MICROINSURANCE PRE-FEASIBILITY STUDY

UGANDA

Prepared for:
Kreditanstalt für Wiederaufbau (KfW)
German Financial Cooperation

Development of Instruments for Financial Cooperation
in the field of microinsurance

Hanns Martin Hagen, Senior Economist
Financial Sector and Private Sector Participation

Prepared by:
Michael J. McCord
The MicroInsurance Centre

12 April 2004

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List of Abbreviations

AAR	Africa Air Rescue Health Services
AIG	American International Group
AMFIU	Association of MicroFinance Institutions of Uganda
APR	Association for Pension Reform
CERUDEB	Centenary Rural Development Bank
CIDR	International Centre for Development and Research
CMS	Commercial Marketing Strategies (a project of USAID)
DFID	Department for International Development (UK)
FASERT	Foundation for the Advancement of Small Enterprises and Rural Technologies
FINCA	Foundation for International Community Assistance
GoU	Government of Uganda
GPA	Group personal accident insurance
HFC	Housing Finance Corporation
HMO	Health Maintenance Organisation
IAA	International Air Ambulance
ILO	International Labour Organisation
MFI	Microfinance Institution
MoH	Ministry of Health
NGO	Non-governmental organisation
NIC	National Insurance Corporation
NSSF	National Social Security Fund
PSDU	Private Sector Development Programme Uganda (a DFID programme)
SEWA	Small Enterprise Women's Association (India)
STEP	Strategies and Tools against social Exclusion and Poverty
STG	Social Security and Pensions Sector Stakeholder Transition Group
UCBHFA	Uganda Community Based Health Financing Association
UIA	Uganda Insurers Association
UIBA	Uganda Insurance Brokers Association
UMU	Uganda Microfinance Union
USAID	United States Agency for International Development
Ushs	Uganda shillings
VCD	Video Compact Disk

Executive Summary

Formal microinsurance in Uganda got its start in the mid-1990s with community- and hospital-based health care financing programs for low-income communities, and a group personal accident policy offered by American International Group (AIG) through microfinance institutions. These products were designed to help low-income people mitigate the two financial risks they identify as the most difficult to manage: health care financing, the expenses related to death, especially that of a breadwinner.

There is clearly a problem with the market understanding insurance, and often a negative attitude arising from insurance company rejected claims. This has severely hindered the growth of insurance and especially life insurance products. These issues are compounded by the 99% devaluation of 1987, and a subsequent additional 30% devaluation which taught people that long term investments were not wise. These factors, among others including an insurance industry that lacks innovation, have resulted in an insurance industry that posted less than US$30 million in premiums in 2002.

Risk management products are now available to MFI clients and some organisation members (group personal accident and limited health care financing). These products have somewhat matured in this market but are limited in coverage, or in geographic spread. Numerous community-based organisations have been formed by development organisations; most of these are extremely weak. Several mission hospitals offer a health-financing scheme though these are generally acknowledged to be cost centres for the hospitals. The government has made serious efforts to improve access to health care facilities by low-income people, and they are now in a process of redesigning the National Social Security Fund. These efforts have thus far been limited in their impact and require additional professionally managed risk management products.

Insurance company management, other than that of AIG who are active in this market, are beginning to explore opportunities in the low-income market but have yet to make any substantial efforts to implement these. Though the regulatory and policy environments are favourable, there are fundamental problems within the structure of the potential market that have retarded growth especially in the low-income market (even though AIG's product has been wildly successfully in terms of individuals covered – over 2.9 million). There are several insurers holding general and life licenses who would like to enter this market but can not or do not get over the initial entry requirements which include investing in new product development, changing market attitudes, assessing risk with limited data, and other market deficiencies.

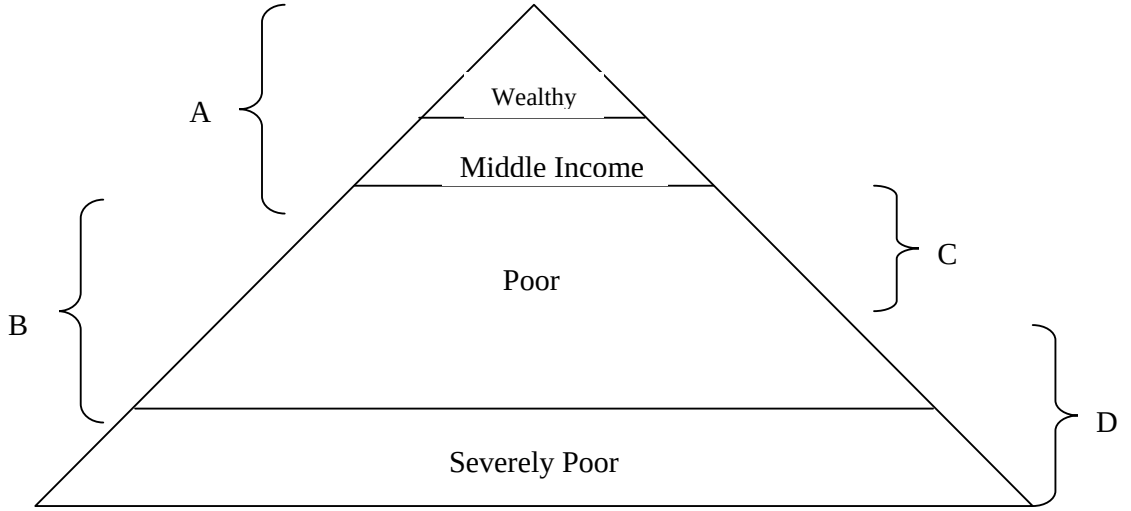
Three potential interventions were identified: (1) an equity and technical assistance grant combination to fund product or regional expansion; (2) creating a re-insurance mechanism to temporarily limit the risk of insurers as an incentive to get them to move downmarket; and (3) as an important complement to these efforts support is necessary for the development and implementation of a major insurance concept marketing program to help the market gain an appreciation for microinsurance dramatically improving the potential success of the first two interventions.

There are significant opportunities for microinsurance in Uganda. The initiatives to develop those opportunities must be complementary to the State's social protection activities, and the local informal mechanisms.

1. Microinsurance

1.1. Where does Microinsurance fit within the Financial Sector?

In Uganda, there are several layers of risk management opportunities. At the high end, wealthy people are obtaining premium health, life, property insurance, and pensions



either individually, or through their companies and employers. The middle-income group often obtain cover for health and sometimes life from their employers. A provident fund for this group is supposed to be provided by the National Social Security Fund (NSSF). The severely poor have no access to formal insurance cover, though they may benefit from "free" health care at government health centres and hospitals. The poor often have informal mechanisms for risk management, but these are usually insufficient. They only have access to formal insurance products through their MFIs, and even this is rather limited.

Formal sector insurance companies focus on the area identified as "A" with an array of traditional insurance products. They reach slightly into the poor range with regards to third party motor insurance required of all automobile owners. This is the same market focus of the traditional banking industry in Uganda.

The aggregate market for microfinance institutions is in the area identified as "B". Some MFIs focus on the higher range and others more towards the lower range. Of this population of perhaps ten million people of working age, MFIs provide services to up to eight-hundred-thousand.[1] Most of these clients are accessing credit services. Very few are accessing formal savings services. Up to five-hundred-thousand of these clients (with their families) are receiving group personal accident cover through AIG. Some in this group (eight thousand) receive medical cover from Microcare, and about 2,500 obtain such cover from hospitals and community-based groups

Other than mandatory insurance cover required by MFIs for some of the group labelled "D", it is unlikely that others receive any access to formal risk management products. Indeed, these people are the responsibility of the GoU and their social protection activities. These are not a market for formal insurance products.

[1] This represents the sum of the number of MFI client accounts reported by the various MFIs. There is currently no efficient mechanism for identifying the actual total number of people served by MFIs. The actual number of individuals serviced is likely much lower than this because of clients obtaining services from more than one MFI, or even obtaining more than one service from the same MFI. (Source: AMFIU)

Area “C” indicates the range within the continuum of income levels that could be expected as a market for specialised microinsurance[2] products. This market is an effective market microinsurance products because, though mostly poor, they have some income stream and some recognition of a need for additional, more formal risk management tools. This range includes around four million people. However, the effective demand, discussed below, is far from this volume.

1.1.1 What are some microinsurance products?

In Uganda, there are a limited number of microinsurance products available, although they influence large numbers of people. The group personal accident policy[3] that AIG offers through microfinance institutions covers about 2.9 million individual lives. The comprehensive health care financing plan of Microcare covers about eight thousand people. Various health care financing programs by hospitals and community groups cover maybe 2,500 lives.

Products relatively easily available to MFIs to help their clients with risk management include emergency loans and specialised savings products. Effective products to address these opportunities are not significantly available from MFIs in Uganda.

AIG’s growth in terms of premiums and lives covered has been rather rapid though has reached plateau because it has acquired the clients of virtually all significant MFIs in Uganda. Using this delivery channel has allowed for this rapid and efficient growth, but now that these channels are nearly fully accessed, growth potential for this product is limited in Uganda. Certainly, AIG could take their product to other countries. Indeed, they cover lives with this basic product in at least three other countries.

Growth now for AIG, must come from product enhancements or even new product offerings. However, again AIG is limited by its lack of a life license. An easy product to add on would be full life cover but this is legally excluded from their product options. Recently there has been some discussion between life insurers and AIG to combine the products of two companies into one more comprehensive product for this market. AIG management note their satisfaction with the levels of profitability for this product, and they would be interested in adding other product with assistance in managing the controls for such products (such as fire and theft cover).

1.1.2 How is microinsurance delivered?

Several models of microinsurance delivery are in use in Uganda. These models fall into the following groups:

- **Partnership model**: AIG (the largest insurer in the world) has paired with almost all significant MFIs in Uganda to offer a group personal accident to microfinance clients. Three other insurers approached the author during the visit noting they are interested in these partnerships, though others have not yet accessed this conduit.

[2] Microinsurance is the protection of low-income people against specific perils in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved. Low-income people can use microinsurance, where it is available, as one of several tools to manage risks.

[3] Though slightly different at different MFIs, this product covers the loan principle and interest, and pays a benefit on the accidental death of a spouse, and up to four (under 21 years of age) dependents.

- **Community-based model**: This model is prolific in Uganda where organisations including ILO, CIDR, CMS, and DFID work with communities to help them develop and administer a risk fund, usually for health care. The ones that are still operating are doing so with difficulty due to the burden placed on local people to effectively manage a mini-insurance company. The multiple responsibilities, with limited support make this model difficult to reach organisational sustainability.

  One type community-based initiative that has been successful is the Ngozi society. In these groups, local people build a gurney to transport people to the hospital when in need. The community designates someone to manage the gurney and a team of people to carry it.

- **Provider model**: Several mission hospitals throughout Uganda have developed their own insurance schemes with community groups. These have been difficult to manage because insurance skills are limited among hospital administrators. This is compounded by the problem that these hospitals are having with pricing their own services. There is an ongoing discussion about the value of these insurance schemes if they are simply bringing in more people who are receiving health care services at a price that is below cost. Additionally, most of these programs are run through the books of the hospitals and are unable to reasonably provide data on the sustainability of these schemes.[4]

- **Full service model**: Regulated insurers have not developed any products that effectively help them move down market without a marketing partner. One of the MFIs has clients contribute to a "loan insurance fund". This is nothing more than coerced savings in the form of self-administered default insurance.

