishes the potential for long-term public insurance for the informal sector.

Unclear lag time before the health microinsurance community is added:

- The proposed approach considers CBHIS as transition vehicles only, not as a long-term option to enrol and manage the healthcare risks of the informal sector. In other words, health microinsurance would be crowded out of the delivery and distribution of products to the microinsurance community.
- The expected initial roll-out is for those who are currently insured and government employees. This means that there will not be coverage for the informal sector in the short to medium term.
- The NHIS bill includes government agencies to code, create tariffs, and manage enrolment through groups only. This could potentially take place through existing group or community ties.

CONCLUSION: The most vulnerable population will be added after the current system has been rolled out to individuals employed by the Government and the private sector. It is unclear whether the current health microinsurance channels (including CBHIS) will be featured.

Creating a new public health insurance system that manages itself may present operational, competition and governance conflicts:

- Operational management of the NHIS will be provided for by the Government. The Government may not have experience in terms of professional and efficient healthcare management.
- A purely public system (even with the potential for employer opt-outs) may discourage provider competition.
- Typically governments finance and regulate. In markets like Germany and Switzerland, health insurance is financed by the government, but there is external involvement in the managing of the healthcare risk. In the case of Uganda, the Government intends to organise, deliver, and manage the healthcare of its residents.

CONCLUSION: Healthcare management is complicated by many stakeholders with conflicting behaviours. For example, a provider may want to practice defensive medicine and potentially over-utilise services. At the same time the government may want to keep medical costs low. The government taking over all responsibilities of financing, managing and governing itself may create unintentional conflicts.

While it is important to consider the long-term sustainability of the NHIS, and we have highlighted some points to be examined, the core question for the health microinsurance community is how soon it will be able to participate in the public health system. Two scenarios are outlined in table 14:

Table 14: Scenarios for NHIS Roll-Out

Scenario	Likelihood	Comment
1. The NHIS roll-out is sustainable and covers the potential health microinsurance population in the short term <=10 years	Low	There are significant financial, doctor and hospital shortages in the country that are unlikely to be resolved within five years. At the same time, the cost of insurance premiums is too high (even in the rural areas) to be considered a viable mechanism for financial protection.
2. There is limited/no NHIS benefit for the potential health microinsurance community within the next five years.	Probable	In the event that the NHIS Bill is passed, there is the potential that the informal community will continue to financially defend itself against medical risks until the operational and funding issues are resolved. However cost of health insurance premiums remains an important barrier even in rural areas.

Given the likelihood that the NHIS rollout will not cover potential health microinsurance clients in the short to medium term, some interim recommendations are warranted.

5.2 Product and Operational Considerations

The following paragraphs detail important product and operational issues that may impact the long-term sustainability of the NHIS Bill, including the concept of free access and what that means to health economists, the importance of standardisation to keep health microinsurance premiums competitive, and ensuring quality health outcomes.

5.2.1 Free access to healthcare may lead to overutilisation

The NHIS Bill excludes coinsurance or copayments for medical treatments. The impact of "free access" to medical care will overwhelm an already overburdened system. However, requiring the informal sector to pay for even part of the healthcare might also have negative consequences. The Rand Study[91] provided two important lessons to consider:

- On all the plans in the experiment, poor people were less likely to seek healthcare in the course of a year, but more likely to be hospitalised.
- People given free healthcare had better health results at the end of the study regarding blood pressure control, corrected vision, and oral health.

At the same time, this study demonstrated that cost sharing is one strategy for managing healthcare costs, but it should be addressed carefully. Specifically, "free" medical care can lead to overutilization,[92] but high coinsurance or copayments could deter people from accessing medical care at the appropriate time. Therefore, ensuring appropriate collection and analysis of detailed enrolment and claims data (through standardised coding and tariffs) as well as introducing effective quality management strategies are critical to long-term NHIS success.

5.2.2 NHIS system currently does not have a specific plan for a standardised platform

In conversations with stakeholders, there are trust issues with medical doctors. Specifically, will the doctor be able to diagnose correctly so that I am treated once rather than having to return with the same symptoms. In Uganda, where there is an undersupply of providers and equipment, primary care doctors and nurses are often expected to know more than they were trained to treat.

91 "Effects of Cost Sharing on Use of Medical Services and Health" Emmett B. Keeler, Ph.D. Rand Corporation, Health Policy Program, Santa Monica, CA 90407-2138.

92 The **RAND Health Insurance Experiment** (**RAND HIE**) was an experimental study of medical costs, utilisation and outcomes in the United States, which assigned people randomly to different kinds of plans and followed their behaviour from 1974 to 1982. It concluded that forms of cost sharing (copayments, coinsurance, etc.) reduced "inappropriate or unnecessary" medical care (aka overutilisation), but also reduced "appropriate or needed" medical care.

In many mature markets, there are Evidence Based Medicine Guidelines[93] that aim to standardise the treatment and management of common primary care or specialist diagnoses and treatment. Evidence-based medicine has been defined as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients".[94] These guidelines do not replace a doctor, but are available to doctors to provide the latest treatment recommendations based on medical studies. This process seeks to assess the strength of the evidence of risks and benefits of treatment (including lack of treatment) and diagnostic tests. This helps clinicians predict whether a treatment will do more good than harm.

In discussions with the facility based HMOs and Mulago Hospital, interest was expressed in considering the introduction of Evidence-Based Medicine, in particular when there is an undersupply of specialist providers.

5.2.3 Importance of measuring healthcare outcomes

As the NHIS Bill approaches introduction, consideration of quality components will assume a more prominent position. These should ideally include:

- hospital and provider accreditation and continuing medical education requirements (as applicable);
- pharmaceutical sourcing and management;
- methods to track and measure quality outcomes at a facility and specialist level (either through claims or including random audits);
- rewards / recognition of quality outcomes.

5.2.4 The prospect of an NHIS Bill

While doubts were expressed regarding the timing and long-term successes of the Bill in its current form, all agree that it is likely that the Bill will make it through Parliament with initial roll-out discussions to begin in 2014.

The impact on the health microinsurance market in the short-term is likely to be minimal, as it is not expected that health microinsurance clients will be included in the early stages of the launch. Over the long-term, however, though the coverage and benefits and charges may change, in general it is expected to provide medical insurance coverage even at a basic level to all residents of Uganda, potentially crowding out private health microinsurance.

93 An example of an evidence based medical guideline can be found here http://onlinelibrary.wiley.com/book/10.1002/0470057203.

94 Sackett DL, Rosenberg WM, Gray JA, Haynes RB, Richardson WS (January 1996). "Evidence based medicine: what it is and what it isn't". BMJ 312 (7023): 71–2. PMC 2349778. PMID 8555924.

6 Proposals for Market Development

In this section, some general proposals for further market development are discussed. Although new products will clearly be required in the future, providing recommendations on specific product development is beyond the scope of this Report. Product development requires substantial research into the target population's habits, needs, perceptions, occupations etc. as well as actuarial work to determine appropriate premium levels. In the circumstances, we do not discuss specific products in detail in this section.

6.1 Strategies for Microinsurance Market Development

Before considering specific development strategies, it is vital to appreciate that microinsurance will not be successful beyond the short term unless microinsurance clients believe that it provides good value and that claims will be paid. As we have previously indicated, claims ratios are generally low and expense ratios very high. This is most likely to be caused by a number of factors, including high administrative and delivery costs and a failure to pay claims.

Unless the insurance industry is able to deal with the fundamental lack of trust and demonstrate improved claims ratios and client value, any strategies for microinsurance market development are likely to have minimal impact. A substantial reduction in expenses should be the primary focus of any insurance company, irrespective of whether it wants to serve the low-income segment or not. The ability to provide good value products is severely limited at the current level of expense ratios.

Given the existence of a large, unserved population segment and the keen interest from a variety of stakeholders to further strengthen and develop the microinsurance market in Uganda, a coordinated approach is clearly indicated. Market development could and should be approached from various angles. It is noteworthy that the Authority has already taken concrete steps to create an enabling regulatory framework to specifically promote microinsurance, although there are issues concerning this framework (see section 7). However, a revised regulatory framework alone is unlikely to quickly create an innovative, but robust microinsurance market serving the population with good products. Product development, organising and delivering training and support to product development is not an appropriate role for the Authority.

In order to support existing and new players in the microinsurance sector and to ensure customers receive a good

service, a number of support initiatives could be launched by individual insurers, the Uganda Insurance Association, or even development partners. Four main clusters are proposed: research, training, product development and awareness:

- Research: in Uganda, promising distribution options beyond financial institutions have not yet been tested. With a large population not being served by formal banks and living in rural areas, new ways of reaching them should be identified. Customer demand is another research area. To make this relevant for practical product development, customer demand should be analysed once potential delivery options have been identified.
- Training: given the relatively limited experience of most Ugandan microinsurance players, targeted training for insurers and potential delivery channels should be offered in order to help them get kick-started. Microinsurance-specific training topics could include demand research, business planning, product development, partnership management, process design and educational marketing.
- Product development: in specific areas, such as agriculture or health, direct involvement and substantial support in product development would certainly be warranted, as related expertise may be insufficient in the market.
- Awareness campaigns: in order to better educate the public on general insurance principles, the value of insurance and customer rights, a broad awareness campaign could help individual players to move forward quickly – providing that claims settlement has increased noticeably.

Although the Authority may be able to assist in raising market awareness, it is not considered appropriate for it to take an active role in the other areas highlighted. See the discussion on the appropriate functions of an insurance regulator in section 7.4.1.3.

Research and training could, at least in a first phase, be market-wide activities. Efficient but low-cost distribution is likely to be a main bottleneck in expanding the microinsurance market into rural areas. A favourable change of the Banking Act allowing the introduction of bancassurance is clearly required and would be likely to give the whole sector a tremendous boost. In consequence, the Authority should actively discuss this topic with the BoU in order to advance the issue.

However, microinsurance distribution will have to go beyond partnerships with lending institutions. Research into delivery options and awareness campaigns are best produced as a public good. Of course, some private players will do their own research, but much of the background research could be funded through joint public-private sector funded schemes and made available to all.[95]

Many industry players have mentioned public awareness campaigns as essential to ease their market expansion. However, it is important to bear in mind that awareness campaigns alone will not be sufficient: if most people don't have access to valuable products sold by companies that can ensure high service levels, then the impact of awareness campaigns on insurance sales will certainly be negligible and may even be counterproductive. It is doubtful that, at the current time, such campaigns will have a significant impact, as the prerequisites of building trust and providing good value products are not yet fully satisfied. However, insurers and their distribution partners, most notably banks and MFIs, could increase their customers' understanding and appreciation of insurance through educational marketing and, where group policies are used, by actively informing the customers about details of the cover and their rights.

All insurers interested in microinsurance expressed their interest in having access to international experience, knowledge sharing and training opportunities. What they did not mention, however, is a better understanding of the real risks faced by the low-income population, which is likely to be just as important. Even though a lot of microinsurance-specific knowledge is freely and easily available online, experience from other markets has shown that in-person training events are essential to stir interest and let professionals translate theory into their specific circumstances.

In the beginning, general training could be provided at an industry-wide level. The recently created Insurance Institute of Uganda could and should integrate such training sessions into its curriculum. The Insurance Association of

95 For example, in 2012, GIZ Ghana has sponsored a study into delivery channel options for microinsurance. This has helped both insurers and new delivery channels to identify partners and has led to several new partnerships within six months.

Uganda and the Uganda Insurance Institute have expressed strong demand for capacity building in microinsurance. However, as the market matures, individual companies will require highly specific training and support in sensitive areas where they do not want competitors in the same room. Here, mentoring programmes and grants could be two instruments worth exploring. Finally, a challenge fund could be set up to promote advances in a specific area.

Further ways to promote the sector are the creation of a microinsurance working group at the Insurance Association. Such a working group could serve as a place to share information, explore new ideas and join forces to advance the cause. Zambia is a good example of such efforts, which have translated into practical progress on the ground. The microinsurance working group could also, in collaboration with the Authority, create an award for the best microinsurance product of the year.

Two topics that are usually only considered at a later market development stage are worth keeping in mind: the use of cost-efficient technological solutions to support microinsurance operations, as well as a customer-friendly complaints process. In the latter area, Uganda has already made some significant progress in the area of traditional insurance. The Authority actively encourages clients to voice their concern and make complaints through the use of a toll-free number or a web portal.[96] With the development of a wider microinsurance market, it will be important to make sure that these new customer segments feel at ease using the existing mechanisms.

Regarding technology, the situation is likely to be more difficult: there is no widely used and tested standard software available to support microinsurance and hence players tend to use either the same software as they use for their traditional business, or a tailor-made solution. The first option is often not ideal, as traditional insurance software is not designed to handle microinsurance products and support the related processes. The second option is very costly and can lead to situations where not all the information required is adequately captured, stored and reported.

In Uganda, the absence of a national identification system poses an additional hurdle to be overcome: customers and beneficiaries have to be clearly identified. It is obvious that a uniform solution for the whole market would present significant advantages for all involved. However, the insurance industry alone is unlikely to drive this process and probably should not, as clear, secure and fast identification of citizens is required in many more areas.

In summary, there is ample scope for significant synergies in the area of technology and centralised registers. To realise this potential, all stakeholders should come together and support one solution that satisfies the needs of all.

6.2 Strategies and Products for Health Microinsurance

A sustainable health insurance market includes balancing of access, cost and quality of medical care. In Uganda, there is an undersupply of providers that is worse in rural areas (where most of the potential health microinsurance communities reside), and it is costly for the rural population to travel for healthcare. Though there are mission-based hospitals offering low cost healthcare, it is still unaffordable for many. The NHIS Bill anticipates that funding will improve access, but this is a long-term initiative that will have to address the persistent problem of qualified medical personnel leaving Uganda to work in countries offering higher salaries.

In terms of cost of healthcare, levels vary from public to private hospitals. In general there is unclear use of activity-based costing that helps providers understand the volume of treatments required to ensure cost-effective use of personnel and equipment. Additionally, it is difficult to standardise costs without standard coding and reporting. The NHIS Bill anticipates controlling costs, but current projections point to a funding gap. There is insufficient funding to finance the potential health microinsurance population at this time. It is unclear how coding and claims will be standardised.

Quality of healthcare is also variable in Uganda, with perceived quality at the referral hospitals and private hospitals, but less trust in the available providers in rural areas. Many general practitioners (GPs) perform specialist services with limited training (potentially leading to poor

96 However note our comments in section 7 on the Authority's arbitration role.

quality outcomes). The NHIS Bill does not directly discuss quality reporting yet, but recognises its importance.

Finally, providing a safety net for communicable diseases involves both preventive and curative aspects. For example, if malaria is a health threat, there can be low cost access to medications as well as education on preventive strategies. With non-communicable diseases like diabetes or congestive heart failure, a health insurance policy can provide financial security against an adverse event by providing financial remuneration for hospitalisation. However, it is equally important to focus on prevention. This can be accomplished through education empowering the individual to take responsibility and control of the lifestyle factors that contribute to this health event.

6.2.1 General health economics

Before discussing specific health microinsurance strategies, products, and guidelines, this brief section itemises some health economics concepts that may be considered as the health market develops.

6.2.1.1 Importance of risk sharing

In some markets, coverage excludes coinsurance or copayments for medical treatments. The impact of "free access" to medical care may overwhelm an already overburdened system. However, requiring the informal sector to pay for even part of the healthcare might also have negative consequences. The Rand Study[97] provided two important lessons to consider:

- On all the plans in the experiment, poor people were less likely to seek healthcare in the course of a year, but more likely to be hospitalised.
- People given free healthcare had better health results at the end of the study regarding blood pressure control, corrected vision, and oral health.

At the same time, this study demonstrated that cost sharing is one strategy for managing healthcare costs, but should be addressed carefully. Specifically, "free" medical care can lead to overutilization,[98] but high coinsurance or copayments could deter people from accessing medical care at the appropriate time. Therefore, ensuring appropriate collection and analysis of detailed enrolment and claims data (through standardised coding and tariffs) as well as introducing effective quality management strategies are critical.

6.2.1.2 Standardisation

In conversations with stakeholders in Uganda, it became apparent that there are trust issues with medical doctors. Specifically, will the doctor be able to diagnose correctly so that I am treated once rather than having to return with the same symptoms? In Uganda, where there is an undersupply of providers and equipment, primary care doctors and nurses are often expected to know more than they were trained to treat.

In many mature markets, there are Evidence-Based Medicine Guidelines[9]9 that aim to standardise the treatment and management of common primary care or specialist diagnoses and treatment. Evidence-based medicine has been defined as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients".[100] These guidelines do not replace a doctor, but are available to doctors to provide the latest treatment recommendations based on medical studies. This process seeks to assess the strength of the evidence of risks and benefits of treatment (including lack of treatment) and diagnostic tests. This helps clinicians predict whether a treatment will do more good than harm. In discussions with the facility-based HMOs and Mulago Hospital, interest was expressed in considering the introduction of Evidence-Based Medicine, in particular when there is an undersupply of specialist providers.

6.2.1.3 Measuring healthcare outcomes

To increase the trust of the public in the healthcare system, consider increasing quality initiatives, including:

- hospital and provider accreditation and continuing medical education requirements (as applicable);

97 "Effects of Cost Sharing on Use of Medical Services and Health" Emmett B. Keeler, Ph.D. Rand Corporation, Health Policy Program, Santa Monica, CA 90407-2138.

98 The RAND Health Insurance Experiment (RAND HIE) was an experimental study of medical costs, utilisation and outcomes in the United States, which assigned people randomly to different kinds of plans and followed their behaviour from 1974 to 1982. It concluded that forms of cost sharing (copayments, coinsurance, etc.) reduced "inappropriate or unnecessary" medical care (aka overutilisation), but also reduced "appropriate or needed" medical care.

99 An example of an evidence-based medical guideline can be found here http://onlinelibrary.wiley.com/book/10.1002/0470057203.

100 Sackett DL, Rosenberg WM, Gray JA, Haynes RB, Richardson WS (January 1996). "Evidence based medicine: what it is and what it isn't". BMJ 312 (7023): 71–2. PMC 2349778. PMID 8555924.

- pharmaceutical sourcing and management;
- methods to track and measure quality outcomes at a facility and specialist level (either through claims or including random audits);
- rewards / recognition of quality outcomes.

6.2.2 Health microinsurance strategy development

To support the informal market in this period of transition and uncertainty, the following recommendations are offered:

1. Evaluate the potential for health microinsurance products:

Identify microfinance businesses and other potential partners including commercial insurers and brokers interested in tapping into the informal market sector with the health products previously noted.

- Perform a due diligence on the potential for a health savings account-style product that includes both savings and catastrophic cover.
- The health microinsurance product ideas outlined in this Report include insurance, banking, as well as pure service offerings. Conduct research with interested groups to identify potential product details, vendors, and distribution channels.
- To enable economies of scale and potentially reduce the costs of these new products/ services to the informal sector, research the interest in the general population for these products.
- If the HMO model is selected, identify potential supplemental funding
- Identify and evaluate the correct formula for product/ distribution

2. Create awareness of the role of prevention in the informal community:

The current healthcare approach is focused on curative care with low focus on prevention education and management of important illnesses. One way to keep healthcare costs in check includes addressing healthcare issues before they become serious. We recognise that the major determinants of health in Uganda include levels of income and education, housing conditions, access to sanitation and safe water, cultural beliefs, social behaviour and access to quality health services. A direct relationship exists between poverty and prevalence of diseases such as malaria, malnutrition and diarrhoea, as they are more prevalent among the poor than the rich households.[101] Recognising the additional burdens due to absence of information and proactive management of healthcare, it is essential to address the preventive educational aspects of a healthy lifestyle for the informal sector.

6.2.3 Health microinsurance product recommendations

Given the informal sector's need for medical care, the current undersupply of providers, the need of those in rural areas to travel for medical treatment, and the low likelihood that the NHIS will be able to serve them in the near term, the products mentioned in table 15 are recommended.

6.2.4 Developing the infrastructure to regulate health microinsurance

Health microinsurance is a sub-set of health insurance. While we recognise that our focus is not on general health insurance issues, these issues impact on the development of products for the potential health microinsurance population. Key recommendations to be considered in regulating general health insurance are:

1. **Develop a policy on health insurance regulation:** currently there are regulations for health insurers, but the increase in HMOs in the market indicates focused attention on these vehicles. Review foundational regulations and opportunities to streamline and improve.
2. **Create reporting requirements** across the insurance companies and HMOs so that market trends and costs of medical care can be collected and evaluated. It will be helpful to see claims and administrative costs associated with the healthcare line of business. However, multi-line insurers may find it difficult to know the administrative costs associated with the health business and sometimes allocate administrative expenses based on premium volume. This may not correctly represent the actual administrative costs, as there is typically more administration involved in health insurance management.
3. **Decide on the interim role of alternative insurance** vehicles for the working poor prior to NHIS roll-out.
4. **Ensure an understanding of the healthcare industry** regarding
   a. provider access and accreditation (personnel, beds, equipment, pharmaceuticals, specialist access);

101 "The Second National Health Policy: Promoting People's Health to Enhance Socio-economic development" July 2010: The Republic of Uganda Ministry of Health.

Table 15: Potential health microinsurance solutions that could be considered for the informal market

Product	Description	Core Mechanisms	Impact of NHIS
Health Savings Account (individuals, but requires group participation for the top-up catastrophic health cover) (HSA/CAT)	• Long-term bank account (potentially for a family) that requires a certain minimum annual balance in an interest bearing account • The minimum balance serves as the deductible for healthcare expenses at an "in network" provider that agrees to a negotiated fee schedule • Deductible costs up to the minimum balance can be drawn through mobile money • Medical expenses above the minimum balance to a higher threshold can be paid for through a loan or through savings • Claims costs over the threshold are covered under a combination of banking reserve / catastrophic health insurance policy	Savings Catastrophic cover	The main advantage of this policy is that it offers a savings product with catastrophic health insurance in the event it is needed. Typically, catastrophic cover is associated with a low premium. Even with a fully functional NHIS in place, this kind of a product encourages savings and the option to opt out for care not available through the NHIS. Additionally, this product may make sense for a larger group of Ugandans (not only the informal sector).
HMO based Health Insurance (group only) (HMO)	• Facilities agree to assume the risk for members at an annual rate. Rural premiums can run from about 60,000 per person per year and in Kampala may be as high as 400,000 per year • Premiums paid to the facility are non-refundable, though the option of a no-claims bonus or inclusion of "rewards" programme may be attractive • Lower premiums would require some donor subsidisation, possibly through maternity vouchers and an individual copayment	Insurance	As the NHIS approach focuses on provision of free healthcare, this type of product is "transitional" only and could be organised through CBHIs attached to HMOs.
Hospital Cash/ Transportation Allowance (HC)	• Low-cost inpatient insurance that covers a small per diem for each day in a pre-authorised inpatient admission • Per diem can be used for multiple reasons including: food, missed work, transportation	Insurance	This insurance type is low-cost and could remain in place with the NHIS in full swing.
Dial – a – Doctor: offering advice by telephone from general and specialist physicians accessing clinical best practices (DAD)	• Though not insurance, given the important undersupply of providers and high cost of transportation, providing access to an East African dial-a-doctor type of service could help individuals better assess whether or not to visit a doctor	Service	This kind of service could support the NHIS concept, as it would help triage individuals, particularly those in the rural areas without easy access to transportation.

b. position concerning availability of evidence-based protocols, specifically in areas where experience with certain fields of specialisation and equipment are lacking;
c. standardised protocols for the new NHIS product (e.g. standardised benefits, pharmaceutical sourcing and availability, procedure costs based on facility and professional components, claims forms, and coding) to enable effective measurement (and ultimately management) of medical trends;
d. absence of competition under the NHIS proposed plan, including an understanding of how the MoH will manage the cost and quality of the proposed monopoly;
e. ability of the Ministry to both finance, manage and govern itself in terms of health insurance;
f. definition of a clear position on curative versus preventive healthcare, including ways to link public health initiatives regarding prevention and education.

Potential regulations to support the development of health microinsurance products should ideally fulfil the interim needs of the micro-health insurance community prior to NHIS roll-out. However, as the NHIS envisions a limited CBHIS role and the current concept excludes outsourcing health claims network and medical cost management to HMOs or insurers, it is unclear how aggressively social protection should be pursued at this time.

6.2.5 Health microinsurance recommendations

To support the informal market in this period of transition and uncertainty, the following recommendations are offered:

Evaluate the potential for health microinsurance products: Identify microfinance businesses and other potential partners including commercial insurers and brokers interested in tapping into the informal market sector with the health products previously noted.

- Perform a due diligence on the potential for a health savings account-style product that includes both savings and catastrophic cover.
- The health microinsurance product ideas outlined in this Report include insurance, banking, as well as pure service offerings. Conduct research with interested groups to identify potential product details, vendors (in the case of Dial-a-Doctor), and distribution channels.
- To enable economies of scale and potentially reduce the costs of these new products/ services to the informal sector, research the interest in the general population for these products.
- If the HMO model is selected, identify potential supplemental funding.
- Identify and evaluate the correct formula for product/ distribution.

Create awareness of the role of prevention in the informal community:
The current healthcare approach is focused on curative care with low focus on prevention education and management of important illnesses. One way to keep healthcare costs in check includes addressing healthcare issues before they become serious. We recognise that the major determinants of health in Uganda include levels of income and education, housing conditions, access to sanitation and safe water, cultural beliefs, social behaviour and access to quality health services. A direct relationship exists between poverty and prevalence of diseases such as malaria, malnutrition and diarrhoea, as they are more prevalent among the poor than the rich households.[102] Recognising the additional burdens due to absence of information and proactive management of healthcare, it is essential to address the preventive educational aspects of a healthy lifestyle for the informal sector.

It is suggested that there should be three main **objectives** for health microinsurance in Uganda:[103]

1. universal coverage and social health protection, meaning universal access to necessary curative care without running the risk of catastrophic health expenditure and with equity in financing;
2. sustainable, effective, efficient health financing for quality services;
3. good governance in both operational and financial sectors, meaning well defined responsibilities, transparency and accountability in institutional set-up and operations.

102 "The Second National Health Policy: Promoting People's Health to Enhance Socio-economic development" July 2010: The Republic of Uganda Ministry of Health.
103 This borrows from the "Tanzania Health Insurance Regulatory Framework Review" J. Bultman, MD, Prof. J. L. Kanywanyi PhD, H. Maarifa, G. Mtei. 30 march 2012, which we consider is also applicable to Uganda.

However, given the constraints of the Ugandan healthcare system and the increased risk of non-communicable disease, we include a **fourth objective**:

4. focus on both preventive and curative treatments that are aligned with Ugandan public health initiatives.

The current health insurance system is complicated by overlapping regulation from different bodies, including the Authority (which supervises the insurance component) and the MoH (which supervises the delivery of healthcare).

6.2.6 Recommendations regarding the interface with HMOs and HIOs

Health microinsurance is a sub-set of health insurance. While we recognise that our focus is not on general health insurance issues, these issues impact on the development of products for the potential health microinsurance population. Key recommendations to be considered in regulating general health insurance are:

1. **Develop a policy on health insurance regulation:** currently there are regulations for health insurers, but the increase in HMOs in the market indicates focused attention on these vehicles. Review foundational regulations and opportunities to streamline and improve.
2. **Create reporting requirements** across the insurance companies and HMOs so that market trends and costs of medical care can be collected and evaluated. It will be helpful to see claims and administrative costs associated with the healthcare line of business. However, multi-line insurers may find it difficult to know the administrative costs associated with the health business and sometimes allocate administrative expenses based on premium volume. This may not correctly represent the actual administrative costs, as there is typically more administration involved in health insurance management.
3. **Decide on the interim role of alternative insurance** vehicles for the working poor prior to NHIS roll-out.
4. **Dialogue with the MoH regarding**
   a. provider access and accreditation (personnel, beds, equipment, pharmaceuticals, specialist access);
   b. position regarding availability of evidence-based protocols, specifically in areas where experience with certain fields of specialisation and equipment are lacking;
   c. standardised protocols for the new NHIS product (e.g. standardised benefits, pharmaceutical sourcing and availability, procedure costs based on facility and professional components, claims forms, and coding) to enable effective measurement (and ultimately management) of medical trends;
   d. absence of competition under the NHIS proposed plan, including an understanding of how the MoH will manage the cost and quality of the proposed monopoly;
   e. ability of the Ministry to both finance, manage and govern itself in terms of health insurance;
   f. definition of a clear position on curative versus preventive healthcare including ways to link public health initiatives regarding prevention and education.