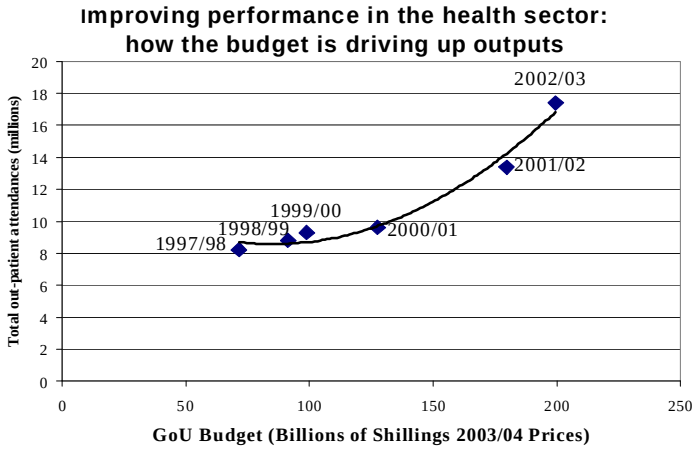
- **Social protection models**: In 2000, the Government of Uganda, with significant assistance from donors, abolished user fees on state run hospital services. This caused an average doubling of patient contacts within these hospitals. They have made a strong effort to reduce the support funding for Kampala hospitals and have funnelled much more money to the rural clinics and hospitals. Patients and others note that now there are long queues, and although the consultation is "free" additional services often require non-receipted payments, and it is generally acknowledged that these hospitals do not have the necessary drugs (usually the most expensive aspect of the treatment).[5]

The key consideration with these models is: Where does the risk lie? Almost all the programs observed in Uganda make the insurance risk the responsibility of a party that is not likely capable to effectively manage that risk. Only with the partnership model,[6] using regulated insurers, places the risk with professional insurance risk managers. These managers have reserves, access to reinsurance and actuaries, and insurance capacity that the others most often do not. Any intervention in microinsurance should both ensure proper "placement" of the risk, and support the government's efforts at social protection.

[4] There is an effort being made now to improve the accounting and pricing within at least the Catholic mission hospitals.
[5] This leads to an array of problems because people will purchase just what they can afford, and frequently this is not a complete regimen of anti-malarials, or antibiotics. Partial dosages have the potential to breed resistant strains.
[6] We could also include the full service model though there are yet any insurers moving down-market.

1.2 How does Microinsurance fit within the broad policy environment?

The GoU has made significant investments in social protection in terms of the abolition of user fees at public hospitals, and now stated efforts to reform the National Social Security Fund so the fund can also provide an array of social protection tools such as unemployment insurance, pensions, medical care, funeral benefits, and others as per the ILO list of suggested social protection cover. The ideals are strong, but effective implementation has been difficult with health care reform, and will be even more so with the NSSF reform.

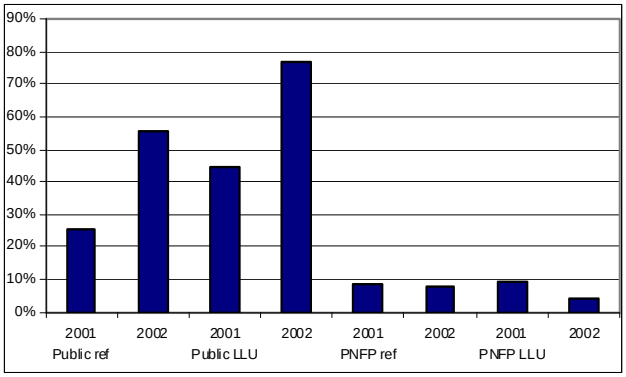


The GoU efforts have resulted in significant additional utilisation of the public health care facilities. They have shown (see graph above "Improving performance in the health sector: how the budget is driving up outputs"[7]) that financial inputs from the government, as a replacement for user fees, have resulted in additional utilisation. Since 2000/1, when user fees were abolished, the outpatient attendance at public facilities has increased about 80% while investment from the government in the health sector has increased by about 75%.

The MoH notes that the increase in utilisation has been seen in the public sector health care facilities and not in the private facilities. This is clear from the chart titled "The Impact of Abolishing Fees and a Rising Health Budget, Changes Since 2000".[8] This is important as it shows that the government policy is having a positive impact, at least in terms of getting people into the government facilities.

[7] Rob Yates, Uganda MoH, Lessons from the Uganda health Financing Reforms"
[8] Ibid.

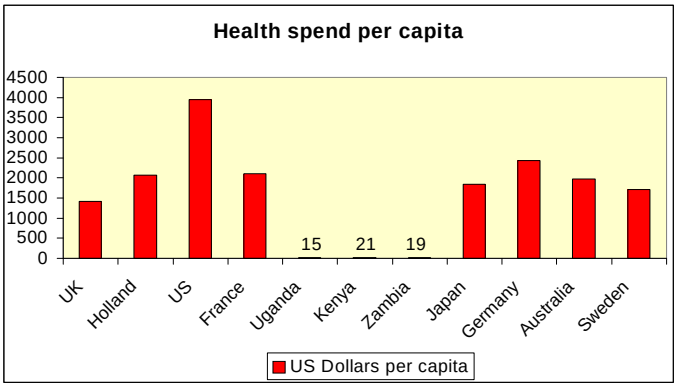
The impact of abolishing fees and a rising health budget, changes since 2000



Key: PNFP=NGO, Ref = Hospitals, LLU= Lower level units (health centres)

The MoH reports efforts to improve quality of care, however, users of the facilities (in Kampala at least) note that quality is limited, there are often non-receipted payment requirements, and even the MoH acknowledges that there are usually no drugs available at the facilities.

Even with these efforts, the GoU is still only spending about US$15 per capita on health care. This is far lower than industrialized countries, and even significantly lower than some of Uganda's neighbours. The chart below, ("Health Spend Per Capita"[9]) shows the per capita health expenditure in selected countries. Though still low, Kenya spends 40% more and Zambia 25% more than Uganda.



This clearly shows scope for additional complementary mechanisms of health care financing. The government and its social protection activities do generate a positive impact. However, if low-income people are going to obtain quality health care, health microinsurance is an important addition to this social protection regimen.

The NSSF has acted as a provident fund making a single payment to those participating. Participants now number about 5% of the working age population. This limited coverage and limited product range has concerned government and a major effort is under way to restructure the NSSF. This has become a highly contentious activity with the Social Security and Pensions Sector Stakeholder Transition Group (STG), assigned by government to redesign the NSSF to allow for real pensions. Their

[9] Ibid.

proposal calls for dramatic new powers for the NSSF, and limits private sector involvement. Additionally the STG proposal calls for collection of 20% of earnings from the informal sector. These workers are expected to voluntarily report to an office each month the pay in their 20% contribution. As an incentive, the group proposes that the GoU will match all contributions.

The private sector (insurers, brokers, manufacturers, and bankers associations) has formed a team in response to the STG, called the Association for Pension Reform (APR). This group has presented a rebuttal to the government, as have the different private sector associations.

The Finance Ministry has not taken part in the development of the proposal. The NSSF falls under the Ministry of Gender and Labour. No one has carefully looked at the numbers with regards to the STG proposal and it has come out much as a wish list. It is highly unlikely that this proposal will be implemented in any form even close to the proposal. This initiative is not something to count on in the short, or likely the medium term.

Social protection measures have been weak in Uganda. There is significant effort to improve their effectiveness, yet still microinsurance is an important complementary activity that will help to fill the gaps in the current programs and allow choice to the low-income people.

2. The Insurance Sector in Uganda

Uganda's insurance sector is one of the least developed in the region, a situation that the government sought to address with the passing of the Uganda Insurance Statute in 1996. The Act introduced the concept of minimum share capital in the sector. Previously, anyone could start an insurance business as long as the company had a Board of Directors.[10]

The Insurance Statute (1996) creates a formal structure under which the insurance industry is controlled and overseen. It created the Insurance Commission (the insurance supervisor), and gave powers to the Insurance Association (requiring licensed insurers to maintain membership in the Association effectively gives the Association power to de-license an insurer). The Statute defined the requirements for operating an insurance company (at least two experienced senior managers, a certified accountant, one million dollars in capital for a foreign insurer, $200,000 for a domestic insurer).

The Statute also addresses issues of brokers, agents, and reinsurers. It requires 5% of its reinsurance business to go to Africa-Re, and 10% to the preferential trade area reinsurance company. In 2000, 40% of all premiums were paid to external reinsurers including the 15% mentioned above. This ratio has increased in 2001 through 2003. There is a strong concern among insurers and the Commission that so much money is being sent to international markets while not providing any benefit to the Uganda economy.

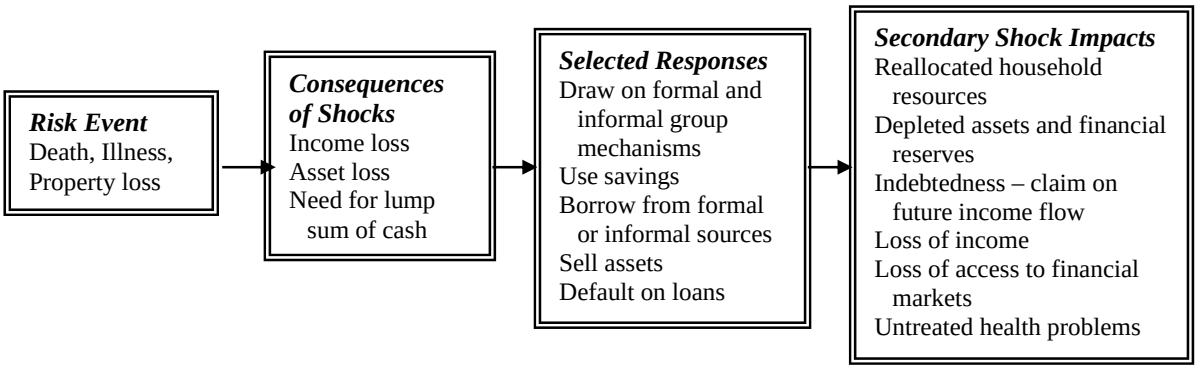
[10] Lillian Nsubuga "*Uganda Gets Its Own Reinsurance Firm*" The East African, July 15, 2002

The Insurance Regulations 2002 were an effort to formalise some of the insurance documentation, but more importantly, it was an attempt to bring about consolidation within the market. To affect this, minimum capital requirements were increased to $500,000 for each type of insurance license (this is down from the one million because of exchange rate fluctuations). The commission hopes to reduce the number of insurers from the current twenty, to between eight and ten.

So far, there have been no consolidations in the market (the final capital requirements are not fully enacted until 2005). Two new insurers were licensed in December 2003, and two traditional insurance companies were sold and changed their names. It is possible that these companies will generate some activity in the microinsurance market, but it is unlikely. Additionally, the remaining insurance companies are focused on generating the required capital, and are unlikely to approach the microinsurance market without a strong incentive.

2.1. Risk management options for the poor[11]

When low-income people suffer from a risk event, a series of consequences,



responses, and impacts follow. These are outlined in this diagram. These low-income people need mechanisms to help keep them from losing everything. Some risk management options are available, even in the low-income market.

2.1.1. MFIs and banks

MFIs and banks have a great opportunity to provide risk management tools to the low-income market because they are already conducting financial transactions within this market. MFIs in Uganda in numerous studies have found that often clients will use their disbursed loan to pay for emergencies. Thus, in a sense, even the normal credit offered by most MFIs (intended for business uses) is providing a level of risk management for their clients.

2.1.1.1. Savings

Special savings products designed to help clients access funds in an instant on the occurrence of certain events has not been addressed in Uganda. The Uganda Microfinance Union is by far the most flexible of the MFIs in Uganda, and would be most likely to create such a product on demand. Otherwise, nothing is happening in this area.