Potential regulations to support the development of health microinsurance products should ideally fulfil the interim needs of the micro-health insurance community prior to NHIS roll-out. However, as the NHIS envisions a limited CBHIS role and the current concept excludes outsourcing health claims network and medical cost management to HMOs or insurers, it is unclear how aggressively social protection should be pursued at this time.

7 The Legal and Regulatory Framework

7.1 Introduction

Following this introduction, section 7.2 sets out a summary of the current legal and regulatory framework applicable to the insurance sector in Uganda (including the health insurance sector), by identifying the relevant laws, regulations and any other legal documents that may impact on the sector. Section 7.3 summarises certain non-insurance legislation that is relevant to insurance.

In section 7.4, the laws and regulations summarised in sections 7.2 and 7.3 are assessed with a view to identifying issues that may constrain the regulation and supervision of microinsurance and health microinsurance or their market development. Recommendations are provided for changes to the framework. Given that microinsurance is a sub-set of insurance, many of the issues identified are relevant to insurance generally. However, it is argued that as microinsurance is a form of insurance, many of these issues are also relevant to microinsurance.

One of the primary objectives of this Report is to set out policy considerations for the development of new Microinsurance Regulations. In section 7.5, we therefore identify regulatory and supervisory issues and challenges that will need to be taken into account in designing the Regulations and matters that we consider should be covered in the Regulations.

7.2 Laws, Regulations and Other Instruments Directly Applicable to Insurance

The following laws and regulations are directly relevant to the insurance sector:

- The Insurance Act (Cap. 213)
- The Motor Vehicle Insurance (Third Party Risks) Act 1989 (Cap. 214)
- The Workers' Compensation Act (Cap. 225)
- The Insurance Regulations, 2002
- The Insurance (Investment of Paid-Up Capital and Insurance Funds) Regulations, 2008 (as amended)
- The Guideline on Reinsurance Strategy, Management Procedures and Arrangements
- The Interim Licensing Guidelines HMOs and CBHFs.[104]

The following proposed legislation would, if enacted, also be of relevance to the insurance sector:

- The Anti-Money Laundering Bill, 2009
- The National Health Insurance Bill, 2010.

104 Although Community Based Health Financing Schemes are not currently licensed.

The National Health Insurance Bill is considered in section 5 and the Anti-Money Laundering Bill in section 7.4.6.

Finally, the Authority has provided us with some correspondence relevant to its supervision of the insurance sector, which is referred to as far as relevant.

No Microinsurance Regulations have been made or Guidance issued.

7.2.1 Insurance Act

The Insurance Act (Cap. 213) is the principle legislation governing the insurance sector in Uganda. It first came into force in 1996, but has since been amended several times. The most recent amendments were made in 2011 by the Insurance (Amendment) Act, 2011.

The Act is broad in scope applying to insurance and reinsurance companies, insurance and reinsurance broking companies, insurance agents, loss adjusters and assessors, risk managers and representatives of foreign companies carrying out these activities. The 2011 amendments extended its scope to cover health insurance organisations (HIOs) and health membership organisations (HMOs).

The Insurance Act covers the following main areas:

Establishment of the Insurance Regulatory Authority and its functions

Part II of the Act establishes the Authority (which was named the Uganda Insurance Commission prior to the 2011 amendments) as the insurance regulatory and supervisory authority for Uganda. Although the Authority, which is a body corporate, is largely autonomous, section 16 of the Act enables the Minister responsible for finance to give the Authority directions of a general nature on matters of policy and the Authority's power to make regulations may be exercised only in consultation with the Minister.

The object, functions and powers of the Authority include the following:[105]

- establishing standards for the conduct of insurance and reinsurance business,
- issuing licences under the Act,
- approving texts of policies and proposal forms,
- approving minimum rates of insurance premiums and maximum commissions in respect of all classes of insurance,
- safeguarding the rights of policyholders and beneficiaries,
- receiving complaints from members of the public on the conduct of persons licensed under the Act and arbitrating and granting restitution to the complainants (as far as possible),
- Promoting a sound and efficient insurance market in Uganda,
- supervising and controlling transactions between insurers and reinsurers,
- ensuring compliance with the Act and the Regulations.

The Authority does not have specific functions in relation to the development of microinsurance.

Part II of the Act also:

- specifies the composition of the Authority,
- species some basic governance provisions applicable to the Authority,
- provides for the staff of the Authority, including the Chief Executive Officer,
- makes provisions relating to the Authority's funds and imposes certain reporting requirements on the Authority.

The accounts of the Authority are required to be kept in accordance with the Public Finance and Accountability Act, which has not been reviewed for the purposes of this Report.

The Authority has the power to make Regulations, in consultation with the Minster. The regulation-making power includes a general power to issue Regulations generally to give effect to the Act.

Insurance and insurance business

The Act does not define either "insurance" or "insurance business". However, section 5 of the Act sets out various classes of business.

Life insurance and non-life insurance are treated as separate types of insurance business and the Act prohibits any person[106] from transacting both types of business.

105 Please note that these are paraphrased.
106 The word "person" includes natural persons and legal persons.

Composite insurers are therefore prohibited. However, existing composite insurers have been given a period of three years to separate their life and non-life businesses by incorporating separate life and non-life insurance companies (which may be subsidiaries of the same holding companies or parallel companies).

There are no separate classes of life insurance, but non-life insurance is separated into 18 classes. These classes include the usual property and casualty lines, personal accident insurance, employers' liability and public liability insurance, marine and aviation insurance (three separate classes), motor insurance and agricultural insurance.

The classes of non-life insurance also include four new classes inserted by the 2011 amendments: health insurance, health membership, microinsurance and bancassurance. These are considered more fully in section 7.4.

Reinsurance is treated as a separate type of insurance business.

Types of insurer
The Act permits the following types of entity to be licensed as an insurer or reinsurer:

- a company incorporated under the Companies Act
- an insurance corporation established by law
- a cooperative insurance society registered under the Cooperatives Societies Act
- a mutual insurance company.

In addition, the 2011 amendments introduced new categories of health membership organisation and health insurance organisation, which are considered later in this Report.

At the date of this Report, all licensed insurers are companies incorporated under the Companies Act as companies limited by shares.

Licensing of insurers, intermediaries and other persons required to be licensed

A licensing regime is established for various market players, including

- insurers and reinsurers (collectively referred to as "insurers"),
- brokers, agents, loss adjusters and risk managers (collectively referred to as "intermediaries").

It is an offence for any person to carry on any licensable activity without a licence.

Section 29 contains very detailed application requirements for insurers and section 30 sets out the factors that the Authority must consider before determining an application. These include:

- financial status,
- the competence and integrity of the proposed management and administration,
- the adequacy of the applicant's capital structure, earning prospects, business and financial plans and reinsurance and retention proposals.

In addition, an insurer must comply with the paid-up capital requirements and the requirements for security deposits before being granted a licence.

There are no detailed application requirements in the Act in respect of intermediaries. These are to be prescribed by the Authority. Only a company incorporated under the Companies Act may be licensed as a broker. There are no equivalent requirements for other licensed intermediaries.

All licences granted under the Act are renewable on an annual basis.

Section 33A provides separately for the licensing of HMOs and HIOs, which are to be regulated in accordance with Regulations made by the Authority after consultation with the Minister of Health and other stakeholders.

Prudential requirements
There are some core prudential requirements specified in the Act in relation to insurers, which are supplemented by the Insurance Regulations and the Insurance (Investment of Paid-Up Capital and Insurance Funds) Regulations. In summary the Act requires licensed insurers to maintain:

- minimum paid-up capital (section 6)
- a security deposit (section 7)
- a minimum solvency margin (section 44)
- insurance funds (section 46)
- insurance reserves (usually referred to as technical provisions) (section 47).

Insurers are required to hold as investments assets in Uganda at least equal to "the funds in the insurance business shown in the balance sheet" (section 48).

Brokers, loss adjusters and loss assessors are required to hold a minimum paid-up capital level and maintain a security deposit. No prudential requirements are imposed on other types of intermediary.

Changes of management and control
An insurer is required to notify the Authority of any change in directors or senior executive and technical personnel, but not to seek prior approval. The Act does not require insurers to seek the approval of the Authority for changes in ownership or control.

No requirements concerning changes in directors, senior management, ownership or control are imposed on insurance intermediaries.

Accounts and audit
Insurers are required to prepare specified types of annual accounts, which must be audited. The audited accounts must be submitted to the Authority within 90 days of the end of the financial year, together with other specified documents.

Insurers are also required to submit, within 120 days of the end of each financial year, a certificate of solvency which, in the case of a life insurer, must be signed by an actuary or other person authorised by the Authority.

The accounts of an insurance broker, risk manager, loss assessor, loss adjuster, insurance surveyor and claims settling agent are also required to be audited and submitted to the Authority on an annual basis.

Actuarial requirements
Every insurer carrying on long-term business (which is not defined) is required to appoint an actuary. An insurer shall in respect of its life business cause an actuarial investigation to be undertaken by an actuary. Although it is unclear, it is assumed that this is intended to be on an annual basis. An actuarial investigation is also required before any distribution of profits by a life insurer.

Approval of policies and premiums
As indicated, the functions of the Authority include the approval of policies and premiums. It is not clear whether an unapproved policy is valid or invalid.

If an insurer lowers a non-life premium, the Authority can order the cancellation of the policy.

Reinsurance
Insurers are able to reinsure their insurance risks either by contract (treaty) or on a facultative basis. An annual reinsurance report must be submitted to the Authority.

The Act contains mandatory cession requirements. An insurer is required to offer to cede to Africa Re (5%), ZEP-RE (10%), and a reinsurance company incorporated in Uganda (15%). This appears to apply to all lines of business.

Apart from the above mandatory cessions, an insurer is required to reinsure all its risk with a reinsurer specified above or a licensed insurance company to the maximum extent possible, before reinsuring outside Uganda.

Supervision and enforcement
The Authority is required to inspect every insurer, insurance broker, loss assessor and loss adjuster at least once in three years. Other than that, the Authority may only undertake an inspection of an insurer for cause.

The Authority may suspend or revoke a licence for cause. The grounds for suspending or revoking a licence are specified in section 33 (insurers) and section 78 (intermediaries).

The only other enforcement remedies available to the Authority are:

1. in the case of an insurer, to petition for the winding up of the insurer
2. a public or private admonition
3. the imposition of a fine, most of which do not exceed 25 currency points (which is the equivalent of less than USD 200). [107]

A maximum fine of USD 200 is so low that it is unlikely to be dissuasive.

In the case of an intermediary, the Authority has additional powers to impose a fine under section 78(2).

The Act creates a number of offences that are punishable by a fine and, in some cases, imprisonment. However, offence provisions are not regarded as an enforcement remedy available to the Authority.

107 A currency point is defined in Schedule 1 of the Act as 20,000 shillings.

Insurance intermediaries
Various requirements and restrictions are imposed on insurance intermediaries, including:

- prohibiting intermediaries of one type from conducting business of another type,
- requiring brokers to pay premiums to insurers within 30 days of receipt,
- an agent shall not act for more than one insurer transacting the same class of business (i.e. all agents are tied agents),
- agents may only be compensated by commission or other approved incentive or bonus scheme.

Amalgamation and transfer
Any amalgamation or transfer of insurance business requires the prior approval of the Authority (Part VI). The Act sets out the procedures for an application for and the granting of approval.

A portfolio transfer by an insurance intermediary also requires the prior approval of the Authority (section 90).

Policyholders' Compensation Fund
The Act establishes a Policyholders' Compensation Fund to be managed by a board of trustees. The Fund is funded by a premium levy paid by insurers, although the Fund may utilise other sources of funding specified in the Act (section 71A). The Fund is used to compensate the policyholders of an insolvent insurer.

Insurance Appeals Tribunal
The Act establishes an Insurance Appeals Tribunal to hear appeals against decisions of the Authority. The Tribunal has the power to uphold, revoke or vary any decision of the Authority. Appeal against a decision of the Tribunal goes to the High Court.

Insurance Institute
Every licensee is required to be a member of the Insurance Institute and all insurers are required to pay an insurance training levy to the Institute, calculated on gross direct premium income (training levy).

Important areas not covered by the Act
Areas not covered by the Act include:

- corporate governance and risk management,
- market conduct, including consumer protection.

7.2.2 The Motor Vehicle Insurance (Third Party Risks) Act 1989 (Cap. 214)

The Motor Vehicle Insurance Act is the legislation that makes motor third party liability insurance mandatory in Uganda. It is an offence to use a motor vehicle, or cause or permit a motor vehicle to be used, on a road in Uganda without the required minimum third party liability insurance cover in place. The minimum cover is limited to liability for death or bodily injury, i.e. it does not include liability for damage to property, such as another vehicle.

In the event that an insured person becomes insolvent, the Act provides third parties to whom the insured is liable with the right to enforce any claim that the insured has in respect of the liability against the insurer.

The Act establishes a Nominal Defendant Council, which has responsibility for paying claims in relation to uninsured or unidentified vehicles. The Council is funded jointly by Government and by insurers. Section 38 provides that all licensed insurers must underwrite motor third party liability insurance policies complying with the Act.

7.2.3 Workers Compensation Act (Cap. 225)

The Workers Compensation Act establishes a statutory scheme that requires employers to pay compensation where an employee is injured in the course of his or her employment. Where the employee suffers a fatal injury, compensation is payable to dependant members of the employee's family, otherwise it is payable to the employee. The Act provides for the calculation of the amount of compensation. If the employer fails or refuses to pay, the claim must be enforced through the Court. An employee cannot contract out of the Act.

The Act also requires an employer to pay medical expenses in relation to an injury and related travel and other expenses and, in the event of the death of the employee, burial expenses.

The Act has relevance to the insurance sector because section 28 requires every employer to effect insurance in respect of liability under the Act. The Act provides employees and their dependants with rights to claim directly against the insurer in the event of the employer's insolvency.

7.2.4 The Insurance Regulations, 2002

The greater part of the Insurance Regulations consists of a Schedule of prescribed forms to be used for applications and other matters in relation to the Act.

Other than prescribing forms, the Insurance Regulations:

- specify the minimum paid-up capital to be maintained by insurers and brokers,
- provide for the notice to be given for suspension of revocation of a licence,
- set out the procedure for certain appeals to the Minister,
- specify the qualifications of directors and principal officers,
- specify the assets of an insurer that are admitted assets and provide for the calculation of their value,
- specify the liabilities of an insurer that are admitted liabilities and provide for the calculation of their value,
- specify the business records to be kept by an insurer,
- specify the form of the report of an actuarial investigation,
- specify the matters that must be included in a statement of reinsurance,
- provide for financial reports to be submitted to the Authority by intermediaries.

7.2.5 The Insurance (Investment of Paid-Up Capital and Insurance Funds) Regulations, 2008 (as amended)

These Regulations require an insurer to have an investment policy and specify permitted investments for an insurer's paid-up capital and insurance funds. The Regulations cover some other matters including the maintenance of investment records, reporting requirements and the investment of retained earnings.

Finally, the Regulations provide some administrative sanctions that may be taken against an insurer for breach of the Regulations.

7.2.6 Guideline on Reinsurance Strategy, Management Procedures and Arrangements

The Guideline covers a number of matters relating to reinsurance, including the following:

1. An insurer must establish and maintain a reinsurance strategy and policies and procedures for implementing the reinsurance strategy that must cover certain specified matters.
2. An insurer must set retention limits and maintain a list of reinsurers that it has approved.
3. Internal controls in relation to reinsurance must be in place.
4. Certain specified matters, such as the need for reinsurance cover to protect against catastrophic risk, the appropriate levels of adequate retentions and negotiation of terms, must be taken into account.
5. The placing of reinsurance business with Uganda Re or an insurance company licensed under the Act to the maximum, extent possible.
6. Procedures for coinsurance.
7. The requirements and procedures applicable to fronting, including the specification of a memorandum of understanding to be signed by the persons who intend to front the business.

7.2.7 Interim Licensing Guidelines HMOs and CBHFs

The Interim Guidelines cover, the licensing requirements and procedures for HMOs and Community Based Health Financing Schemes (in this Report termed CBHIS), the qualifications of key personnel, requirements to establish a complaints/grievance procedure and disciplinary action that may be taken by the Authority.

The Guidelines also require prior approval of benefits packages and service agreements and policies and procedures for medical records. Finally, the Guidelines set out certain members' rights.

7.3 Other Legislation and Regulations Relevant to Insurance

Other legislation that is relevant to insurance includes the following:

- the Financial Institutions Act, 2004
- the Micro Finance Deposit-Taking Institutions Act, 2003
- the Cooperative Societies Statute, 1991
- the Companies Act (Cap. 110).

7.3.1 Financial Institutions Act, 2004

The Financial Institutions Act establishes the legal framework for the regulation and supervision by the Bank of Uganda of Tier 1 and Tier 2 financial institutions. Its principal relevance to insurance is in relation to the intermediation of insurance by these institutions (bancassurance).

Section 37(a) of the Act provides that a financial institution shall not "engage directly or indirectly for its own account, alone or with others in trade, commerce, industry, insurance or agriculture, except in the course of the satisfaction of debts due to it in which case all such activities and interests shall be disposed of at the earliest reasonable opportunity".

Section 37(a) clearly precludes financial institutions from acting as insurance intermediaries, whether directly as insurance agents or indirectly through their staff. As discussed, banks and MFIs are using group polices to circumvent this provision. This is considered further in section 7.5.7.

The Bank of Uganda has proposed to the Minister that the Financial Institutions Act should be amended to allow banks to engage in bancassurance in 2010. A Bill is with Parliament, but not yet enacted. It is not clear when it will be enacted.

Once the Act has been amended, this would clear the way for Tier 1 and Tier 2 financial institutions to intermediate all insurance products, not just credit life insurance. However, the Bank of Uganda advised that it would only permit Tier 1 financial institutions to act as insurance intermediaries, as it does not consider that Tier 2 (or Tier 3) financial institutions have sufficient track record at this stage.

7.3.2 Micro Finance Deposit-Taking Institutions Act, 2003

The Micro Finance Deposit-Taking Institutions Act establishes the legal framework for the regulation and supervision by the Bank of Uganda of Tier 3 financial institutions. Again, its relevance to insurance arises because the Act contains an almost identical provision to the Financial Institutions Act. However, there is a critical difference. Whereas the Financial Institutions Act contains an outright prohibition, section 19 of the Micro Finance Deposit-Taking Institutions Act provides that the institution cannot conduct these activities without the approval of the Bank of Uganda.

This Act does not, therefore, need to be amended to permit Tier 3 financial institutions to intermediate insurance products. It simply requires the Bank of Uganda to give its approval on a case-by-case basis.

7.4 Assessment of and Recommendations Pertaining to the Current Legal and Regulatory Framework

7.4.1 The Insurance Act

7.4.1.1 Introduction

It is usual for primary legislation[108] governing the insurance sector to be enacted as principles-based framework legislation. Framework legislation sets the broad policy objectives and establishes a statutory framework for detailed provisions to be set out in delegated or subsidiary legislation, such as regulations. Primary legislation may also provide for the issuance of Circulars, Codes and other documents, which may or may not have legislative effect.

A framework structure is intended to provide a flexible approach and also recognises that technical details are better dealt with by a body with appropriate knowledge and expertise, rather than by the legislature. Given that the regulation of insurance is both complex and technical, it is an area that is particularly suited to framework legislation.

It is important that Uganda's legislative and regulatory framework is able to evolve over time, not least for the following reasons:

- International standards and best practice are not static. The new ICPs issued by the IAIS in October 2011 are the fourth set of ICPs issued since the IAIS was established, and the IAIS continues to issue new standards and policy papers on a regular basis.
- The insurance sector in Uganda will continue to develop and mature and new types of insurance products are certain to be designed by the industry.
- The capacity of the Authority to supervise the insurance sector will increase over time, permitting more sophisticated regulation and supervision of insurers.

It is both impracticable and undesirable for primary legislation to be changed frequently. It is impracticable because the parliamentary process in most countries is usually slow and there is significant competition for parliamentary time. It is undesirable for frequent amendments to be made to primary legislation, not least because heavily amended legislation tends to lose its coherence. It is therefore important that the legal and regulatory

108 Primary legislation is legislation enacted directly by the legislature.

framework can be readily adapted to the types of changed circumstances set out above, without the need for parliamentary intervention.

7.4.1.2 General weaknesses in the Act

The Insurance Act contains significant detail and is very far from modern principles-based framework legislation. Much of this detail would be better placed in the Regulations. Furthermore, as discussed in more detail later in the Report, there are important areas missing from the Act, some of which are inappropriately covered in the Regulations.

There are a number of inconsistencies in terminology and language that, in some instances, are significant enough to place the meaning and effectiveness of the Act in doubt. See, for example, the discussion of the meaning of the term "insurance business" in section 7.4.1.4 below.

The Act has a number of significant weaknesses, including the following:[109]

- The Act is not framework legislation, as discussed above.
- The Act is compliance based, rather than risk based. It does not require, or for the most part even allow, the Authority to supervise licensees on a risk sensitive basis. Therefore, the Act, as currently enacted, would not enable the Authority to establish effective risk-based supervision.
- There are no corporate governance or risk management obligations imposed on licensees.
- Apart from suspension and revocation of licenses, the Authority has very few enforcement powers.
- The solvency framework contains detailed requirements that should not be in primary legislation but does not contain basic general solvency requirements and other requirements that should be in primary legislation.
- The Authority has some functions that are not usually regarded as appropriate for an insurance regulator, such as setting or approving premium levels.
- The Act does not give the Authority powers in relation to changes of management and control.
- The Act does not impose any requirements on the Authority to keep documents and information that it receives confidential (section 17(6) only applies to members of the Authority and, in any event, is too narrow).
- The Authority does not have powers to exchange information and documents with other regulatory authorities, although arguably in the absence of confidentiality provisions it does not need them.
- The Act provides for the annual renewal of insurance licences, which is contrary to the ICPs.[110]

A full assessment of the Act against the most recent ICPs (October 2011) has not been undertaken for the purposes of this Report. However, a high level review of the Act and the wider regulatory framework indicates that the Act does not enable Uganda to comply with many of the Core Principles. As discussed later, the Act also imposes constraints on both the regulation and supervision of the insurance sector and on the development of microinsurance. This should not be surprising, as the Act was enacted in 1996 and was probably drafted some time before that. This was just two years after the IAIS was established and before the first set of ICPs was issued in 2007.

Whilst it may be thought that wider problems in relation to the Insurance Act are not relevant to microinsurance, this is not the case. Microinsurance is a form of insurance and, except to the extent that exemptions can be made, has to operate within the framework of the Act. Therefore problems with the Act are likely to impact on microinsurance, although the extent of the impact will vary. Some issues are more relevant to microinsurance than others.

Although the issues highlighted in this section may not have caused any problems in practice to date, this is no guarantee that problems will not arise in the future.

We therefore recommend that a full assessment of the Insurance Act be conducted in relation to the most recent ICPs. The assessment should also seek to identify inconsistencies and identify matters in the Act that should be covered in the Regulations and matters that should be included in the Act.

Following the full assessment, we recommend that consideration be given to advising Government that the Act should be amended or that it should be repealed and replaced with a new Insurance Act. In our view, very extensive amendment would be required to materially change the structure of the Act.

109 Some of these weaknesses are discussed later in the Report.
110 A full explanation of why licences should not be renewable on an annual basis can be provided, if required.

7.4.1.3 Functions of the Authority

It is important that the core functions of the Authority, as set out in the Act, are comprehensive and appropriate, as its functions form the basis for the Authority's activities and for defining its powers.

Although the ICPs do not contain a comprehensive list or schedule of the appropriate functions of an insurance regulatory and supervisory authority, these can be identified from a general review of the ICPs. A summary of the appropriate objectives and functions of an insurance regulatory and supervisory authority, drawn from the ICPs, is set out below.

Table 16: Appropriate objectives and functions of an insurance regulator/supervisor

Objective/Function	Type of Objective or Function	Activities
Setting appropriate prudential and non-prudential regulatory framework	Regulatory	Issuing Code, reporting forms and guidance
Licensing and authorisation	Supervisory	Developing fit and proper criteria for applicants, controllers, directors, senior management and auditors Fit and proper assessments
Approving changes of control and transfers of business	Supervisory	Assessing suitability of new controllers Where a transfer of business is proposed, assessing adequacy of persons to whom business is to be transferred and appropriateness of arrangements in place to protect interests of policyholders
Off-site monitoring	Supervisory	Reviewing documents submitted to the Authority, including: • financial statements; • statutory returns; and • compliance with solvency and other prudential requirements
On-site monitoring (compliance inspections)	Supervisory	Carrying out compliance inspections to assess and verify compliance with legal and regulatory obligations. These may be: • themed, i.e. where a particular aspect of the business, or compliance with particular regulatory obligations, is assessed on an industry-wide basis • general, where all areas are assessed • targeted, where a particular insurer or licensee is assessed is response to a particular problem or concern
Requiring insurer to demonstrate sound and prudent management of its business	Regulatory and supervisory	Setting requirements for systems and controls, compliance, management, business plans, reinsurance plans, investments etc. Assessing whether insurers are managing their risks, maintaining appropriate rating and claims handling systems, establishing and maintaining adequate technical provisions, managing their investments in a sound and prudent manner and complying with their capital resource and solvency requirements

Objective/Function	Type of Objective or Function	Activities
Undertaking risk assessments of insurers	Supervisory	Setting internal early warning ratios, triggers, flags and other indicators Assessing and monitoring insurers for regulatory risks, including following up information received, monitoring early warning ratios, triggers and other indicators
Ensuring insurers apply good governance, including corporate governance, principles	Regulatory and supervisory	Setting corporate governance requirements Providing guidance on good corporate governance Assessing compliance through on-site and off- site monitoring
Monitoring and analysing insurance market	Supervisory	Collecting and analysing market data
Cooperation with national law enforcement and foreign regulatory authorities	Supervisory	Responding to requests for information and assistance, assessing whether information and assistance can be properly provided, obtaining information on behalf of foreign regulatory authorities
Requiring insurers to take corrective action in the event of a compliance failure or regulatory risks	Supervisory	Assessing whether appropriate corrective action is required, and appropriate corrective action Issuing directives and imposing financial and other requirements with respect to business
Taking enforcement action or imposing sanctions against insurers in breach of legal and regulatory requirements	Supervisory	Putting enhanced risk assessment procedures in place for problem insurers Imposing appropriate sanctions and ensuring compliance with sanctions and that breaches are remedied, where possible
Overseeing the orderly winding up of insurers and run-off of business while protecting policy-holder interests	Supervisory	Monitoring companies in run-off and being wound up
Setting, monitoring, overseeing and enforcing conduct of business requirements	Regulatory and supervisory	Setting conduct of business requirements and assessing compliance with the objective that insurers treat their customers fairly, provide appropriate information to policyholders and deal with claims and complaints fairly
Setting public disclosure requirements for insurers on their financial condition and risks to which they are exposed	Regulatory and supervisory	Issuing appropriate regulations
Requiring insurers to prevent, detect and remedy fraud and other criminal activity	Regulatory; if it has power to set AML/CFT requirements, then supervisory	Issuing appropriate regulations

In addition, as recognised in the IAIS Issues Paper "Issues in Regulation and Supervision of Microinsurance", the Authority may be given a development objective, although this does need to be carefully worded.