2.1.1.2. Emergency Credit

The organisation Save for Health has as its core product an emergency loan that covers in-patient care at a local hospital. This is a supervised community-based

[11] "MicroInsurance Centre Briefing Note # 6: Financial Risk Management Tools for the Poor." Monique Cohen and Michael J. McCord, Jauary 2003.

program, and has found that people much prefer the credit option than the insurance product that Save for Health offered as their core product.

2.1.2. Informal structures

Informal structures include community-based organisations as well as hospital-based programs. These have been well discussed above.

3. The Demand for Risk Management Services in Uganda

There are a number of lessons that have been learned in Uganda for the successful development and sale of micro insurance products. These come from working with and watching the demand side respond to insurance products in Uganda.[12]

From the outset, it must be realized that the society is generally not well educated about insurance and the concept of risk pooling. When one is dealing with low levels of understanding of a concept, simplicity and clarity are very important. It was surprising that the very people who were meant to sell these products did not understand them well enough themselves. Even where a product was mandatory, such as the AIG Group Personal Accident policy offered by most MFIs, credit officers in both Faulu Uganda and FINCA Uganda were open in admitting that they were still grappling with grey areas and many clients complained that they had asked many unanswered questions. It is of utmost importance therefore that the individuals selected to market micro insurance products be competent people, well informed about the products, well trained, and well motivated. Significant investment has to be made in this exercise.

When one is dealing with low levels of understanding of a concept, simplicity and clarity are very important.

Where an insurance product is going to be marketed or delivered by a third party, it should always contribute added value to the success of the product. The third party should as much as possible have some kind of a stake in the service or product being delivered.

Almost none of the respondents from the focus groups seemed to be fully convinced that the MFI insurance policies were really put in place for their benefit. The restriction to “accidental death” was seen as some kind of a trick and many respondents expressed the view that if the MFIs really care about them, this policy should cover all manner of death even for their immediate families.

Commonly MFIs are charging a 1% fee on loans as the premium. Where it went above that, some clients (e.g. Faulu) did complain. It must be especially noted that where loan sizes became really large, especially on individual loans (where for example the largest individual loan in Faulu Uganda at the time of writing this report was Ushs 10,000,000/- repayable over one year with an insurance premium of 2.25% of loan value) the premiums became extremely expensive.

3.1. What types of risks are good candidates for insurance and why?

“Not all risks are insurable. There are seven basic insurance principles that determine whether a loss is insurable:

[12] Much of the demand information in this section is based on the studies of Grace Sebageni in “*Assessing the Demand for Microinsurance in Uganda – Final Report.*.” Published in Nairobi by *MicroSave* in 2002. It relates to extensive participatory rapid appraisal based qualitative microinsurance demand research that she conducted. A brief discussion of qualitative versus quantitative research, and why qualitative research was most appropriate for this study is provided as Appendix 6.

1. The loss must occur by chance, and not be caused intentionally by the insured.
2. The loss must be definite, with reasonable confidence that the loss indeed occurred, and its loss must be measurable.
3. The probability of the loss occurring must be calculable as this is a key component in setting the premium.
4. There must be a large number of similar insured units exposed to the risk because of the law of large numbers which states that the larger the sample observed or studied, the more likely accurate the estimate or prediction.
5. The loss must not be catastrophic, creating losses for large numbers of insured at the same time as costs might be beyond the insurer's ability to honour claims. An insurer can avoid huge losses by means of reinsurance or the transfer or some or all risk to other insurers.
6. The policyholder must have an insurable interest in the event, and this event must cause a genuine loss to the policyholder. Ownership of property and family or financial ties of a beneficiary are two ways of establishing an insurable interest.
7. Premiums must be affordable.

These fundamental principles guide, on the most basic level, what can and cannot be normally insured. Thus, for example, a non-suicidal death can be insured, while school fees or marriages normally cannot."[13]

In terms of microinsurance, the practicality of selling and managing these products requires simplicity, innovative premium payment mechanisms, and the ability to implement effective controls against moral hazard, adverse (or anti-) selection, fraud, and overuse. Because of these, the available number of options for more complex products is proportional to the insurance specific management expertise available. For example, an MFI might be able to offer basic credit life insurance on its portfolio, but it would take an insurer with health care financing expertise to offer health insurance. Because of this, the most prevalent microinsurance is credit life, followed by other life covers (where a settlement is made to beneficiaries), and some health cover and (very limited) property insurance. What can be offered is directly related to a combination of the demand and the institutional capacity.

In terms of health insurance, an additional fundamental input is required - at least one provider of quality health care services. Without available quality services, insurance cannot reasonably be sold. The purpose of insurance is to help people manage risks. Sending them to poor quality facilities will have a negative impact on them through poor care, and will be more costly to the insurer due to additional costs related to the poor care. This is a limiting factor to growth (especially geographically). In Uganda, health microinsurers are either directly related to a single provider, or work through a network of mission hospitals. Public hospitals are not seen as options for insurance because of their recent policy of no cost health care, though even with this, the is limited quality, and difficulty in managing the controls.

It is possible for insurers to improve the quality of care to providers that are least reasonably good to start with. The additional level of oversight can be quite beneficial to policyholders. For example, many people spoke of "shotgun" treatment (provided when a doctor does not know what is wrong so prescribes an array of medicines with

[13] The Working Group on Microinsurance. "Preliminary Donor Guidelines for Supporting Microinsurance". October 2003, pp 27-28. Accessible from www.microinsurancecentre.org.

the hope that one will cure the illness). In a number of cases, microinsurers have been able to curb this practice by not paying for such treatment and requiring a real diagnosis and its related medicines.

3.1.1. Risk in the Uganda Context:

The risks faced by the participants of the focus groups are shown below. This table does not reflect the level of perceived severity of the risks or the level of concern of the participants, it simply reflects those issues that were identified by the focus groups. They included:

Theft	Accidents	Water Shortage	Forced change of business premises
Sickness	Fire	Animal/Poultry diseases	Loss of goods in transit
Death	Weather		
Price Fluctuations	Bad debts	Crop diseases	

Taking those identified risks, and further refining them into risk components, the focus groups were then directed to rank them in order of severity of the impact on their household finances when these risks are faced. In terms of these risk priorities, the highest priority risks for mitigation mentioned by participants were, in order:

1. Health related risks
2. Death
3. Disability
4. Loss of assets due to idiosyncratic risks (e.g. fire, theft, evictions, loss of goods in transit)
5. Loss of assets due to widespread disaster (drought, floods, earthquakes etc.)
6. Crop and animal diseases (perhaps including loss through malicious damage, such as risks to fish traders when fish were being poison)

It is important that great flexibility be availed in making premium payments, including payment during harvest periods, special insurance savings products, premium loans, standing orders from savings accounts, and other options that improve ability to pay.

"Finally, the concept of insurance should be widely taught with extensive public awareness campaigns. Insurance education should also be incorporated into the training manuals of microfinance institutions and offered by them as a financial services option."[14]

3.2. Who Demands risk Management Services?

The demand for risk-management services among the low-income markets has been significantly retarded because of a lack of understanding of the option of formal risk management tools. This lack of knowledge or bad attitudes towards insurance hinders the ability of any insurance product to reach a massive market.

Indeed, even among the formal business sector insurance expenditures are limited. Kenya is said to do twenty times as much insurance business (by gross premiums) as Uganda. Based on the size of the economies, this should be closer to four or five times Uganda's activity. Clearly, the Uganda market is much less vibrant than that of Kenya.

[14] Grace Sebageni. "*Assessing the Demand for Microinsurance in Uganda – Final Report*." Nairobi, MicroSave, 2002. p.30.

This suggests significant opportunity in Uganda given identification and remedial action on the causes for the low uptake.

Details of the life, non-life, and brokers business activity helps to identify some of the trends in the insurance business and what products are in demand.

The Non-Life Insurance business includes all short terms insurance products. The table below shows that Motor insurance is the largest single category of insurance demand. This is because of the GoU regulation that requires third party motor insurance. The other miscellaneous types include business insurances as well as the group personal accident offered to MFIs[15] and others. The growth rates of these products have been substantial. The loss ratios (the percentage of premiums expended on claims) in the 15-45% range are very low compared to other countries. This suggests inefficiencies in the industry that would inflate the premiums. A likely cause of this inflation is that there are too many insurance companies and many of them are unable to survive without very high margins. This problem should begin to adjust itself given a consolidation in 2005.

Uganda - Insurance Companies' Gross Premiums and Loss Ratios

Non-Life Insurance

(in thousands of US$)

Years	Fire	Marine	Motor	Misc Acc.	Total	Total # Insurers	# non-life insurers >1 bill in annual premiums	Avg. total premiums non-life
Premiums (using annual exchange rates)								
2000	4,223	2,091	7,841	7,025	21,180	18	7	1,177
2001	4,124	2,705	7,875	9,815	24,519	16	10	1,532
2002	4,863	2,525	9,305	11,061	27,754	18	9	1,542
Year to Year Changes								
2000/1	(2%)	29 %	%	40 %	16 %			30 %
2001/2	18 %	(7%)	18 %	13 %	13 %			1 %
2000/2	15 %	21 %	19 %	57 %	31 %			31 %
Loss Ratio by Class								
2000	14 %	40 %	44 %	38 %	35 %			
2001	13 %	27 %	49 %	32 %	34 %			
2002	17 %	52 %	42 %	30 %	34 %			
Average	15 %	39 %	45 %	32 %	34 %			

Source premium data: Uganda Insurance Commission (author's calculations)
Source exchange rates: CIA World Fact Book – Uganda[16]

Life insurance production has been dismal in Uganda. Although there are five licensed life insurers only four have written policies, and only one has written more than US$500,000 in any year. One other, AIG, has let their life license lapse and is simply paying out benefits for an old portfolio.

[15] The premiums from the GPA policy offered to MFIs amount to about 14% of the total in the "misc. acc." Category, or about 6% of the total non-life business written in Uganda.
[16] Ugandan shillings per US dollar - 1,797.55 (2002), 1,755.66 (2001), 1,644.48 (2000), 1,454.83 (1999), 1,240.31 (1998)

The universal explanation for this extremely limited life insurance activity is that in 1987, in an effort to control the economy, the currency was devalued to 1%. This left long term savings and life insurance benefits virtually valueless. Subsequent to this major devaluation, the currency was further devalued by 30%.
Prior to these devaluations there were several additional life insurers, many of whom were said to have been doing significant business. These devaluations however, completely dried up demand for life products among the market.

> One insurer relates the story of a man who had a well-endowed whole life policy pre-1987. When he came during the 1990's to collect the proceeds, he spent more for the taxi ride to get to the insurance company than he collected as his benefits.

The trust and understand of these products has not returned, and there has been little done to improve the situation. No major campaigns have been undertaken. No real effort to revive the life business has occurred. That said, the Commissioner of Insurance has indicated a strong desire to see more life business activity, but is not in a position to pressure insurers into this side of the business (he heeds to remain neutral in terms of product lines).

It has been fourteen to seventeen years from the devaluations. Demand from the low-income market is strong for life products (as indicated in the Cohen and Sebstad demand research, as well as that by Sebageni). This is a good time for life products to be reintroduced, at least to the low-income market.

One company, National Insurance Corporation (currently a parastatal expected to be sold by the end of the year) has had seven new life products designed by a South Africa actuarial firm (QED Actuaries). Management expects these products to be offered to the wealthy and middle level markets, without any effort to sell them to the low-income market (there are likely design problems relative to the low income market that would require significant adjustment to work for this market). The progress of these products should be monitored to better understand the demand structure of such products.