The board of directors of an insurer has ultimate responsibility for the management of the insurer. Whilst it is important that the Authority has sufficient powers and information to supervise insurers, insurance intermediaries and other licensees effectively, it is also important that the Authority is not put in a position whereby it is taking responsibility for matters that should properly be the responsibility of the board or senior management. Furthermore, it is important that the Authority is not being asked to approve matters where, in reality, it does not have the necessary information, experience or capacity to reach a decision.

In particular, the following are not usually considered part of an authority's regulatory or supervisory functions, even though many insurance supervisory authorities in Africa and elsewhere do have some of these functions:

- approving business, investment or reinsurance plans,
- **setting or approving premium levels** or rating methodologies,
- **approving products**,
- setting procedures for establishing policy limits or sums insured,
- setting accounting standards,
- training insurers or their staff or other industry participants, including agents, brokers, auditors or actuaries, other than on matters relating to compliance,
- **handling complaints made against insurers or market participants (although knowledge of serious complaints is good supervisory information),**
- **acting in any form of arbitration capacity with respect to disputes between insurers (or other market participants) and their clients.**

Those functions listed above that are italicised and in bold print are currently functions of the Authority under the Act.

Approvals

It is recommended that a balance should be drawn. In relation to some matters, instead of being required to approve or refuse to approve the matter (or action), a "file and use" system would be more appropriate. Under a file and use system, insurers would be required to provide the Authority with certain key documents. Where a submitted document relates to an action proposed to be taken by the insurer, the Authority would be provided with sufficient notice to consider the information and intervene if it considered this necessary. For example, the Authority may require the insurer to amend the document or may prohibit it from taking the intended action. The period of time provided before the insurer submitting the document can safely act on it would depend on the nature of the document. It would be sensible to specify different periods for different documents.

There are a number of reasons for substituting a file and use requirement for approval in relation to products, business and other plans and premium rates. They include the following:

- The works diverts resources and capacity from undertaking the Authority's core regulatory and supervisory functions. It is not a risk-based approach.
- Supervisory authorities do not usually have the necessary experience, expertise, information or time to undertake the rigorous process that a full approval process requires. If approval is given without a thorough review, a misleading impression is given to persons who rely on the approval.
- By, in effect, becoming part of the decision process, the regulatory authority's position in relation to enforcement is undermined if, for example, a product turns out to be badly designed.
- Approval encourages senior management to rely on the supervisory authority, which is often easier than undertaking a thorough internal assessment.

The Uganda insurance market is still in a stage of development with new and innovative products being developed. In the circumstances, it may not be appropriate for the Authority to immediately cease approval of products and premiums, but it is recommended that this should at least be a medium-term goal.

There are functions in the table above that are not functions of the Authority, such as approving changes of control, cooperation with other internal and external supervisory authorities, and overseeing the winding up of insolvent insurers.

Finally, the Act gives the Authority a clear arbitration role. Whilst, from a supervisory perspective, it is important for

the Authority to be aware of serious complaints (or frequent less serious complaints) made against licensees and complaints that suggest a systemic problem, an arbitration role is in conflict with its supervisory role. Furthermore, an arbitration role distracts from the Authority's core functions. In the long term, therefore, it would be very much better if an ombudsman or equivalent was to be established for Uganda, perhaps covering the entire financial services sector. In the meantime, we accept that it is better for the Authority to have that role than for there to be a vacuum. In order to provide sufficient flexibility, we recommend that the current arbitration function be converted into a power. A power is something that the Authority may exercise, which is not as strong as a function. The Authority would then be able to continue to exercise the power to arbitrate until an alternative system is established.

7.4.1.4 Insurance business

One of the essential functions of insurance legislation is to establish the boundaries of the regulated activity. If these are not clear, then definitions of sub-sets of that activity (such as microinsurance and health microinsurance) will also be unclear.

Most insurance legislation uses the concept of "insurance business" to define the regulated activity. Although the Act uses the concept of "insurance business", the term is nowhere defined and is not used exclusively. For example, in section 3(2), although the section heading refers to "insurance business", section 3(2) prohibits a person other than a licensed insurer from issuing certain types of insurance policy. This is unsatisfactory, not just because it is inconsistent, but because it is almost certainly not comprehensive. The usual meaning of an insurance policy (which is also not a defined term) is the document evidencing a contract of insurance. Furthermore, the types of policy are not comprehensive, as they cover only policies on persons or assets. This appears to exclude certain commonly insured risks (e.g. third party liability) and does not cover weather index insurance, where the insurance is not issued specifically on crops or livestock.

Section 28(1) appears to deal with the same issue. It provides that: "No person shall transact insurance or reinsurance business in Uganda without a valid licence for that purpose".

Although the term "insurance business" is used here (which is much preferable), as noted, the term is not defined. This is also unsatisfactory because "insurance business" is used in a number of other definitions. There is an inclusive definition of insurance i.e. that it includes assurance and reinsurance. This does not provide any assistance in determining the meaning of insurance business.

As discussed, the ambiguity surrounding this is important for all types of insurance, including microinsurance.

7.4.1.5 Classification of insurance business

The Act distinguishes generally between life and non-life insurance (section 5). Although non-life insurance is divided into a number of classes, there are no separate classes of life business. The classes of non-life business include health insurance, health membership, microinsurance and bancassurance. There is also a residual class of non-life insurance which covers any other insurance not specified. Section 5(2) provides that no person shall transact both life insurance and non-life insurance as a composite.

As considered in section 7.5, there is widespread use of short-term (covering up to three-year loans) credit life policies, which are written predominantly by non-life insurers, but also by life insurers. Indeed, credit life is the most common form of microinsurance. It is apparent that there is some confusion within the industry as to whether non-life insurers can write short-term life insurance. Although one company clearly does write the business, others take the view that they are limited to writing personal accident insurance with death cover, but cannot insure against natural death.

Section 5 of the Act seems fairly unambiguous. Although "life insurance" is not defined, its usual customary meaning is clear, i.e. insurance on the life of a person. Equally, non-life insurance would seem to exclude any type of life insurance. Although personal accident normally includes cover for accidental death, its classification as non-life business would appear to exclude accidental death. The residual class of business in section 5(b)(xiv) has been used extensively to write short-term credit life insurance. However, construed strictly, the Act does not allow this, as credit life insurance is clearly life insurance.

As noted in section 7.2.1, new classes of non-life business were inserted by the 2011 amendments: health insurance, health membership, microinsurance and bancassurance. Health membership is discussed separately in the next section of this Report.

There are potential issues in relation to the other two new classes of insurance business:

Microinsurance: As microinsurance has been added as a class of non-life business only, there is ambiguity concerning whether life insurers can write micro life insurance products. This ambiguity could be resolved:
(a) by also specifying microinsurance as a class of life insurance business
(b) by giving life insurers the power to write microinsurance.

Health insurance: As health insurance is specified as a class of non-life insurance, it is not clear that the Act allows life insurers to write health insurance either as a stand-alone product or with life insurance, although life insurers do write health insurance.

Bancassurance: The term "bancassurance" is normally used to cover the intermediation of insurance products by banks and other types of financial institution. Even in countries that permit bancassurance, banks and financial institutions are not permitted to act as risk carriers. In the circumstances, it is unclear why bancassurance has been added as a class of insurance, as this suggests that it is a type of insurance rather than a method of intermediation or distribution. Furthermore, by including it as a class of non-life insurance, it is uncertain whether bancassurance is possible in relation to life insurance products.

Whilst the Authority and industry may place a different interpretation on the issues considered above, if a case was to come before the Court, the Court would have to interpret the words of the Act, which we consider are at best ambiguous and expose insurers to both legal and regulatory risk.

Finally, it is usual to find the classes of insurance business specified in Regulations rather than in primary legislation. Section 5 illustrates very well the dangers of including too much detail in primary legislation. It is very inflexible, as any changes or additions to the classes of insurance to deal with and accommodate new and evolving products would require an amendment to the Act.

We recommend that:
- The specification of classes of business should be removed from the Act and that this is covered in the Regulations.
- Life insurance business should be divided into classes.
- Microinsurance should be specified as a class of life business as well as non-life business.
- Short-term life microinsurance should be a class of non-life business to legitimise the writing of credit life products by non-life insurers.
- Bancassurance should be removed from the classes of business set out in section 5 and, instead, provided for in Part VIII (Intermediaries).

7.4.1.6 Mutual insurers and cooperative insurance societies

Mutual insurers
As previously noted, one of the four permitted forms of insurer is a mutual company. A "mutual insurance company" is defined as a "company of which by its constitution only policyholders are members of the company and which has no share capital" (section 2(l)(y)). Section 9 provides that a mutual insurance company must have at least 25 members, but no more than 300 members.

The capital requirement for a mutual insurance company is 115% of the value of its assets. This is likely to be lower than the capital requirement for an insurer that is a company limited by shares. However, the Authority can require an increased level of capital.

Although permitting mutual insurance companies should, in theory, enable the establishment of smaller mutual insurers, the maximum membership limit of 300 members is almost certainly too low to enable the creation of a large enough risk pool to write insurance sustainably, unless the members are large entities.

The rationale for the low maximum number of members is unclear. Furthermore, given that cooperative societies can be registered as insurers, and new categories of HMO and HMI have been established, it is unclear whether there is still a need for mutuals.

We recommend that the Authority consider whether there remains a need for the licensing of mutual insurers and, if not, that the category be abolished. If there is considered to be a need, we recommend that consideration be given to either abolishing the maximum number of members and increasing the minimum number of members, or raising the maximum number of members significantly.

Cooperative insurance societies
The other type of member-based organisation that is able to provide insurance under the Act is a cooperative insurance society registered under the Cooperative Societies Act. The term "cooperative society" is not defined in the Cooperative Societies Act, but section 3 sets out the criteria for registration. These are that the society has for its object "the promotion of the economic and social interests of its members in accordance with cooperative principles and which, in the opinion of the registrar, is capable of promoting those interests". The Cooperatives Society Act is enforced by the Registrar.

The Act does not specifically enable cooperative societies to carry on insurance business. However, there are provisions in the Cooperative Societies Act that conflict with the Insurance Act (for example voluntary amalgamation of societies, the audit provisions, transfer of assets and liabilities to another society). Although, as the more recently enacted legislation, the Insurance Act almost certainly trumps the Cooperative Societies Act, it would be prudent if the Insurance Act specifically disapplied conflicting provisions of the Cooperative Societies Act.

7.4.1.7 Definition of "microinsurance"

If a special regulatory regime is to apply to microinsurance, it is essential that the term "microinsurance" be defined and that the definition be legally certain.

If special provisions are to apply to insurers who write microinsurance contracts or to persons who distribute or intermediate microinsurance products, those insurers or intermediaries must be absolutely certain what microinsurance is. If there is any uncertainty, an insurer or intermediary could unwittingly open itself up to regulatory action or, worse, commit an offence by believing that an exemption applies when it does not because the activity, contrary to the view of the insurer or intermediary, does not fall within the definition of microinsurance.

A number of countries have microinsurance regimes, but many appear to have struggled with an appropriate definition. Although definitions of microinsurance vary from country to country, almost all definitions incorporate qualitative criteria, quantitative criteria, or both qualitative and quantitative criteria.

Quantitative criteria may include, for example:
- a maximum premium, which may be a fixed sum or a variable amount linked, for example, to GDP or average or minimum wage; and
- a maximum insurance payment or sum insured.

However, quantitative criteria tend to be somewhat arbitrary. In the case of premium size or insurance payment, a single sum for premium or insurance payment is not appropriate for all policies. Furthermore, not all insurance products for which a small premium is charged are necessarily microinsurance. Specific quantitative criteria can quickly become out of date and, if specified in law or regulations, may impose significant inflexibility. Finally, quantitative criteria can be difficult to assess, particularly if linked to some kind of national average, such as the average wage.

Qualitative criteria may include, for example, that the insurance:
- is affordable;
- is accessible by the low-income population; and
- has the objective of protecting the social economic living conditions of the low-income population against specific risks.

Although qualitative criteria are better able to capture the concept of microinsurance, they are rather vague and too difficult to assess for a legal definition.

The Act defines microinsurance as "insurance for the protection of low-income people against specific perils in exchange for regular premium payments proportionate to the likelihood and costs of the risk involved". It therefore takes a qualitative approach.

The first test of "microinsurance" is that it is insurance "for the protection of low-income persons". This imports a number of value judgments into the definition, which deprive it of legal certainty. Without a clear definition of

low-income person, that test is a matter of judgment and judgment should not be imported into a definition. Even if "low-income person" were to be defined, whether or not a product actually protects that person is also a matter of opinion or judgment.

Even if the above issues could be resolved, there are other issues, including the following:

- What would be the position if it were to be discovered that persons who are not low-income persons have purchased the insurance, perhaps without the insurer's knowledge? Would it then cease to be microinsurance?
- There must be regular premium payments. First, it is unclear whether "regular premium payments" would cover a policy with a single premium.
- The premium payments must be proportionate to the likelihood and cost of risk involved. Although this language is used in a descriptive way in the IAIS Application Paper (discussed further in section 7.5.1), we do not consider that it is suitable for a legal definition. In relation to individual microinsurance policies, which may be rated on a community rather than an individual basis, it is unlikely that the premium would be proportionate to the likelihood and cost of the risk involved (at an individual policy level). Furthermore, many microinsurance policies pay out a fixed sum (e.g. hospital cash products), where the insurance payment, and therefore the premium, do not bear any relationship to the cost involved to the policyholder.

In the circumstances, it is considered that the definition of microinsurance in the Act entails problems and that it therefore forms an unsatisfactory basis for establishing Microinsurance Regulations.

As discussed, in order to ensure legal certainty, there must be criteria that can be unequivocally verified. Although some quantitative criteria would pass this test, there are difficulties in establishing appropriate quantitative criteria across a wide range of microinsurance products.

In order to ensure that everyone can be sure whether or not an insurance contract is a microinsurance contract, there appear to be two options:

- a microinsurance contract could be defined as an insurance contract that is approved (or registered) by the Authority as a microinsurance contract; or
- a microinsurance contract could be defined as an insurance contract that is filed by the insurer as a microinsurance contract (under a file and use system).