The loss ratio on life insurance is also extremely low and extremely profitable for these insurers. This provides some room for premium reductions if volumes could be increase substantially. Because of the profitability potential, these products should be interesting to insurers, if they could overcome the cost of sales, and the market acceptance of these products in general.

Uganda - Insurance Companies' Gross Premiums and Loss Ratios							
Life Insurance							
(in thousands of US$)							
Years	Indiv. Life	Group Life	DAP (Investments)	Total	Total # Life Insurers	# life insurers >1billion in premiums per annum	Avg. premiums life
Premiums In Thousands of US$ (using annual exchange rate)							
2000	101	581	1,939	2,621	2	1	1,310
2001	68	690	1,619	2,377	4	1	594
2002	43	292	1,727	2,062	4	1	515
Year to Year Changes (US$)							
2000/1	(33%)	19 %	(16%)	(9%)			(55%)
2001/2	(37%)	(58%)	7 %	(13%)			(13%)
2000/2	(58%)	(50%)	(11%)	(21%)			(61%)
Loss Ratio by Class							
2000	6 %	8 %	30 %	25 %			
2001	3 %	41 %	36 %	37 %			
2002	23 %	12 %	36 %	32 %			
Average	9 %	24 %	34 %	31 %			

Source premium data: Uganda Insurance Commission (author's calculations)

Source exchange rates: CIA World Fact Book - Uganda

The insurance brokers in general have not shown much innovation. The “industry” is dominated by one broker, Aon (the largest broker in the world), which generates about 60% of the total income of 26 brokers. Aon has developed a health care administration department to assist its premium customers in addressing their responsibilities to their employees. This has proven awkward for Aon, and outside their core business. Thus, they have sought out proper health care financing, but have found none. To address this, Aon is leading an effort to license Microcare Uganda as a health insurance company providing health cover for the low-income market. This effort is likely to be supported by DFID’s Financial Deepening Challenge Fund. There is a strong new broker coming to Uganda from South Africa, and this is likely to shake up the current “industry” and may push them towards further innovation.

Uganda - Insurance Brokers' Gross Income						
(in millions of Uganda Shillings and Thousands of US$)						
	AON	All Others	Total	AON Market Share (by income)	Total # Brokers	# Brokers with no income
Broker Income (millions of Ushs)						
2000	1,738	1,118	2,856	61%	32	6
2001	2,028	1,454	3,482	58%	28	2
2002	2,390	1,772	4,162	57%	26	1
Year to Year Changes (Ushs)						
2000/1	17%	30%	22%		-13%	-67%
2001/2	18%	22%	20%		-7%	-50%
2000/2	38%	58%	46%		-19%	-83%
Income in Thousands of US$						
2000	1,057	680	1,737			
2001	1,155	828	1,983			
2002	1,330	986	2,315			
Year to Year Changes (US$)						
2000/1	9%	22%	14%			
2001/2	15%	19%	17%			
2000/2	26%	45%	33%			

2000 US$1=Ushs 1,644.48
2001 US$1=Ushs 1,755.66
2002 US$1=Ushs 1,797.55

Source premium data: Uganda Insurance Commission (author's calculations)
Source exchange rates: CIA World Fact Book

There are also two prominent health maintenance organisations (HMO) - AAR Health Services (AAR), and the International Air Ambulance (IAA). These are generating large numbers of covered individuals (over 4000 at the time of the visit) who pay, or whose employers pay, for managed care cover. These unregulated enterprises and have grown to a size and prominence that the Commissioner of Insurance has become concerned about their status.[17] Several major companies have been drawn to these HMOs as a means of efficiently covering the health care needs of their employees.

During the visit, IAA launched an addition to its "gold" policy, anti-retroviral drugs for employees at no additional cost (total cost for the Gold card is US$160 per person per year which is substantially beyond the range for the low-income market). This is the new area for market competition in Uganda. AAR is also trying to obtain anti-retroviral drugs for their clients, as is Microcare (which works with the low-income market).

Finally, there are informal mechanisms for funeral and health care assistance. Low-income people frequently use these systems that often have more social importance than financial. These are often the only products available for the informal sector and low-income households, while all the other options are available for the middle and upper income levels.

[17] At this point the issue for the commissioner is more their prominence with one of them actively marketing themselves as an insurance company, which is clearly illegal under the insurance statute.

3.3. How is the Market Segmented?

The market for insurance and social protection is clearly segmented by employed status. Those that are formally employed generally have access to some level of risk management tools through their employer. Employers usually have a substantial role with the burial of employees and their family members, and they usually offer some form of health care financing, either on a reimbursement basis, or through direct relationships with providers. These people also contribute to the National Social Security Fund that currently offers a provident fund.

Those that are not formally employed can access informal risk management networks, as well as social protection structures relating to health care. Some also have access to GPA cover through MFIs, and others can access health care financing through Microcare (though their outreach is very limited currently).

3.4. Effective versus Potential Demand

3.4.1. Willingness to pay / Affordability

Willingness to pay and affordability of microinsurance in Uganda have several components.

> "**Affordability**" – a function of:
> The needs – product match
> The mechanism of premium collection
> The total cost
> Product understanding and trust
> Household income

When these factors are addressed in the design of a product, it is much more likely to attract real demand.

3.4.2. What is the Estimated Demand for Microinsurance Services?

The demand for different products will be different based on the affordability factors noted above. Assuming that these factors are in preferential alignment, the demand for risk management products is likely substantial.

Based on estimates of the volume of the likely market for microinsurance, and conservative uptake ratios for life, comprehensive health, in-patient health, and property insurance (fire and theft) the following represent the likely effective demand for these products if offered as voluntary (not mandatory as with the AIG product):

Product	Estimated Total Potential Market Volume	Conservative Uptake Factor	Conservative Estimated Effective Demand	Potential Annual Premiums (US$)
Life (general)	8 million[18]	20%	1.6 million	4 million
Comprehensive Health Care	8 million	10%	800,000	24 million

[18] Includes four million adults and an equal number of minor dependents.

Product	Estimated Total Potential Market Volume	Conservative Uptake Factor	Conservative Estimated Effective Demand	Potential Annual Premiums (US$)
In-Patient only health care	8 million	1%	80,000	0.8 million
Fire and theft	2 million[19]	25%	500,000	1 million

Additional research on effective demand would be necessary before any significant investment in the market.

4. Supply of Microinsurance in Uganda

4.1. Who are the current and potential suppliers of Microinsurance in Uganda?

Several products are being supplied to the low-income market by an array of suppliers formal, informal, government, and others.

- Health
  - Microcare, Uganda Community Based Health Financing Association (UCBHFA), Foundation for the Advancement of Small Enterprises and Rural Technologies (Fasert), mission hospitals, Government providing "free" care, Ingozi societies (stretcher groups to take people to the hospital when they are in need), two HMOs.[20]
  - New entrants are limited. The HMOs will likely continue their focus on the middle and upper market. Insurers like Lion Insurance and Phoenix Insurance (both with new owners) state that they will offer health insurance but it is unclear if this is actually a part of their business plan, or simply a ruse to facilitate their application with the commissioner. Regardless, it is unlikely that they will work the low-income market. The community and hospital based programs will likely close due to management and funding problems unless significant and professional intervention is provided. Informal mechanisms will continue. Microcare will move from its pilot phase to rollout. United Insurance management has indicated that their board has mandated entry into the health care financing area. However, this is unlikely to impact the low-income market.
  - There is scepticism among the insurers about offering health insurance because of the dramatic failure of Pan World Insurance's bankruptcy attributed to their health product. Their problems were clearly related to very weak controls, but it will take someone being successful to get the others to notice.
- Life
  - Life cover for this market is supplied by funeral groups, and AIG (for credit life only).
  - During the visit two insurers sought out the author to discuss the issues surrounding creating a complementary life product to complete the AIG GPA product.
  - Others with a life license noted that they would be interested in the low-income market if they could access it efficiently, and have some way to

[19] Those with businesses at risk from fire or theft.

[20] Note that IAA stated that other than their international evacuation cover they have no insurance or reinsurance. This creates a dramatic risk. AAR notes that all their in-patient cover is insured by a regulated insurer.

market these products so that people gained confidence in these products.
    - Life provision has on the wealthy level has been extremely limited, but insurers are beginning to see the opportunities in the market, but still recognise the need to overcome severe negative attitudes in the market.
- Group personal accident
    - AIG offers a group personal accident policy through most MFIs. They have rapidly expanded throughout the MFI industry. They have noted an interest in providing property covers, but need assistance in addressing the control issues.
- Disability
    - Disability cover is offered as part of the AIG product, but otherwise this product is not available to the low-income market.
- Pensions
    - Several of the very large companies manage their own pension scheme for their workers, but otherwise it is only the NSSF that offers a provident fund payment at retirement. NSSF is currently accessible to about 5% of the working population of Uganda.
    - The NSSF is being restructured and there is a hope from the insurance industry that the pension management will be opened to private investment. However, there appears to have been no realistic consideration of pension plans for the low-income.
- Property
    - Upper market real property insurance is limited and provided by AIG through the Housing Finance Company. The HFC noted that they could open the mortgage business to lower income borrowers if they had specialised property insurance products, however they also require written books of account which are usually not kept by people in this low-income market.
- Rainfall
    - CeRuDeB had planned to test rainfall insurance in Eastern Uganda, but this has not been implemented. It appears that CeRuDeB, formerly an MFI bank, is moving back up market and away from the low-income clients.

4.1.1. Government

Government and IAA (an HMO) are offering "free" anti-retrovirals (IAA as a no cost addition to their $160 per person per year policy). The GoU has recently finalised a national policy to provide free anti-retroviral drugs to needy people living with AIDS.[21] Details of the implementation are still being developed.

In 2001, the MoH abolished user fees at state medical facilities. This has led to a doubling of utilisation at the facilities, and has had an effect in pushing people with funds out of the free system so that they can access better quality care, and experience shorter wait times. Patients noted that although some services are free, the one that often is most expensive – the drugs – are usually not available at the hospitals, forcing people to search for them at external pharmacies.

[21] From a speech by the President of Uganda read by the State Minister for Health Dr. Alex Kamugisha reported by Anne Mugisa, in "Govt finalises plan to offer free AIDS drugs" The New Vision, 21 January 2004.

4.1.2. Parastatal Insurers

NIC is a licensed Life and General Insurer. Their life business has fallen by 30% between 2000 and 2002. They are currently in the process of privatising, and expect a sale by the end of the year, given the alignment of several factors. Previously an attempt to sell it was aborted with two bidders, Met Life of South Africa, and United Assurance (Uganda). Met life abandoned the process, and United required certain guarantees from the government due to the poor state of the accounting. This problem has been cleared and the current transaction analysts note that this is best prepared parastatal insurance company they have worked with.

The Executive Chairman noted that they intend to launch seven new life products over the next few months. These products (annuity, endowment, term life, education, funeral, and two others) will be offered to the employed market first.

4.1.3. Specialised Microinsurers (regulated)

There are no regulated specialised microinsurers in Uganda. Microcare will be applying for a license as an insurer and will focus on the low and medium income market.

4.1.4. Downscaling Formal Insurers

AIG Uganda has offered a group personal accident policy to MFI clients since 1996. The product started as voluntary, but in 1998 became mandatory for the test MFI. Starting in 2000, the product was rolled out to almost every large MFI in the country where it has been a compulsory product (or simply purchased as part of the interest expense). This product has grown to cover 2.9 million lives in Uganda, and is said (by AIG) to have generated three billion Uganda shillings in premiums last year. This represents twenty percent of their total premiums for 2003. Other insurers are showing interest in moving down market given assistance in market development.