The latter approach is the approach that is to be adopted by Ghana under its proposed new microinsurance framework.

Which approach is taken will depend on the view of the Authority concerning the approval of policies, which is discussed generally in section 7.4.1.3 of this Report where it is recommended that the better approach is for the policy to be submitted on a file and use basis.

With either approach, the criteria become the basis for the decision rather than fundamental to the legal definition. Under the first approach, a contract would be a microinsurance policy from the point of approval by the Authority as a microinsurance contract until that approval is revoked. Under the second approach, the policy would become a microinsurance policy once the insurer has identified it as microinsurance, unless the Authority were to direct otherwise.

7.4.1.8 Microinsurance organisations

Section 6(3a) of the Act provides that the Regulations may specify different paid-up capital requirements for a microinsurance organisation. Other than that, there is no definition of "microinsurance organisation" and no further references to them. Therefore, although there is a separate licence for HMOs and HIOs (section 33A), there is no separate licence for microinsurance organisations.

Although the concept of a microinsurance organisation is intended to cover a specialist microinsurer, without a definition and either a special microinsurance organisation licence or exemptions, there appears to be no legal basis for microinsurance organisations.

In the circumstances, a specialised microinsurance insurer would have to be licensed as an insurer and, apart from the paid-up capital requirements, would otherwise have to comply fully with the obligations of an insurer under the Act.

This is clearly not intended. If the policy objective is to allow specialised microinsurers (which is discussed further in section 7.5.4 of this Report), it is recommend that "microinsurance organisation" should be defined and that there should be appropriate exemptions from the Act. There should also

be clear restrictions that, for example, limit microinsurance organisations to writing microinsurance.

7.4.1.9 Definition of "health membership organisation"

Although HMOs are far from specialist health microinsurers, as they may provide health microinsurance, the definition of "health membership organisation" is relevant and needs to be considered.

A health membership organisation is defined as "a person engaged in the business of undertaking liability in respect of funding healthcare, by way of membership".

As already noted in this Report, most licensed HMOs are actually health service providers. For the most part, the benefits that they agree to provide comprise access to their own services. However, we understand that at least one HMO is not a heath service provider.

The definition of health membership organisation in the Act certainly goes well beyond health service providers.

There is a significant difference between the risk carried by an HMO that is a health service provider, which in effect provides solely or mainly benefits in kind, and an HMO that is not a health service provider which, in the event of a claim, must finance healthcare provided by others. An HMO that is not a health service provider carries a greater financial risk, as a health service provider, which already has the facilities in place, only has to cover the marginal cost of providing the benefit. It is also much more difficult for it to control costs, as the provision of services lies outside its control.

An HMO that is not a service provider is in reality a specialised health insurer that is formed as a members' organisation, in effect a mutual health insurer. Given that non-service provider HMOs present a much greater regulatory risk to the Authority, it is recommended that HMOs should be limited to organisations that are also service providers. If it is considered that there is a case for permitting non-service provider HMOs, we recommend that they should be subject to a significantly more stringent regulatory regime.

Once a policy decision has been taken, we recommend that the definition of HMO be redrafted appropriately.

7.4.1.10 Definition of "health insurance organisation"

A health insurance organisation is defined as "a person engaged in the business of undertaking liability in respect of heath care, by way of insurance".

The definition is very wide and would appear to cover licensed insurers that undertake health insurance as part of their business. Given that there is no exemption from section 33A(1) for licensed insurers, strictly construed the Act requires licensed insurers to hold an additional licence as an HIO. On the assumption that this is not the intention, it will be necessary to amend the Act to include an exemption.

If an exemption is granted for licensed insurers, an HIO licence would be granted to an organisation that undertakes only health insurance business. It is assumed that once granted an HIO licence, such an organisation would only need an HIO licence and not a full insurance licence. However, the Draft HMO Licensing Guidelines states (paragraph 6.3) that the Authority will only issue a HIO licence to a company that complies with section 29 of the Act (which sets out the general licensing requirements). The Guidelines then provide that this does not apply to CBHIS.

Given that CBHIS are membership organisations (as recognised in the definition in the draft Guidelines), it is unclear why CBHIS are considered as HIOs rather than HMOs.

In fact, CBHIS are a very special form of health insurance organisation. It is recommended that, rather than fitting them within the definition of HMO or HIO, they be treated as a separate category. The regulatory regime would then be adjusted to take account of their special characteristics.

7.4.1.11 Ambiguities, HMOs and HIOs

Although it is intended that both HMOs and HIOs should be separately licensed, it is not clear that this separation is fully achieved, as it is unclear whether HMOs and HIOs are regarded as licensed insurers for the purposes of the Act. Without an exemption, it appears that they should be. If so, both HMOs and HIOs are subject to all the provisions of the act that apply to licensed insurers.

7.4.1.12 Enforcement

The supervision and enforcement powers given to the Authority under the Act are weak and inadequate and do not comply with the ICPs. This is important for microinsurance and health microinsurance as there is a risk that the Authority would not be able to adequately supervise and enforce the microinsurance regime.

In summary, the weaknesses include the following:

1. Although the Authority is required to inspect insurers and most intermediaries once in every three years, other inspections may only be made on cause. The Authority should have the power to inspect any licensee at any time it wishes without having to justify the inspection. The only (possible) restriction would be that it is required to give reasonable notice for routine inspections, although even then in appropriate cases it should be able to inspect without notice. Of course, as a matter of procedure, when conducting risk-based supervision, the Authority would give notice of routine inspections and provide the licensee with some guidance on the areas that it wishes to inspect.
2. The Authority does not appear to have a general power under the Act to obtain documents and information from licensees and others associated with them.
3. The Authority does not have general powers to impose conditions or restrictions on licensees or to issue directives.
4. The Authority does not have the power to examine directors and senior management, whether on application to the Court or otherwise, and does not have any power to apply to Court for a search warrant (or equivalent).
5. There is no provision for the appointment of an administrator to take over a licensee or its business (this is often something for which an application to Court is required).
6. There is not a well-developed administrative penalty regime.

There is an emphasis on revocation or suspension of licence. Current best supervisory practice is that a licence (particularly an insurer's licence) should only be revoked once an insurer has no liabilities or after it has been wound up. Whilst it still has liabilities, it should be handled through enforcement powers (for example by the appointment of an administrator).

7.4.2 The Motor Vehicle Insurance (Third Party Risks) Act 1989 (Cap. 214)

Although the Motor Vehicle Insurance Act has been reviewed, it is of very limited relevance to microinsurance. From a practical perspective, as has been noted, the claims payment record in relation to claims under these policies is very poor and that has contributed to a lack of trust in insurance generally.

It is interesting to note that fuel stations can sell mandatory policies without a licence. This could be considered to provide a precedent for microinsurance. This is discussed in the next section.

7.4.3 The Workers' Compensation Act (Cap. 225)

Again, this Act has little relevance to microinsurance, particularly as the percentage of people in formal employment is low.

7.4.4 The Insurance Regulations, 2002

The ICPs require that an insurance regulatory authority has the power to issue and enforce rules. It is therefore positive that Regulations are made at a regulatory, rather than a political, level. Section 98 of the Insurance Act requires the Authority to consult with the Minister. If this phrase bears its normal meaning, i.e. to seek the opinion of the Minister before making the Regulations, this is not a concern. However, if it is construed as requiring the agreement of the Minister, this raises two issues:

1. First, the Authority does not, in fact, have the power to issue Regulations, as they can be blocked at a Ministerial level.
2. Second, the Authority must be in a position to issue Regulations reasonably expeditiously to meet changes in international standards and developments in the market. If, in practice, the consultation process introduces significant delays, it is likely that the legal framework would be considered as non-compliant with the ICPs in this regard.

We have already noted generally that the Insurance Act contains issues and details that would be better included in the Regulations. In our view, the Insurance Regulations also contain matters that should be in the Act or, at least in a legislative instrument made by a person or body other than the Minister. For example:

- Regulation 9 provides that the Authority shall serve notice of intention to suspend or revoke a licence on a licence holder 30 days before the suspension or revocation takes effect. It is not appropriate, in our view, for the Authority to make regulations that impose obligations on itself.
- Regulation 10 sets out the powers of the Minister on hearing an appeal from a decision of the Minister. It is inappropriate for the Authority to specify the Minister's powers on appeal. An issue as fundamental as this should be in the Act.

It is accepted that both of the above are specifically provided for in section 98, so this is perhaps a criticism of the Act rather than the Regulations, but in our view, both provisions are wrong in principle.

As indicated, the bulk of the Regulations consist of forms. Forms are better regarded as administrative documents that can be adapted very quickly to meet changing circumstances and changes in the information required by the Authority. Embedding forms in Regulations is rather unwieldy. We recommend that forms are specified by the Authority and issued on its website.

Apart from prescribing forms, perhaps the primary function of the Insurance Regulations is to specify detailed prudential requirements. A detailed analysis of the prudential requirements is beyond the scope of this Report. However, from a general perspective, we note that the prudential framework taken as a whole is not risk-based. We consider that the prudential framework should be assessed and consideration given to moving to a risk-based solvency framework.

7.4.5 Guideline on Reinsurance Strategy, Management Procedures and Arrangements

We have two principal concerns in relation to the reinsurance requirements established by the Act and these Guidelines. The first relates to the constraints on the placing of reinsurance risk into the international market. The second relates to the encouragement to front business that cannot be retained in Uganda. These are considered more fully below.

Many countries with emerging insurance markets seek to ensure that premium income is, as far as possible, retained in country. This is achieved by requiring direct insurers to utilise local reinsurance capacity fully before utilising the international reinsurance market. The underlying objectives are market development and economic, not supervisory. Whilst these objectives are important, it is necessary to ensure that this does not compromise supervisory objectives. For an insurer, reinsurance is both a capital substitute and an important part of the insurer's underwriting and risk management strategy.

Primary responsibility for determining how best to meet the prudential requirements and, within the constraints of the regulatory framework, appropriate underwriting and risk management strategies and policies, lies with the insurer's directors and senior management. The ICPs require that insurers be required to establish and maintain risk management strategies and policies that are appropriate to the scale, nature and complexity of their businesses. The directors of an insurer are in the best position to understand the risks that the insurer faces and will also wish to ensure that the reinsurance strategy and policies fit into its wider strategic objectives. The concern is that non-supervisory constraints not only undermine the fundamental supervisory principle that it is the responsibility of directors and senior management to manage insurers, and also that requirements to place reinsurance in country will force an insurer to adopt a sub-optimal risk management strategy.

These requirements deprive the insurer of the ability to select a reinsurer with a specific financial strength rating. This increases other areas of risk, such as credit risk.

Although fronting appears initially attractive, it often simply adds cost. Where business is fronted, the fronting company usually takes what is in effect a commission, which is built in to the premium or reinsurance premium charged by the insurer or reinsurer to which it is fronted. This is all passed on to the policyholder. To the extent that a company seeks to reinsure any of its microinsurance business, this could well impact on the cost of the premiums paid by low-income policyholders.

Finally, international reinsurers provide insurers with excellent exposure to international experience which is important for developing expertise within the local market. International reinsurers can also assist in the development of new and innovative products. By forcing placement within the market, the risk is that these benefits will

not reach local insurers. Where the business is fronted, it is unlikely that even Ugandan reinsurers will benefit.

7.4.6 The Anti-Money Laundering Bill, 2009

In considering the Anti-Money Laundering Bill, we are only concerned with the provisions concerning money laundering prevention measures. For the reasons that follow, the concern is that these may constrain the development of microinsurance in Uganda.

The Bill, in the Second Schedule, specifies a category of "accountable persons". An accountable person includes:

- an insurance company licensed under the Insurance Act; and
- a person who conducts the business of underwriting and placement of life insurance and other investment related insurance, including non-life insurance business.

The footnote in the Bill indicates that persons under the second bullet point include insurance undertakings and insurance intermediaries (agents and brokers).

Accountable persons are subject to the money laundering prevention measures specified in Part III. These include the requirement to identify all clients and to verify their identity using reliable independent source documents, data or information and to conduct ongoing due diligence. We would expect to see more detailed requirements contained in Regulations.

There are also strong record-keeping requirements that would require accountable persons to keep records on identification and other matters for seven years.

Although, of course, it is essential that microinsurance clients be identified, our concern is that, particularly in rural areas, it may not be practicable to obtain and verify identification information to the standards required by the anti-money laundering regime. We are also concerned that the strong record-keeping requirements may be impracticable for some individual agents.

The international standards applicable to money laundering are contained in the Financial Action Task Force Recommendations (the FATF Recommendations) and accompanying Methodology.[111] The preventative measures in the FATF Recommendations apply to "financial institutions" and "designated non-financial businesses and professions".

The Recommendations define a financial institution, as far as relevant to insurance, as a person who carries on the business of "underwriting and placement of life insurance and other investment related insurance". This is identical to the first part of the definition of "accountable person" in the Bill, but the Bill adds the extra words "including non-life insurance business". Furthermore, the definition in the Bill includes all licensed insurance companies.

It is clear therefore, that although international standards only extend to life insurers and insurers carrying on "investment related insurance" together with intermediaries carrying on business in relation to life and investment-related business, the Bill also includes general insurers and intermediaries acting in relation to general insurance.

Whilst we do not consider that there is any issue concerning the inclusion of non-life insurers, generally, it is critical that the framework allows for a reasonable and practicable approach in relation to microinsurance. Clause (e)(ii) of the Bill leaves open the possibility of reduced or simplified due diligence measures, although it is unclear what this means in practice.

The Interpretative Note to the Recommendation 10 of the FATF Recommendations provides that the following product, service, transaction or delivery channel risk factors may be considered low risk:

- life insurance policies where the premium is low (e.g. an annual premium of less than USD/EUR 1,000 or a single premium of less than USD/EUR 2,500);
- financial products or services that provide appropriately defined and limited services to certain types of customers, so as to increase access for financial inclusion purposes.

Microinsurance would fall within both of the above. The FATF Recommendations therefore leave open the possibility of reduced or simplified due diligence in the case of microinsurance.