4.1.5. NGOs (unregulated)

NGOs will continue in this market, but none have shown the likelihood of sustainability.

4.1.6. Credit Unions and Cooperatives

The Credit Unions and Cooperative movements are extremely weak in Uganda. It is possible that some could act as agents for insurance companies, however additional research into their capacity would be necessary prior to any investment. Given proper operations and reasonable management these could offer an important conduit to the low-income market.

4.1.7. Hospitals

Mission hospitals will continue to offer health care cover. At least until they realise the full cost of these programs.

4.1.8. Other Suppliers

The social mechanism that people have used will continue and any new products should be complementary to these rather than expecting them to be eliminated. The social benefits of these are much too important to expect them to disintegrate.

4.2. What is the anticipated Market Evolution?

Given no change in the market, the insurance industry will grow based on premiums from upper middle and upper income levels. It is unlikely that insurers will move into this market, and the informal sector programs will become less and less relevant in financial terms. NGOs will also diminish as these programs, most of which are in rural areas, will collapse under the weight of poor premium pricing and limited management capacity.

If some relatively simple interventions are made there could be substantial expansion of the industry through the range of income levels. These will be addressed in the recommendation section.

AIG Uganda has shown that Group Personal Accident policies sold through MFIs can be profitable, with returns of +/-30% on premiums. Health insurance has been less successful but the trend is promising. Property insurance has been untested, except for government crop insurance which was a dismal failure (as in so many other places). Because AIG has not advertised its success, it was not well known in the market.

During the visit, the consultant discussed the popularity and potential of AIGs product with several insurers. Life insurers especially were interested as they saw a gap in AIG's cover that they could fill given AIG's lack of a life license. Subsequent to obtaining the information insurers approached AIG and one has now developed a product to sell with the AIG group personal accident policy. In this case, as elsewhere, all the life insurers needed was information about the current and potential success. Insurers are looking for new markets and as they come to see the low-income market's possibilities, many become interested. Such a market evolution is beginning to be seen in other countries as well, as information on this market begins to filter out.

Clearly, others who were told of this success did not move towards this market. They were not interested in entering new markets, or working with AIG, or competing with AIG for these clients. Such "competitors" are seen in most markets and they simply allow the others to do the innovation.

5. The Legal and Regulatory Environment

The insurance act (1996) and statutes (2002)[22] do not recognise microinsurance as different from insurance. There are no special provisions for insurance provision to the low-income market. There are no restrictions to insurers providing products to these markets. As with all new products, however, any microinsurance products will need to be reviewed and approved by the Commissioner.

Two issues of concern arise relative to insurers using MFIs and other groups as agents.

(1) Insurance statute 1996, Section 8, item 72 notes that "no person shall carry on the business of an …. insurance agent ….unless he is licensed for that business by the Commission." Two issues arise here: (a) there is no accommodation for institutional agents such as MFIs, and thus (b) any individual selling insurance as an employee of an MFI or other organisation would need to be licensed. None are at this point.

[22] These documents will be attached as an appendix to this paper.

(2) Insurance Statute 1996, Section 4, item 41 notes that "An institution falling under the financial institutions Statute of 1993, shall not oblige any person transacting business with it to deal with a particular intermediary for an insurance policy or to insure with a particular insurer in connection with business being transacted." Though most intermediaries fall outside the financial Institutions Statute some like the HFC are potentially in breach of the Statute. Additionally, when MFIs start to obtain licenses as Microfinance Deposit Taking Institutions this may create a conflict. Potentially the AIG product would need to be reviewed, and unless there is competition in the market, it will be difficult to provide options to clients.

Other than these issues, insurers are totally free to develop, sell, and service products for the low income market.

5.1. What are the Legal and Regulatory Frameworks?

The Insurance Statute of 1996, and the Insurance Regulations of 2002, govern the insurance business in Uganda. An Insurance Commission supervises adherence to the Statutes and Regulations with the overall mandate to protect the interests of the insurance consumer. All insurers are required to maintain membership with the Insurance Association and adhere to their Code of Conduct.

5.1.1. Framework for unregulated insurers

There is currently no special framework for unregulated "insurers". The commission is currently seeking suggestions from the industry about how to address the two significant HMOs (AAR Health Services and International Air Ambulance).

5.1.2. Framework for MFIs

The insurance act forbids any organisation from conducting any insurance business without a license (Insurance Statute 1996, Section 1, item 3). Thus, MFIs cannot legally develop and sell their own insurance products without a license. There appears to be no specific Statute that precludes an MFI from operating an insurance business, as long as they comply with the requirements for a license.

6. Developing a Microinsurance Sector in Uganda

6.1. Creating an enabling environment at the policy level

At this point the policy level is neutral to microinsurance mostly because it has not shown up on their radar in any significant way. The issue with the HMOs, and especially IAA (who post a sign selling their "insurance" on the main road in Kampala) has made the insurance commission begin to take notice. There incentive for them to look at these because (1) they are mandated to protect the consumer, and (2) the commission is funded through the receipt of 1.5% of all policies written. So far, however, the Commission has ignored microinsurance because "they are doing a good thing." This is a common approach to microinsurance the world over.

The government is making significant investments in social protection mechanisms, and actively works towards providing risk management tools to this market. However, their abilities are limited. What will be important is that microinsurance initiatives are complementary to social protection measures, as well as local strategies.

6.2. Building an enabling environment through donor coordination and stakeholder education

Stakeholder education is much more important in developing an enabling environment for microinsurance. Poor understanding and negative attitudes are significantly retarding the growth of the insurance industry, and indeed microinsurance. Major efforts to educate the market are fundamental to any significant initiatives in microinsurance. If people can understand insurance, and recognise how it can aid them, this would be the most important step in building an enabling environment.

Donor coordination in Uganda has traditionally been exemplary, especially with regards to the low-income financial sector. Where donors can help is by following the guidelines promoted by the Working Group on Microinsurance. At least in the broad picture the most active donors learned a strong lesson from the intervention of DFID and their creation of the UCBHCFA. This has shown that there are particular competencies required on the part of the donor and the partners, and has made others reluctant to enter this market.

The ILO SEED and STEP programs have been active in providing trainings for community- and hospital-based health microinsurance programs. The problems with these have been discussed elsewhere in this document, and continued intervention by these organisations seems to have little impact.

6.3. Creating Demonstration Models

6.3.1. Supporting New Entrants

There are no licensed insurers providing health care cover in Uganda at this time. This is the most important microinsurance product for the low-income market because of the severe damage to family finances that often result from these events. A new entrant into the regulated health microinsurance market would be important. Microcare expects to legalise its operations as the first regulated health microinsurer. Support is expected from DFID, but as this company expands there will be very important support requirements to help them to maximise their positive impact.

6.3.2. Supporting Current Players

From this visit, it was clear that there are insurers interested in this market and that relatively few significant interventions would mitigate the barriers to their successful entry into the low-income market. Some fundamental interventions that would have a dramatic impact on microinsurance include:

- Market education – to create a receptive audience for their products
- New mortality tables – so they can have a more accurate means of assessing their insurance risk (current tables are from 1962)
- Insurance training for the industry – management laments that staff are woefully uneducated in their business

Without these issues addressed, insurers will remain reluctant to invest in expansion to the low-income markets.

6.4. Supporting Innovation

Insurance management, the Association, the Brokers, and the Commission all agree that there has been very little innovation with insurance products in Uganda since

before the currency collapse of 1987. The large insurers seem reasonably happy with their product range, or they admit that they have not had the staff able to follow a new product development process. Smaller insurers have had limited capital to invest in research and development, and especially now when they are desperate to meet the new capital requirements it is unlikely that they will invest, even if it means the potential for higher earning in the future. Their future is 2005.

Supporting research and development among Uganda insurance companies, even working with them to understand a demand led new product development process most likely to lead to success would be an important input to developing competition and an array of microinsurance products.

7. A Possible Role for Intervention

Though still nascent in many ways, microinsurance is beginning to show itself as a profitable product for insurers and MFIs, as well as a valuable tool for low-income people in mitigating their risk. Among the best examples internationally are in Uganda, including the AIG product offered through MFIs which provides a 25-30% profit on premiums to the insurer, as well as 25-50% commission to the MFI, both of whom experience limited operational costs because of the partnership. In terms of health, clearly Microcare is moving towards profitability, though on a much lesser scale than AIG. The low-income market in developing countries is proving both profitable to the insurer / MFI partnerships, and important to the low-income market. There is much scope for scaling up the provision of these products in an efficient manner, and donors can have a clear and positive role in opening this market to professional insurance products.

In identifying opportunities for intervention, a list of principles was developed to guide the process. The principles are:

- Formal sector regulated insurers have the most appropriate skills base to manage microinsurance products, and thus they should be worked with as appropriate.
- Efforts should reduce the overall risk in the risk management system.
- There should be no attempt to adjust regulatory requirements for this market.
- Ultimately the impact of the sum of the interventions should be very large, and positively affect low-income people regardless of geography.
- Where the private sector is likely to develop itself in terms of microinsurance, investors and donors should not intervene.
- The demand for microinsurance from the low-income market is for health care financing, than cover for the death of a breadwinner, and then for property risk covers, respectively, with an overwhelming demand for health financing.[23]

Based on the above principles, the information gathered in Uganda and from desk research, three core activities are recommended. These are detailed in Appendix 1. In addition, four other activities are noted because they are fundamental to the success of any significant effort to expand microinsurance in Uganda. These suggestions are detailed in Appendix 2.

The core suggestions:

[23] Monique Cohen, Michael J. McCord, and Jenefer Sebstad. Reducing Vulnerability: Demand for and Supply of Microinsurance in East Africa – A Synthesis Report. *MicroSave*, December 2003.

1. An equity investment in Microcare to aid it in significant expansion of its product line and / or its products beyond the borders of Uganda. (Additional information on Microcare is presented in Appendix 5).
2. A pseudo-reinsurance mechanism to incentivise an insurer to work with the significant community- and hospital-based health microinsurance programs. The insurers would take the complicated insurance activities from the management leaving them to simply sell the products.
3. A precondition to the success of these and any other microinsurance development or expansion is, at a minimum, a major market education campaign designed to get the low-income market (and others by default) to gain some confidence in insurance products, and recognise how they can benefit from such products.

Additional suggestions:

1. Upgrading the insurance institute to provide relevant training on microinsurance delivery, as well as fundamental insurance theory and practice.
2. Update the mortality tables to reflect the reality of HIV/AIDS.
3. Conducting the research and development for the testing and introduction of three new microinsurance products, based on market demand.

Details of both sets of suggestions are provided in Appendix 1 and 2.

In this list there are limited suggestions related to life insurance and pensions. This is the case for life because there has recently been significant interest from the private sector in entering this market, either as a partner of AIG (filling the natural death void in the GPA policy sold to MFIs), or on their own. As these are private sector initiatives, the suggestion is to let them move forward without additional inputs on these products other than the related suggestions.

Three of the above suggested options, if implemented will improve the potential for life insurers to move down market: the marketing campaign (to create a positive image of insurers); upgrading the insurance institute (provides the opportunity to develop specific courses to aid insurers in developing and selling appropriate products to this market); the updated mortality tables will allow them to improve pricing and understand the risks better, as well as the product development suggestion.

With a life license comes the opportunity for an insurer to offer long-term savings products such as endowments and pensions. These may become opportunities for intervention; however, it is impossible to identify particular interventions at this time. In Uganda now there is a highly contentious attempt to restructure the National Social Security Fund, partly to convert it from an endowment program to a pension plan. The draft of this plan (at the time of the visit) indicated that almost all such long term savings would be controlled by the NSSF. The insurers, and many others in the business community, were outraged and had mounted a counter argument for this structure. This process, currently funded by the World Bank and DfID, is likely to go on at least through 2004. Once this is settled out, it would be appropriate to review the final structure and identify potential interventions at that point.

8. Conclusions

Uganda is a country where much has already been done in terms of microinsurance, but where there is strong demand for more and varied products. The unregulated sector

has a number of microinsurance activities around the country, mostly for health care financing, and most desperately clinging to life because of extremely limited capacity. There is Microcare which is planning the process of licensure as a regulated insurer. AIG offers a group personal accident policy through MFIs. The government has made dramatic investments in health care financing and infrastructure. The insurers have not come down market but are eager to do so if the environment were more amenable. Still, there is huge potential for microinsurance with its various products in providing the risk management tools that the low-income market needs.

Qualitative research has identified significant demand for risk management products. The supply on a significant level is limited to two companies one for GPA and one for health. The policy and legal environments are conducive to microinsurance and impediments are extremely limited. The insurers and brokers have simply not seen this market and its potential. What is missing from this market are some fundamental points that if corrected should provide for a dramatic expansion of all types of microinsurance, and an expansion of competition that will help ensure that the low-income market has access to professional quality products, at a reasonable price.

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Appendix 1: Core Suggestions

A1.1 Equity Investment in health microinsurer

Problem	There is extremely little professional health care financing available to the low-income markets in Uganda and indeed much of the rest of Africa. Most people go without. Those who do have access to such financing are often cheated by management either directly through graft, or indirectly through incompetence. Microcare Ltd in Uganda (see more details in Appendix 5, Additional Information on Microcare) has shown through its pilot test that it can improve health care access and quality for low-income families. Microcare is just now emerging from its pilot test to greatly expand its market reach. Within the next twelve to twenty-four months Microcare should be in a position to begin the process of both expansion of its product line to life products, and / or expand it system for health care financing to neighbouring countries. However, at this point it is difficult to foresee investors that will be able to make such an investment to make this occur.
Impact	The impact of a lack of availability of health care financing products can range from seeking treatment later in the disease cycle, to liquidating productive assets at deep discounts, to death.[24]
Potential Intervention	A substantial input of commercial equity could provide the input the Microcare would need to expand either or both its products and markets to beyond the Uganda borders. This could have a dramatically positive impact on the health of low-income families.
Likely Intermediaries	Microcare Ltd. Uganda
Type of Financial Investment	Equity investment and Grant
Form of TA	Insurance industry financial analyst (Adam Smith Institute is doing this for the privatising National Insurance Company), insurance management, feasibility studies, actuary, attorney
Estimated Cost	US$ 1.4 million (US$700,000 in equity – US$250,000 in voting shares and US$450,000 in non-voting shares or long term debt, and US$700,000 in supportive TA)

[24] On the timing of health seeking, see Michael J. McCord. "*Health Care Microinsurance – case studies from Uganda, Tanzania, India, and Cambodia*." Small Enterprise Development, Volume 12, Number 1, March 2001, pp. 25 – 38.

A1.2 Pseudo-Re-Insurance Fund to get insurers to absorb willing provider based and community based health care financing programs

Problem	There are numerous provider-based and community-based microinsurance programs throughout Uganda. Many of these were started as part of a DFID grant to form and fund the Uganda Community Based Health Financing Association (UCBHFA). In 2000, the DFID project was discontinued because it was structured with weak controls and perverse incentives. This left numerous institutions with marketing potential but far from financial sustainability. The managers of these programs have limited training and limited oversight and yet are expected to manage all the complexities of an insurance business including premium setting, claims management, control implementation, product refinement, marketing, and others. Many of scheme managers do not have the capacity to manage all these aspects of their businesses. Most of these programs have experienced slow growth, financial difficulties, and numerous other difficulties. The Association that was set up to assist them, itself has limited capacity.
Impact	The impact of these problems is multifaceted. 1. Where there might be potential to improve outreach of quality health care, this is limited by the limited capacity of the managers. 2. In some cases, low-income people are losing their money because of poor management. 3. Mission hospitals that sponsor these programs are potentially losing money because they are effectively taking on the insurance risk of these programs that have poor pricing. (It was noted the many of the mission hospitals themselves to not price their products properly and this is leading to a double loss.[25])

[25] Daniele Giusti, Executive Secretary for the Uganda Catholic Medical Bureau which has a relationship with several Catholic Mission hospitals with such schemes

Potential Interventions	There is some interest from these health care financing organisations to obtain improved insurance management so that their schemes can be better run, and they might have more time to market the product(s). In theory at least, insurers would be the best able to manage the insurance side of this business whish would leave the current managers of the schemes to simply sell the insurance products. Insurers have been reluctant to enter the health financing business even in the upper market. To attract insurers (an insurer?) to take over this business, a pseudo re-insurance mechanism could be started which would act almost as a stop loss policy so that insurers could test this market with very limited risk (at least initially as the risk of the insurer would be scheduled to increase over a period of three to four years). As a preliminary activity to such a fund, it would be important to make a detailed study of the real benefit to mission hospitals of such insurance programs.[26] This intervention could have a large impact on health care in rural areas as these facilities are mostly located in peri-urban and rural areas, and all their catchment areas certainly include rural markets. The intervention would require some risk on the part of the insurer, maybe 20% in the first year, and rapidly declining over three years after which the insurer would manage all risk and reinsure through a formal reinsurance company. The fund would be professionally managed to provide a market return. Quarterly the loss experience and performance of the program would be reassessed, and whatever, if anything, was due the insurer would be paid from the fund earnings and then principle. The relationship management between the insurer and the health care financing programs would be guided with technical assistance.
Likely Intermediaries	Mission hospitals, the Catholic and Protestant Medical Bureaus, the UCBHFA would not be an appropriate intermediary. Possibly FASERT might be an appropriate intermediary.
Type of Financial Investment	Re-insurance fund, grant
Form of TA	A specialist in partner-agent model institutional development (to bring the institutions together and address control and process issues, as well as training, and marketing strategies. Auditors and a supervisory mechanism. Investment plan.
Estimated Cost	US$1.3 million (US$800,000 for the re-insurance fund, and US$500,000 for technical assistance to support the fund).

[26] Dr. Giusti pointed out that because many of the Catholic Mission Hospitals did not have pricing capacity, their prices are less than their costs to provide the services. He argues that insurance programs that bring in more people only increase the losses to the hospitals. Clearly there are other important issues here, however an assessment of the benefits (or detriments) of health care financing would be extremely helpful in the argument to those that do have insurance programs, that they should.

A1.3 Insurance concept marketing

Problem	Low income people (and many middle income people) either do not understand insurance, or have a bad attitude about it because of two issues: (1) The "old" parastatal insurance company and some others before the 1996 insurance law were not efficient at paying claims, and indeed people noted that premiums had to be paid (especially with regards to third party auto insurance) but they seemed to never pay claims. (2) In 1987 there was a devaluation of the Uganda Shilling to one percent of prior value (i.e., 1 million Ushs became 10,000 Ushs) leaving long-term investments virtually worthless. Later there was also thirty percent devaluation.
Impact	The lack of understanding is likely to limit the market uptake of any insurance products offered to the low-end market. Indeed, Microcare and AIG have had difficulty with getting clients to understand insurance. This has led to low renewals (because people had a different understanding of what they bought). The bad attitude leaves people averse to insurance products, especially long-term products. Without adjusting the understanding and perception of the market, any interventions to improve access to microinsurance are likely to face difficulties.
Potential Intervention	A specialised marketing campaign to market the concept of insurance might help to improve both understanding and confidence. This would be a major campaign that would utilise techniques that are found effective with the low-income market. Already discussed are potential radio shows, travelling theatre, marketing linkages, and promotion with low-income persons focal points (banks, markets, agriculture depots). In addition, DFID is planning the production of a video compact disk (VCD) on consumer education. A segment on microinsurance could be included (DFID is eager for this). In addition, a segment on how microinsurance fits into the range of financial options for the low-income market could also be effective.
Likely Intermediaries	The Uganda Insurance Association would oversee the insurance marketing, including the integration with PSDU. PSDU would produce the VCD. The is a USAID project, Commercial Marketing Strategies, which has conducted other marketing campaigns (condoms and mosquito nets) in Uganda and their experience might be helpful in this programme.
Type of financial investment	Grant
Form of TA	o Marketing research to identify effective and efficient marketing mechanisms to get the message to the low-income market, using qualitative research techniques. (Such capacity exists in Uganda.) o Marketing strategy and development and implementation by a microinsurance market specialist. (Likely requires an international microinsurance marketing specialist.) o General oversight of the intermediary in the implementation of the marketing strategy.
Estimated Cost	US$300,000

Appendix 2: Additional Suggestions

A2.1 Upgrade of Insurance Institute for Microinsurance training

Problem	The Uganda Insurance Institute is in rather dismal condition. They are managed as a sub-committee of the Insurers Association, and have their own director and management committee, who appear to "manage" the institute voluntarily. They offered one course last year to the insurer/broker members' staffs. Almost all insurers lamented the lack of education of their staffs in insurance matters. All insurers noted the importance of an educated staff, especially with regards to innovation and active selling and servicing of insurance products.
Impact	This lack of education of insurance staff and management is one reason for the lack of innovation in the insurance market in Uganda. Additionally, when innovative products are brought to the market (such as suggested in 7.2) it will be difficult to get a professional response from these insurance companies because of the limited training. This will hinder growth of microinsurance (as well as products for the traditional market as we have seen).
Potential Intervention	Two potential options might be appropriate depending on several factors: 1. Support for the College of Insurance (Nairobi, Kenya), which is accredited by the College of Insurance (London), to develop and organise a branch in Uganda. 2. Another lesser option might be to invest in curriculum development that would be implemented by the Uganda Bankers Institute that already has an extensive curriculum offering of banking and microfinance.
Likely Intermediaries	Uganda Insurance Association, Uganda Insurance Institute, The Bankers Institute, The College of Insurance (Nairobi)
Type of Financial Investment	Grant, or long-term concessionary debt
Form of TA	Curriculum development specialist, training institute development specialist
Estimated Cost	US$300,000

A2.2 Updated Mortality Tables

Problem	The current mortality tables in use in Uganda currently are from 1962 – before HIV/AIDS was even known. The impact of this disease is devastating.
Impact	The quantitative likelihood of any risk occurring is a primary component in the calculation of risk premium. A lack of understanding of this likelihood leads to both reluctance of insurers to accept such risk, or poor pricing because major risks are not considered. Having professionally constructed actuarial tables would dramatically aid in premium pricing, likely not just in Uganda, but also in the region. A better understanding of these risks will help insurers to confidently provide more to the low-income market.
Potential Intervention	Funding the development of new mortality tables for use in Uganda.
Likely Intermediaries	Uganda Insurance Association, Uganda Insurance Commission.
Type of Financial Investment	Grant
Form of TA	Actuarial firm, Technical oversight, and review.
Estimated cost	US$400,000