Clause 7(e)(ii) of the Bill also permits reduced or simplified due diligence measure. It is critical for this to be given ef-

111 The FATF Recommendations 2012 and the Methodology for assessing technical compliance with the FATF recommendations and the effectiveness of AML/CFT systems, February 2013.

fect either in the AML Regulations or the Microinsurance Regulations by specifying that microinsurance is regarded as low risk and by providing details of the reduced or simplified due diligence measures that may be applied.

7.5 Designing a New Regulatory Framework for Microinsurance

In this section of the Report, we identify regulatory and supervisory issues and challenges that will need to be taken into account in designing a new regulatory framework for microinsurance and indicate matters that we consider should be covered in the proposed framework.

7.5.1 Application Paper on Regulation and Supervision Supporting Inclusive Insurance Markets ("the Application Paper")

The Application Paper was published in October 2012. As the title suggests, its purpose is to provide guidance to insurance regulators and supervisors on the practical application of the ICPs to support inclusive insurance markets.

Although the Paper's starting point is that the ICPs apply to insurance supervision in all jurisdictions, regardless of market development and the type of insurance products being supervised, it recognises that supervisory requirements can be adjusted in accordance with the nature, scale and complexity of the risks posed by individual insurers. The Paper describes this as the "proportionality principle".

Although there is no need to discuss the Application Paper at length, the following key points made in the Application Paper appear to us to be particularly relevant for the purposes of this Report:

1. Inclusive insurance products and services should be provided within the supervised market – in particular, all entities that act as insurers should be subject to licensing.
2. There is a minimum point below which it will not be possible to retain insurance risk – below this level, entities should be limited to providing other services.
3. Insurance risk should not be carried on the balance sheet of entities that also do other financial or non-financial business – if small entities are operating mixed businesses, they should transition to separation of the insurance business into a separate legal entity.
4. If the regulation recognises a specific class of product with special treatment, arbitrage is reduced if all existing insurers can also provide the product to the market. Similarly, if a specific category of insurer is created it should be restricted to providing limited products under defined circumstances.
5. Innovations are usually needed to overcome barriers to access to insurance markets. Such innovations may include new or different providers of insurance protection, distribution and servicing approaches, or technology. Primary legislation should provide supervisors with flexibility to respond to new innovations.
6. There should be no need for "exemptions" from some or all supervisory requirements - instead, supervisory differences should be based on the nature, scale and complexity of the risk of the insurer and to the achievement of supervisory objectives.
7. The insurance supervisor should be given a lead role when seeking to advance inclusive insurance markets.
8. If a definition is needed in local laws or regulations, qualitative definitions are preferred until a quantitative definition is absolutely needed for other reasons, and then it should have particular characteristics.

Reference to the Application Paper will be made as relevant.

In this section we first consider some of the principal issues that need to be considered when designing a legal and regulatory framework for microinsurance. We then consider in more detail how the Microinsurance Regulations may be framed to cover those issues.

7.5.2 No need for separate Microinsurance Act

Some countries have enacted separate microinsurance legislation. We understand that the Authority has already taken the decision to enact Microinsurance Regulations. In our view this is exactly the right approach. As already indicated, microinsurance is insurance. Although it may be appropriate to apply proportionate treatment to the regulation and supervision of microinsurance, the general legal and regulatory framework for insurance remains fully applicable. We therefore consider that to draft specific Regulations applicable to Microinsurance is fully consistent with the ICPs and the Application Paper.

7.5.3 Proportionate treatment

It is important that the Insurance Act enables proportionate treatment to be applied, as indicated in the Application paper. Although the Act, as amended, defines microinsurance and enables microinsurance to be subject to specific Regulations, we consider that the Act does not fully allow for proportionate treatment. For example, although section 6(3a) enables the Regulations to apply proportionate treatment in relation to minimum capital requirements, there is no facility for the Authority to grant restricted or conditional licences. This is particularly important in relation to distribution channels as discussed below.

We therefore recommend that the Authority should be given the power to issue conditional and restricted licences and to impose conditions after a licence has been granted.

7.5.4 Specialist microinsurers

We understand from our discussions with the Authority, that it is intended that specialist microinsurers should be permitted. The Act anticipates this by providing in section 6(3a) for the Regulations to be permitted to specify different capital requirements for a microinsurance organisation. However, as discussed above, "microinsurance organisation" is not defined and no specific licence is provided for.

Although the Application Paper and the preceding Issues Paper on the Regulation and Supervision of Microinsurance recognise that specialist microinsurers may be appropriate, this is principally in the context of bringing informal insurance within the formal sector. Apart from the Community Based Health Financing Schemes, this does not seem to be a significant issue in Uganda.

It can be argued that enabling specialist microinsurers to be established with reduced capital, solvency and other requirements would give them an unfair advantage over mainstream insurers. This could reduce competition and may even put mainstream insurers off entering or remaining in the microinsurance market. The counter argument is that microinsurance is unlikely to have a significant impact on the capital or solvency position of mainstream insurers and that the increased competition is healthy. This is primarily a market development issue rather than a regulatory and supervisory issue.

The main regulatory and supervisory risks are that:

- specialist microinsurers will not be sufficiently large to support the risk (i.e. they will be below the minimum point envisaged in the Application Paper);
- specialist microinsurers will not have sufficient expertise to understand the business and the insurance risk to which they are exposed.

In the circumstances, although it may seem an attractive option, there could be unintended consequences. Whilst not advising against the approach, we recommend that the Authority should consider very carefully whether the anticipated benefits outweigh the risks.

7.5.5 Distribution channels

The distribution of microinsurance products presents one of the biggest challenges in most, if not all, countries considering the establishment of a microinsurance regime. As discussed in section 4.3.2, for most products the traditional broker/agent model of distribution does not work. We have already considered bancassurance and recommended that this be treated as a method of intermediation rather than as a class of non-life insurance business.

7.5.5.1 Individual and non-commercial agents

In section 4.3.2 we refer to the possibility of the sale of microinsurance through village elders and leaders, who are more likely to be trusted by microinsurance clients. It would almost certainly be impracticable to require such people to obtain a Certificate of Proficiency. The only possible ways of dealing with this would appear to be:

- to allow individual agents and non-commercial[112] agents to sell microinsurance without any licence; or
- to introduce reduced licensing requirements for certain types of specified microinsurance agent.

Is this acceptable from a regulatory perspective?

The starting point must be the ICPs, which clearly indicate that all intermediaries must be licensed (Standard 18.1). However, intermediaries can be licensed at the individual level (i.e. the individual agent) or at the entity level. The ICPs do not state exactly what is meant by licensing at the entity level. The Application paper states that: "inclusive insurance products and services should be provided within the supervised market. In particular, all entities that act as insurers should be subject to licensing". This

112 By "non-commercial agents" we mean agents who, although they may earn commission from the sale of insurance are not selling the insurance as part of a commercial business.

indicates that whereas insurers must be licensed, distribution channels do not need to be licensed, provided that they operate within the supervised market.

Taking the two together, our view is that it would be permissible for an insurance supervisory authority to permit distribution by unlicensed agents. However, in order to comply with the Application paper, they would need to operate within the supervised market and under a licence issued at entity level. We take this to mean that a licensed insurer would have to take full responsibility for any unlicensed agents that it appoints. This includes training and taking responsibility for any errors or frauds. In order to ensure this is effective, it would have to be clear that insurers would not only need to have their unlicensed agents registered, well known and trained, but insurers would also be subject to enforcement action in relation to the actions of their unlicensed agents. Although this would ensure that unlicensed agents operate within the supervised market, insurers may consider taking on full responsibility for their agents in this way as an unattractive option.

The alternative is a reduced form of agent's licence with a lower threshold required to obtain the licence. This is certainly envisaged in the Application Paper and is a clear application of the proportionality principle. Such a licence should almost certainly be limited to microinsurance and possibly to specific microinsurance products. In order not to mislead microinsurance clients, there is a strong argument for giving this a different name, perhaps authorisation or registration.

We do not consider that permitting specialist microinsurance agents carries the same risks as those discussed in relation to specialist microinsurers for two reasons:

- From the perspective of competition, it is doubtful that the traditional broker/agent model will ever work satisfactorily for microinsurance in Uganda; therefore, this business will probably never be available to traditional agents.
- Distributing microinsurance does not require the same levels of expertise as underwriting it, and there is not the same level of risk.

That is not to say that there would not be significant challenges. These include:

- understanding of the product and claims processes
- handling of premiums
- supervision of a significant number of microinsurance agents
- consumer protection.

For example, the licensing or authorisation of trusted persons (such as community leaders) as agents introduces significant consumer protection risks. The main argument in favour is that community leaders are trusted. However, trust often implies power, which can be used, wittingly or unwittingly, to influence a client to purchase an inappropriate product. On the assumption that a community leader receives commission for microinsurance policies sold, the community leader will clearly have an incentive to sell as many insurance policies as he or she can. Of course, because the leader is trusted and probably in a position of authority, the decision to purchase may not be made on the basis of insurance need, but on the basis of obligation or trust. This is in part an issue of market conduct, but it must be accepted that this will be difficult to avoid.

It will be extremely difficult for the Authority to supervise a large number of restricted licence individual agents without the involvement of the insurers for whom they act. Therefore, we consider that insurers should take more responsibility for their microinsurance agents than even for their normal agents. In order to ensure that this is effective, insurers would need to understand that ultimately they are liable to enforcement action in relation to the actions of their microinsurance agents.

These are difficult issues and their importance should not be understated. Significant problems with – or worse the collapse of – a large microinsurance scheme could impact on the entire insurance market by damaging trust in insurance.

In conclusion, we recommend that:

- the Authority consider permitting a range of different categories of individual to obtain a restricted or conditional agent's licence (or perhaps better authorisation);
- insurers should play a greater role in ensuring appropriate market conduct in relation to their microinsurance agents.

7.5.5.2 Mobile network operators and the "Freemium Model"

As discussed in section 4.3.2, MNOs already have significant outreach, which makes them an attractive distribu-

tion network for microinsurance. One form of distribution that is becoming more prevalent is the so-called "freemium model" pioneered by the specialist microinsurance brokers, Microensure, whereby life insurance is provided free with airtime. There are existing schemes in Kenya, Ghana, Tanzania and Senegal. On 11 June 2013, Microensure issued a press release announcing the launch of a new life insurance product with Grameenphone, a mobile operator in Bangladesh. The following two paragraphs from the press release describe the product:

"Grameenphone has introduced "Nirvoy Life Insurance", a microinsurance product underwritten by Pragati Life Insurance and powered by MicroEnsure Bangladesh. Nirvoy Life Insurance rewards Grameenphone subscribers with free life insurance cover based on the amount of airtime used each month. The product has been simplified to make it easy to use and it is free to subscribers.

Subscribers can qualify for Nirvoy Life Insurance by using as little as BDT 250 of airtime each month and the more airtime subscribers use, the more free insurance they earn up to a maximum of BDT 50,000 of benefit upon death. Nirvoy Life Insurance becomes active on the first day of the month following registration and the total insurance benefit is based on the subscriber's airtime usage in the previous month."

These products undoubtedly have significant potential for increasing market outreach, but we consider that they should raise some concerns for an insurance supervisory authority.

In order to ensure that an insurance product protects against risk, it is necessary to understand the insurance need. In the case of life insurance, how much is required to protect the deceased's dependants? In the case of credit life insurance, the need, to repay a specific loan is clear, and the insurance is designed to provide that. In the case of funeral insurance, the policyholder decides how much cover to purchase.

Purchasing life insurance and purchasing airtime are two entirely different decisions and different considerations are applicable to each. A rational decision on the appropriate amount of airtime to purchase should be based on an individual's assessment of the anticipated usage of the mobile phone, taking into account the amount of money at that person's disposal and other uses for that money.

A rational decision on the amount of life insurance to purchase should be based on the insurance need, again balanced with affordability. By mixing those decisions, the concern is that either:

1. the person will purchase airtime on the usual basis, i.e. anticipated mobile usage, in which case the life insurance provided bears no relationship to need; or
2. the person will purchase more airtime than he or she would otherwise have purchased which makes it a very expensive form of insurance.

It may be argued that, as it is free, there should be no concern in relation to scenario (a). However, this ignores two other issues. First, the insurance is not of course free as it is priced into the cost of the airtime. Perhaps more important is the concern that mobile users consider that, as they have free life insurance with their mobile contracts, they do not need to purchase any additional insurance.

One further issue arises out of the determination of amount of benefit. As stated in the press release, the total insurance benefit is based on the subscriber's airtime usage in the previous month. The problem is that if a person dies after a month in which the person has not used his or her mobile very much, the insurance payment will be very small. At best, this makes the size of the payment arbitrary. However, worse than that, the limited mobile use may be for a reason connected with the person's decease. If, for example, a person becomes ill during the course of a normal life insurance policy, if the person should die, the payment is not reduced because of the illness. However, a person who is very sick is probably less likely to use his or her mobile phone resulting in a reduced payment at the point when it is actually needed. This is an extreme example, but it does demonstrate the possible arbitrariness of the benefits received.

The life contracts offered with mobile contracts are very short-term, typically one month, and have the potential to reach a significant number of people. In the event that the mobile provider withdraws support, a large number of customers would be left without any cover at very short notice.

Finally, proponents of the model argue that it provides a good way to get low-income people used to the concept of insurance. However there is a concern that it could have the opposite effect. Most insurance requires a premium,

this is "free". There must be a risk that it has the opposite effect and downgrades the value of insurance. Although this is primarily a market development issue, it may need to be considered by a supervisory authority if it could lead to significant distortions in the market.

The freemium model is not currently operating in Uganda, but with the significantly increased use of mobile payment services, it may well come. Whilst we are not advising against the freemium model, we consider that it should not be accepted as being risk-free.

7.5.5.3 Mobile network operators and other commercial entities as agents

The freemium model must be distinguished from the use of mobile operators to sell insurance. In this case, the insurer is leveraging the MNO's huge client base and, through the use of mobile payment systems, reducing transaction cost. This offers significant potential for increasing outreach, whilst retaining true insurance principles.

There are many other examples of commercial entities that have the potential to sell microinsurance. The insurance could be associated with the particular product or service sold (perhaps the traditional insurance model being the travel agent that sells travel insurance), or it could be a commercial entity which, like mobile operators, has a significant existing client base of low-income people.