A2.3 Research and development on three new microinsurance products

Problem	There has been very little innovation in the insurance market in Uganda. Partly this is due to a lack of funds for investment in research and development, but also because of a limited capacity for innovation.
Impact	Given the general trend in static products in the upper market, it is not surprising that there has been virtually no innovation in the low-income market by the regulated insurance sector – either insurers or brokers.
Potential Interventions	A new product development process could be implemented for three microinsurance products. This process includes extensive demand and supply research (some of this has already been done by the MicroInsurance Centre and MicroSave), which would lead to the design of products and processes in response to that demand and the needs and capacities of the insurance companies. Success will require several important inputs, including: design, development, testing, and implementing a training program for microinsurance for insurers, and one for intermediaries. A product marketing program that focuses specific and effective product marketing to the proper markets (this will be facilitated by 7.1). Qualitative and quantitative market research will be necessary, as well development of procedures manuals and developing processes between insurer, intermediary, and ultimate client. These products would be developed for "the industry" under the responsibility of the project intermediaries (the associations and/or Insurance Institute). Once the products are developed, they would be offered, with training to the insurers and brokers. When these products were sold, the intermediary would charge a commission on them for the first two years and the Insurance Institute could provide classes to train those that are selling and managing these products, both inside and outside the insurance industry. This would provide additional funds on a business basis that these institutions understand to help the associations and institute to improve (develop?) their services to their members.
Likely Intermediaries	Uganda Insurance Association, Uganda Insurance Brokers Association, the Uganda Insurance Institute.
Type of Financial Investment	Grant, however, direct operational funding would come to the associations and institute based on training fees and commissions.
Form of TA	A microinsurance product development specialist, and a curriculum development specialist. These people would work closely with the intermediaries so that the process and skills can be institutionalised with new capacity in the country. The third new product should be developed with mere oversight by the product development specialist.
Estimated cost	US$300,000

Appendix 3: Institutions and People Visited

Life Insurers:

National Insurance Corporation, John Carruthers, Executive Chairman (also Chairman AON Uganda); Florence Obore, Manager Accident and Fire

Insurance Company of East Africa, Jerim Otieno, Assistant Manager; and Petronella Ochom, Tied Life Agent

East African Underwriters, Jim Crossen, General Manager; and Joseph Almeida, Life and Pensions Manager

United Assurance, Gary Corbit, Managing Director

General Insurers:

Lion (formerly Pan World) Insurance Company, Geoffrey Kihuguru, Managing Director

AIG Uganda, Stan Mensah, Managing Director

Statewide Insurance Company, Joseph Kiwanuka, Managing Director; and Geoffrey Musisi,, Technical/Marketing Manager

International Air Ambulance (unregulated), Phoebe Kisibo, Marketing Executive

Insurance Brokers:

Aon Uganda Limited, Jonathan "Johnny" Evans, CEO; and Caroline Athiyo, Assistant Manager Commercial Division

Capital Insurance Consultants (Brokers), Patrick Kaye, Executive Director

Insurance Related Associations:

Uganda Insurers' Association, Geoffrey T. Kihuguru, Chairman; and David Ssebirumbi, Administrative Secretary

Uganda Insurance Brokers' Association, Patrick Kaye, Chairman

Uganda Insurance Institute, Geoffrey Musisi, Managing Director; Florence Obore, Deputy Director; Caroline Athiyo, Board Member; and Petronella Ochom, Board Member

Microfinance Institutions / Banks:

Centenary Rural Development Bank, Dr. Willibrord Okecho, General Manager – Microfinance Products

Housing Finance Company, David Dansor Ninyikiriza, Mortgage Manager

Commercial Microfinance Limited, Tony Singleton, CEO (acting)

Postbank Uganda, Stephen Mukweli, CEO

Standard Chartered Bank, David Cutting MD and CEO; Humphrey Mukwereza, Executive Director – Corporate and Institutional Banking

Microfinance Groups:

Association of MicroFinance Institutions of Uganda, Suleiman Namara, Executive Director

Private Sector Groups:

Federation of Uganda Employers, Rosemary Ssenabulya, Executive Director; and David Etuk, Regional Coordinator

Uganda Manufacturers Association, Marilyn Kamanyire, Policy Manager

Donors:

World Bank, William Steele, Senior Economist
DFID, Adrian Stone, Enterprise Development Advisor
GTZ – Financial Systems Development Programme, Peter Rhode, Programme Director
Financial Sector Deepening Project Uganda (DFID), Paul Rippey, Investment Manager
SPEED (USAID), Joanna Ledgerwood, Microfinance Advisor

Government Representatives:

Uganda Insurance Commission, Frederick Magezi, Commissioner of Insurance; Evelyn Nkalubo-Muwemba, Secretary to the Commission / Deputy Commissioner (Finance and Admin); and George Steven Okotha, Deputy Commissioner (Technical)
Ministry of Finance, Planning, and Economic Development, Microfinance Outreach Plan Coordination Unit, Henry Bagazonzya, Coordinator
Ministry of Health, Rob Yates, Health Economist

Microinsurers:

Foundation for Advancement of Small Enterprises and Rural Technologies (FASERT), Alex Menyha (with four staff members), National Coordinator (providing CBHC)
Microcare Limited, Dr. Gerry Noble, Managing Director

Microinsurance Representatives:

Uganda Community Based Health Financing Association, Namarah Livingstone, National Coordinator
Uganda Catholic Medical Bureau, Daniele Giusti, Executive Secretary (oversees by moral suasion Catholic Mission Hospitals, some of which offer microinsurance).

Large Meetings:

Microfinance Forum, 19 January 2004, met with and spoke before several representatives of donor, government, and microfinance institution managers
Launch of “Free Anti-Retroviral Treatment for Corporate Employees”, International Air Ambulance / PriceWaterhouseCoopers / Federation of Uganda Employers. 23 January 2004. Met with several physicians, and corporate leaders
Monthly Meeting of the Association of Insurance Brokers, 27 January 2004 (spoke on microinsurance and the KfW pre-feasibility study)

Appendix 4: Relevant Documents Collected:

HIV/AIDS: What is Business Doing? A survey of the business community's response to HIV/AIDS in Kenya, Tanzania, Uganda, and Zambia. PriceWaterhouseCoopers. 2004.

Financial Year 2003/4: District Transfers for Health Services, Ministry of Health, July 2003.

Social Security and Pension Reforms in Uganda: The Position of Uganda Insurers Association, Uganda Insurers Association, 2003.

STG's Interim Report on the Proposed Social Security Reforms in Uganda, STG, June 18, 2003.

The Uganda Insurers Code of Conduct, Uganda Insurers Association, May 3rd 2002.

Statute No. 7, *Insurance Statute*, 1996

Statutory instruments, 2002, No. 66, *The Insurance Regulations* 2002

Republic of Uganda: Rural Financial Services Programme, Appraisal Report, 30 September 2002.

The Challenges and Financing of Social Security and Pension Reform ion Uganda: The Tripartate Consultative Process Policy Recommendations and the Way Forward: The Report of the Social Security and Pensions Sector Stakeholder Transition Group (STG). Commissioned by the Minister of Gender, Labour, and Social Development, supported by the World bank, DFID, and Uganda Private Sector Stakeholders. 26 November 2003.

Appendix 5: Additional Information on Microcare

Microcare expects to become profitable during 2006 based on the projections provided below in Table A5-1 Key Ratios. This profitability is based on growth to 100,000 covered lives from several sources including sales through MFIs, sales to low income employees, third party administration, clinic management (all of which Microcare is currently involved on a limited basis). Their growth to date has been rather slow, but they have deliberately constrained growth as they test their product, the systems that manage it, and their financial capacity.

Table A5-1: Key Ratios

	Key Ratios	2004	2005	2006
		£'000	£'000	£'000
	Equity Ratio:			
A	Equity	723	1,320	1,933
B	Net Assets	165	281	835
	Ratio (A / B)	*4.4*	*4.7*	*2.3*
	Current Asset Ratio:			
C	Current Assets	68	191	862
D	Current Liabilities	3	33	146
	Ratio (C / D)	*22.7*	*5.8*	*5.9*
	Liquidity Ratio:			
E	Current Assets less stock	53	176	847
F	Current Liabilities	4	33	146
	Ratio (E / F)	*13.3*	*5.3*	*5.8*
	Return on Investment:			
G	Net Profit (PBT)	0	0	62
H	Capital & Reserves	165	281	835
	Ratio (G / H)	-	-	*0.07*
	Claims to Premium Ratio:			
I	Claims	102	303	926
J	Premiums	111	360	1,224
	Ratio (I / J)	*0.92*	*0.84*	*0.76*

The risk premium (the value or anticipate value of claims) structure is provided in Table A5-2: Premiums. This table shows that although Microcare comes close to breakeven on it claims ratio (claims versus premiums) the actuaries note the necessity to increase the risk premium by as much as 74% for women and children and 6% for men, with a family premium increasing by about 38% (inclusive of the contingency).

Using the actuarially derived adjusted risk premium, the total premium at 100,000 policyholders will need to be around $9.40 monthly for a family of four for a fully comprehensive policy. This volume of clients is realistic given the level of demand as well as several major changes Microcare is implementing including hiring a senior experience health insurance executive, as well as an insurance accountant / controller.

Policy details are shown in Table A1-3 Microcare Health Care Financing Product Details.

Table A5-2: Premiums

Premium Units (in US$)	Current Monthly Total Premiums[27]	Actuarially proposed monthly risk premiums[28]	Actuarially proposed monthly risk premiums (with contingency margin)[29]
Family of four	5.56	6.71	7.54
Adults (male)	1.69	1.59	1.79
Adults (female)	1.69	2.60	2.93
Children	0.81	1.26	1.41

Table A5-3: Microcare Health Care Financing Product Details (taken from Michael J. McCord. "*Microcare Ltd. Health Plan (Uganda): Notes from a visit 17 – 21 June 2002*", MicroSave Nairobi, November 2002.)

PRODUCT	
Eligibility Criteria	▪ Potential clients must be members of a group (not necessarily MFI group) ▪ From each participating group, at least 50% of the members must join the Health Plan (to avoid adverse selection). ▪ Any participating group must have at least twelve premium paying members
Coverage	▪ Outpatient and In-patient services ▪ Surgery ▪ Tests and investigations (x-ray, ultrasound, electrocardiogram, lab tests) ▪ Pharmacy ▪ Maternity ▪ Dental services (fillings, tooth extraction and general consultation) ▪ Optical consultation
Duration of Cover	▪ Policies are written for eight months or one year
Exclusions	▪ Dental surgery ▪ Optical appliances ▪ Sight correction (other than general optical consultation) ▪ Hearing aids ▪ Cosmetic surgery ▪ Self inflicted injury or injury arising from involvement in riots, civil commotion, political or illegal activities ▪ Nervous and mental disorders ▪ Investigation and treatment of infertility ▪ Alcoholism and drug addiction ▪ Injuries resulting from sports

[27] Michael J. McCord. "*Microcare Ltd. Health Plan (Uganda): Notes from a visit 17 – 21 June 2002*", MicroSave Nairobi, November 2002.
[28] Quindiem Consulting. "*Microcare Ltd.: An Actuarial Review*" February 2003.
[29] Ibid.