From a regulatory perspective, commercial entities should be expected to have the resources to comply with appropriate regulatory requirements. The agent's licence would be issued at the entity level, the entity being responsible for controlling its staff. Although reduced regulatory requirements may not be appropriate, the Authority should be prepared to consider tailored regulatory requirements.

7.5.6 Providing client value

In our experience, efforts to increase market penetration and outreach can obscure the need to ensure that, as far as possible, microinsurance products provide value to low-income persons. Although we have advised against product approval at an individual level, an insurance supervisory authority properly has significant influence on microinsurance product design through the issuance of regulations and guidance on product design. As indicated, the supervisory authority should also have the power to intervene to prevent microinsurance products being sold, or to ensure their withdrawal from the market.

We therefore recommend that the Microinsurance Regulations should require insurers to consider client value when developing microinsurance products and in the sale of those products.

As we have indicated (in paragraph 4.3.3), we have formed the view that insurers in Uganda do not seem to invest appropriately into researching market demand or market need. Products are often developed on the basis of a perception of what low-income clients want or need. It is almost certainly going to be necessary for the Authority to issue Guidance on factors to be considered in assessing client need. This may include considering matters such as whether the risk is appropriate for insurance (i.e. insurance is most suitable for low probability, high impact events).

Savings and credit are usually a more efficient way of managing higher probability and lower impact events. The microinsurance framework should therefore allow for the bundling of savings, credit and insurance products. These products are probably most appropriately sold as banking products with an insurance add-on. This underlines the importance of amending the Financial Institutions Act to remove the prohibition on bancassurance. We also recommend that the Authority engage with the Central Bank concerning the use by the Bank of its existing powers under the Micro Finance Deposit-Taking Institutions Act to permit Tier 3 financial institutions to sell microinsurance.

7.5.7 Group products

As discussed earlier in this Report, many credit life products are sold as group insurance products. Group insurance is a long-established method for employers to take out medical insurance for the benefit of its employees. It also has other traditional uses. However, in relation to credit life, group policies are undoubtedly being used, at least in part, to circumvent the need for banks and MFIs to obtain an insurance agent's licence, which of course they cannot obtain.

If bancassurance were permitted, there would be no need for group insurance contracts on that basis alone. However, that does not mean that there are not circumstances in which group insurance is an appropriate and beneficial

way in which to distribute insurance and, in particular, microinsurance. However, we consider that group insurance should be brought more clearly within the regulatory framework. There is, in our view, a need to specify what group insurance is and to specify requirements that should apply.

For example, under a group insurance, the persons whose interests are insured or covered by the contract are not parties to the contract, the only parties to the contract being the insurer and the group policyholder. There is, therefore, no requirement for the person covered under the contract to receive any documentation. However, in our view this is unsatisfactory, particularly if the covered person is paying for the policy, whether directly or indirectly through a higher interest rate.

We therefore recommend that the Authority issue Regulations covering group insurance policies, including group microinsurance policies. The Regulations should cover issues such as:

- the definition of a group policy;
- the criteria for a group policy (e.g. an identifiable group of persons to be covered that exists independently of the insurance policy);
- the need for the policyholder to have an insurable interest in the policy; and
- the documentation to be provided to persons covered by the policy.

7.5.8 Specific recommendations for Microinsurance Regulations

In the previous sections we outlined some regulatory challenges and constraints that the Authority will need to consider in designing Microinsurance Regulations. In this final section on microinsurance, we consider some specific recommendations.

7.5.8.1 Defining microinsurance

In section 7.4.3 we discussed the need for a definition of microinsurance and the issues with the current definition. Although the Application Paper suggests that a definition should be qualitative, as indicated, this introduces the problem of legal certainty, which is essential.
We therefore recommended that a microinsurance contract could be defined as:

- an insurance contract that is approved (or registered) by the Authority as a microinsurance contract; or
- an insurance contract that is filed by the insurer as a microinsurance contract (under a file and use system).

We recommend that this definition be included in the Insurance Act. If the latter approach is taken, the Authority must have the power to intervene, at any stage, and determine that the insurance contract is no longer a microinsurance contract. In order to protect policyholder, insurers and intermediaries, such a decision should take effect from the date that it is made, and not be retroactive.

The qualitative criteria then become criteria used to make the decision, whether by the insurer or the Authority, rather than part of the legal definition.

Qualitative criteria

There are difficulties in arriving at meaningful qualitative criteria. Indicating that microinsurance is insurance for low-income people is not, on its own, sufficient. We consider that, in order to justify a product as microinsurance, an insurer should be able to show that the product has been designed and developed to meet the needs of low-income people or of specific categories of low-income people. The elements of purposeful design and development seem to us to be very important.

We consider the following should also be reflected in the criteria:

- the premiums should be affordable,
- the product should be accessible.

In order to enable the Authority to make a meaningful assessment (whether on approving a product or considering a product that has been filed), an insurer should be required to make a written record of how it reached its determination that the product satisfies these criteria and to file that written record with the product. This will not only enable the Authority to review the basis for insurers' assessments that the product is microinsurance, but will encourage insurers to give real thought to designing their products. This written record should be subject to the record retention requirements.

We also recommend that insurers should be required to periodically assess whether microinsurance products continue to meet the criteria for microinsurance. An annual review would be too frequent, but it would be reasonable for a review to be required say once every three years.

Although we would not recommend the routine filing of these periodic reviews, they would be available for the Authority to review on inspection visits.

7.5.8.2 Easily understood contracts, few exclusions

We recommend that the Regulations should require insurers to ensure that, as far as practicable, microinsurance contracts are written in clear and straightforward language and that they do not contain technical and legal language.

Insurers should also be required to take all reasonable measures to ensure that the contracts will be readily understood by the low-income persons for whom they are designed. When it is expected that that those persons do not speak English, the contract should be written in an appropriate local language.

Although it is desirable that microinsurance contracts are short in length, it is also important that they are comprehensive. Therefore, length of contract should not necessarily be equated with clarity.

Finally, the Regulations should require that microinsurance contracts contain few exclusions.

It should be noted that these are recommendations concerning requirements, not criteria. Failure to comply is a regulatory breach by the insurer, but it does not result in the contract not being a microinsurance contract.

7.5.8.3 Community rating

We recommend that insurers should be expressly permitted to rate microinsurance products on a community basis, rather than on an individual basis.

However, in terms of health microinsurance, a company can only community rate if it has a certain size of membership. If a small community seeks health microinsurance and it is underpriced (if they do not have a full community of members yet are offered community rating), then the product will be unsustainable.

7.5.8.4 Provision of information to policyholder

One of the concerns associated with the sale of microinsurance products, especially those that are sold through a mobile platform, is the provision of information concerning the policy. There are a number of risks. If the policyholder has not been given the opportunity to read the policy before agreeing to the contract, there is a risk that the contract could be set aside or that the policyholder would not be bound by all the terms of the contract.

Apart from legal considerations, it is clearly unsatisfactory for a policyholder to be sold a contract that the policyholder has not read and for the policyholder not to be provided with any record of the policy. A SMS text to the effect that a person is now insured is not sufficient.

We recommend that the Regulations should require insurers to provide potential policyholders with a written policy summary, or digital equivalent, setting out the key terms of the policy before the contract is entered into. This should really apply to all retail insurance contracts, but should certainly apply to microinsurance. The Regulations should specify key information that, at a minimum, should be included in the Policy Summary.

We also recommend that policyholders should be provided with a copy of the microinsurance policy itself. Whilst a written document would not necessarily be required under all circumstances, where the document is electronic, care will need to be taken to require insurers to satisfy themselves that policyholders really have seen the document. At the same time, it must be considered that this should not lead to the effective elimination of key distribution channels, e.g. mobile network operators).

7.5.8.5 Claims

We recommend that the Regulations should require insurers to determine claims under microinsurance policies within a relatively short period of time and that, once a claim has been accepted, payment should be made very soon afterwards, perhaps with a period of say seven days.

7.5.8.6 Composite products

Although the Act bars composite products, there is an argument in favour of permitting non-life insurers to write short-term life products and for life insurers to write certain specified non-life insurance, when added as a rider to a life policy. This would require an amendment to the Insurance Act.

As previously indicated, this is the market reality in the credit life market.

8 Summary of Recommendations

In summary, sections 2, 3 and 4 contain our findings. In section 5 we consider some product and operational issues relevant to the proposed NHIS Scheme. However, as the Scheme is outside our terms of reference, we have not included specific recommendations. Most of our recommendations are found in section 6 (Proposals for market development) and section 7 (The legal and regulatory framework). To assist readers of the Report, the principal recommendations made in sections 6 and 7 are summarised in Table 17.

Table 16: Appropriate objectives and functions of an insurance regulator/supervisor

Section 6 – Proposals for Market Development	
Section	**Recommendation**
6.1	**Address low claims ratio and high expenses:** providing client value is a pre-condition to developing a strong microinsurance market. This requires insurers to address the current low claims ratio and high expenses.
	Support initiatives: develop support and training initiatives focusing on research, training, product development and awareness.
	Microinsurance Working Group: develop microinsurance working group within Uganda Insurance Association.
6.2.1.1	**Include some form of risk sharing in health products:** free access to medical care may overwhelm an already overburdened system.
6.2.1.3	**Measure healthcare outcomes:** to foster increased trust in the healthcare system and accountability of providers; tools include provider accreditation, pharmaceutical sourcing, and rewards/ recognition.
6.2.1.2	**Introduce standardisation as a quality component,** whereby absence of variation is a quality orientation: this could include the introduction of evidence-based protocols for clinical decisions, standard coding and claims forms.

6.2.2	**Evaluate the potential for health microinsurance products:** includes due diligence of innovative products potentially including non-insurance elements (e.g. health savings account), access to quality medical outcomes, supplemental funding, correct formula for product/distribution.
6.2.2	**Create awareness of the role of prevention with the informal community:** in a focus to move mindset from curative to proactive.
6.2.3	**Consider viability of health microinsurance products** including: health savings account/ catastrophic cover, HMO-based health insurance, hospital cash/ transportation allowance, dial-a-doctor (access to medical protocols by telephone).
6.2.4	**Develop an infrastructure to regulate health microinsurance:** develop a policy on health insurance regulation, create reporting requirements, decide on the interim role of alternative insurance (pending NHIS), ensure an understanding of the healthcare industry.
Section 7 – The Legal and Regulatory Framework	
Section	**Recommendation**
7.4.1.2	**Undertake a thorough assessment of the Insurance Act against current ICPs (2011)** to identify weaknesses and gaps.
	Work towards amending or replacing Act: using the assessments, advise and work with the Government on developing amendments to or replacing the Act.
	Amended or new Act should be principles-based and enable risk-based supervision. Note: many of the recommendations below require amendments to the Act.
7.4.1.3	**Reduce the number of Authority approvals required.** As industry develops, the matters that have to be "approved" by the Authority should be reduced. In particular this will enable the Authority to focus its resources on its core functions and avoid capturing what should be management decisions. This will not be possible without amendments to the Act
7.4.1.5	**Move classification of insurance business to Regulations and amend classification provisions.** The current Act contains detailed provisions on the classes of insurance, which constrain the development of a regulatory framework for microinsurance. It is more usual to provide for classes of insurance business to be covered by regulation to enable flexibility. This will require an amendment to the Act.
	Specific recommendations on classes of insurance business: • **Divide life insurance business into classes; legal certainty should be provided in relation to the writing of short-term life products.** • **Specify microinsurance as a class of life business as well as non-life business.** • **Classify short-term life microinsurance as a class of non-life business to legitimise the writing of credit life products by non-life insurers.** • **Remove bancassurance from the classes of business and provide for it in Part VIII (Intermediaries).** These will all require amendments to the Act.
7.4.1.6	**Consider whether there is a need for mutual insurers:** • **if there is no need, remove provisions concerning mutuals;** • **if there is a need, abolish the maximum number of members or significantly increase the maximum number from 300.** This will require amendments to the Act.
7.4.1.8	**Provide definition of "microinsurance organisation" and enable specific licence and regulations.** **This will require an amendment to the Act.**

Section	Recommendation
7.5.5.1	Recommendations on individual and non-commercial agents: • **The Authority should consider permitting a range of different categories of individual to obtain a restricted or conditional agent's licence (or perhaps better authorisation).** • **Insurers should play a greater role in ensuring appropriate market conduct in relation to their microinsurance agents.**
7.5.6	**Client value:** Microinsurance Regulations should require insurers to consider client value when designing products and in sale of products.
	Bancassurance (Tier 3 financial institutions): Authority should engage with the Central Bank concerning the use by the Bank of its existing powers under the Micro Finance Deposit-Taking Institutions Act to permit Tier 3 financial institutions to sell microinsurance.
7.5.7	**The Authority should issue Regulations covering group insurance policies** covering, for example: • the definition of a group policy; • the criteria for a group policy (e.g. an identifiable group of persons to be covered that exists independently of the insurance policy); • the need for the policyholder to have an insurable interest in the policy; and • the documentation to be provided to persons covered by the policy.
7.5.8.1	**Definition of microinsurance: Microinsurance should be defined as** • an insurance contract that is approved (or registered) by the Authority as a microinsurance contract; or • an insurance contract that is filed by the insurer as a microinsurance contract (under a file and use system).
	Criteria for registration: The Authority should develop criteria for determining whether it will register a policy as a microinsurance contract.
	Insurer's assessment: Insurers should be required to assess their products against criteria and provide written justification of how criteria are met on application for registration.
	Periodic review by insurers: Insurers should be required to make periodic assessment of their microinsurance products against criteria.
7.5.8.2	**Easily understood contracts, few exclusions:** Regulations should require microinsurance contracts to be written in clear and straightforward language and to contain few exclusions.
7.5.8.3	**Community rating:** Insurers should be permitted to rate microinsurance products on a community basis.
7.5.8.4	**Policy summary:** Insurers should prepare a policy summary to be provided to customers with the policy document. This could be on the reverse of the policy document.
7.5.8.5	**Fast claims process:** The Regulations should require claims to be determined and settled within a short time frame.

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