	▪ Medication for chronic ailments ▪ Private room charges and any other private charges for drugs or surgeon
Limitations	▪ Medications limited to agreed drugs, dosages, and prescription durations ▪ Hospitalisation for patients with chronic illnesses limited to 3 weeks of within an 8 month period (or a maximum of Ushs 350,000 – US$195) ▪ Only services and products from hospitals, clinics, and pharmacies listed on the approved Microcare list will be covered. ▪ Care is provided starting one week after full payment of premiums.
Mode of Delivery	▪ Health care delivery by hospital physicians staff ▪ Agreed health care costs are paid directly to the provider by Microcare. ▪ Administration for health care services is conducted by the Microcare Check-in Desk nurse at each hospital.
PRICING	
Premium	▪ Family of four – Ushs120,000 (US$67) per year or Ushs80,000 (US$45) per eight months ▪ Additional adults – Ushs36,450 (US$20) per adult per year orUshs27,000 (US$15) per eight months ▪ Additional children (below 16) – Ushs17,550 (US$10) per child per year or Ushs13,000 (US$7) for eight months
Method of payment	▪ Lump sum at beginning of period (one MFI is offering a loan product to assist with this payment)
Other	▪ Patients pay a registration fee to the hospital, like all other hospital patients, before consultation with the physician. The fee represents the co-payment, and varies by provider. This fee ranges from Ushs1,000 to Ushs3,000 (US$0.56 to 1.68) with after hours consultation costing slightly more. ▪ For families covering more than eight members or wanting to make changes to the ID card within the period of the policy, an additional card must be purchased at Ushs5,000 (US$3).
PLACE	
	▪ Services are available at 4 hospitals in the Kampala area – Nsambya, Rubaga, Kibuli and Kisubi, as well as Metromed clinic. Selection of their provider is entirely left to the clients on an incident-by-incident basis.
PROCESS	
Enrolment/Renewal	▪ Group members pay the premiums, completes enrolment form, and provides passport photos of intended beneficiaries ▪ Clients receive their identification cards one week later ▪ Clients are entitled to services commencing one week after payment of premiums
Receipt of Treatment	▪ A detailed process map covering access to health care under the Microcare methodology is provided as Appendix 3. ▪ A copy of Medical Treatment Access Card (MTAC), tracking activities and fees is returned to check-in desk for onward transmission to the head office, and the patient receives a

	copy for their records.
PHYSICAL EVIDENCE	
	▪ Clients receive ID cards with unique numbers for each client and their dependents. These ID cards include photos of the insured members (received upon payment of premium) ▪ Enrolment forms ▪ Check-in desks in the reception area of each participating hospital.
PEOPLE	
	▪ There is a Microcare check-in desk nurse posted at out-patient department of each provider facility ▪ These front line desk staff are all trained nurses to improve the quality of information tracked, the ability to explain issues to clients, and the ability to provide basic quality control over in-patient clients' care. ▪ The success of the product is highly reliant on the doctors and staff of the hospitals, clinics, and pharmacies with which Microcare works.
PROMOTION	
	▪ Word of mouth through marketers ▪ Brochures ▪ MicroFinance Institution front line staff ▪ Microcare senior management marketing to MFI senior management ▪ Commissioned marketing staff ▪ The check-in desks themselves are promotional

Appendix 6: Some comments on qualitative versus quantitative research

Market research is a critical step in understanding a market and the consumers within it. It is appropriately used at critical points along the process of a controlled product development process. Two broad types of market research may be conducted: "qualitative" research and "quantitative" research. These methods have significant differences, as noted in the table below.

	Qualitative	**Quantitative**
Use/Objective	To gain an in-depth understanding of consumer behaviour and attitudes	To measure behaviour and attitudes
Method	Facilitated questioning (open-ended, probing questions, controlled discussion)	Structured surveys (focused, prompting questions, just Q&A)
Participants	Homogeneous, small groups	Statistically representative sample of a population
Output	Consumer words and descriptions	Coded responses
Required Skills	Focus group / PRA facilitation training and expertise	Statistical analysis and survey design

Thus, qualitative research is commonly used in the initial phases of market research while quantitative research is typically used when there is already a product prototype. Quantitative research is inappropriate for exploring the rich complexity of human life and thus market needs. It is difficult to formulate appropriate qualitative questions when there is not a clear idea of the product itself. Thus, quantitative approaches will be more appropriate when seeking to quantify the level of demand for a well-defined product prototype.

Qualitative research is best for generating ideas and concepts, and gaining an understanding of behaviours and attitudes to find out why people behave or think the way they do. It is good for developing ideas to refine existing products, develop new products, identify potential new programmes, and plan new marketing or advertising campaigns.

For these reasons qualitative research was used in this study to understand better the risks people faced, how they address them, and where gaps might be that could lead to potential interventions. It provided a good understanding of what people thought of insurance, and what they felt they needed.

Qualitative research does have some limitations as a result of the limited numbers of participants, and the probing methodology. The results are not necessarily representative of a market because the numbers of participants is limited, and because of the level of interpretation it is possible that an analyst with a particular point of view may interpret the thoughts and comments selectively to support that view. For these reasons, the researchers and analysts selected for this project (for Uganda, Albania, and Georgia) are all fully trained and certified MicroSave microfinance researchers. MicroSave is recognised as one of the most important microfinance market research training organisations in the world. More information on participatory rapid appraisal and its benefits in this type if research is available from www.microsave.org.

Appendix 7: Glossary of Selected Insurance Terms

Accident: An event that is unforeseen, unexpected, and unintended.

Actuary: A person who calculates insurance and annuity premiums, reserves, and dividends.

Adverse Selection: Tendency of persons with a higher-than-average chance of loss to seek insurance at standard (average) rates, which, if not controlled by underwriting, results in higher-than-expected loss levels

Agent: An insurance company representative who solicits, negotiates or effects contracts of insurance, and provides service to the policyholder for the insurer, usually for a commission on the premium payments.

Beneficiary: The person or financial instrument (for example, a trust fund), named in the policy as the recipient of insurance money in the event of the occurrence of an insured event.

Benefits: The amount payable by the insurance company to a claimant, assignee or beneficiary under each coverage.

Broker: A sales and service representative who handles insurance for clients, generally selling insurance of various kinds and for several companies. Brokers resemble agents, except for the fact that, in a legal sense, brokers represent the party seeking insurance rather than the insurance company.

Claim: A request for payment of a loss that may come under the terms of an insurance contract.

Commission: The part of an insurance premium paid by the insurer to an agent or broker for services in procuring and servicing the insurance policy(ies).

Comprehensive medical expense insurance: Insurance that provides coverage, in one policy, for basic hospital expense and major medical expense.

Co-payment: Mechanism, used by insurers to share risk with policyholders and reduce moral hazard, which establishes a formula for dividing the payment of losses between the insurer and the policyholder. For example, a co-payment arrangement might require a policyholder to pay 30% of all losses while the insurer covers the remainder.

Covariant risk: A risk, or combination of risks, that effects a large number of the insured items/people at the same, for example an earthquake, or a major flood.

Coverage: The scope of protection provided under a contract of insurance, and any of several risks covered by a policy.

Credit Life Insurance (or “Outstanding Balance Life Insurance”): Insurance coverage that repays the outstanding balance on loans in default due to the death of the borrower. Occasionally, partial or complete disability coverage is also included.

Deductible(s) (or “Excess”): Mechanism, used by insurers to share risk with policyholders and reduce moral hazard, which establishes an amount or percentage which a policyholder agrees to pay, per claim or insured event, toward the total amount of an insured loss.

Disability: Physical or mental condition that prevents a person from performing one or more occupational duties temporarily (short-term), permanently (long-term), and / or totally (total disability).

Disability benefit: A feature added to some life insurance policies providing for waiver of premium, and sometimes payment of monthly or lump sum income, if the policyholder becomes temporarily, totally and / or permanently disabled.

Distribution Channel: Type of process used to deliver insurance policies to clients. Direct marketing and agents are two examples of different distribution channels

Endowment policies: The insurer pays a lump sum at the end of an agreed period of policyholder investment.

Exclusions (or “exceptions”): Specific conditions or circumstances listed in the policy for which the policy will not provide benefit payments.

Experience: The record of claims made or paid within a specified time period.

Fraud: Intentional perversion of truth in order to induce another to part with something of value.

Group Insurance: Insurance written on a number of people under a single master policy, issued to their employer or to an association or other organization with which they are affiliated.

Group life insurance: Life insurance on a group of people under a master policy that usually does not require medical examinations. It is typically issued to an employer for the benefit of employees, or to members of an association or some other related group, for example, a professional membership group. The individual members of the group generally hold evidence of their insurance.

Health insurance: Coverage that provides benefits as a result of sickness or injury. Policies include insurance for losses from accident, medical expense, disability, or accidental death and dismemberment.

Health maintenance organization (HMO): Organization that provides a wide range of comprehensive health care services for a specified group for a fixed periodic prepayment.

Insurable interest: A financial reliance you have on someone (such as a spouse) or something that can be covered by insurance. For example, you need an "insurable interest" in someone in order to buy a life insurance policy on that person's life.

Insurable risk: The conditions that make a risk insurable are (1) the peril insured against must produce a definite loss not under the control of the insured, (2) there must be a large number of homogeneous exposures subject to the same perils, (3) the loss must be calculable and the cost of insuring it must be economically feasible, (4) the peril must be unlikely to affect all insureds simultaneously, and (5) the loss produced by a risk must be definite and have a potential to be financially serious.

Insurance: A risk management system under which individuals, businesses, and other organizations or entities, in exchange for payment of a sum of money (a premium), offers an opportunity to share the risk of possible financial loss through guaranteed compensation for losses resulting from certain perils under specified conditions.

Insured: The policyholder - the individual(s), businesses, other organizations or entities protected by an insurance policy in case of a loss or claim.

Insurer: The party to the insurance contract who promises to pay losses or benefits.

Lapse: The termination or discontinuance of an insurance policy due to non-payment of a premium.

“Law of Large Numbers”: Concept that the greater the number of exposures (for example, lives insured), the more closely will actual results approach the results expected from an infinite number of exposures. Thus, the larger the number of

people in the insured risk pool, the more stabile the likely results of risk event occurrences.

Microinsurance: Microinsurance is the protection of low-income people against specific perils in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved. Low-income people can use microinsurance, where it is available, as one of several tools to manage risks.

Moral hazard: Hazard arising from any non-physical, personal characteristic of a risk that increases the possibility of loss or may intensify the severity of loss for instance bad habits or low integrity. An example might include failing to properly care for an insured goat because it is insured, thereby increasing the chance it will die of disease.

Mortality table: An actuarial table based on mortality statistics over a number of years.

Mutual Insurer: Insurance in which the ownership and control is vested in the policyholders, who elect a management team to conduct day-to-day operations.

Pensions: The insurer pays an agreed amount to the beneficiary for a agreed period based on a regular investments of the beneficiary until the date disbursement commences.

Policy: The printed document issued to the policyholder by the company stating the terms and conditions of the insurance contract.

Policy term: The period for which an insurance policy provides coverage.

Premium: The sum paid by a policyholder to keep an insurance policy in force.

Property insurance: Insurance providing financial protection against the loss of, or damage to, real and personal property caused by such perils as fire, theft, windstorm, hail, explosion, riot, aircraft, motor vehicles, vandalism, malicious mischief, riot and civil commotion, and smoke.

Reinsurance: A form of insurance that insurance companies buy for their own protection. One or more insurance companies assumes all or part of a risk undertaken by another insurance company.

Reserves: An amount representing liabilities kept by an insurer to provide for future commitments under policies outstanding.

Risk: The chance of loss. Also used to refer to the insured or to property covered by a policy.

Risk Management: Systematic process for the identification and evaluation of pure loss exposures faced by an organization or individual, and for the selection and implementation of the most appropriate techniques for treating such exposures.

Risk Pooling: Spreading of losses incurred by a few over a larger group, so that in the process, each individual group members' losses are limited to the average loss (premium payments) rather than the potentially larger actual loss that might be sustained by an individual. Risk pooling effectively disperses losses incurred by a few over a larger group.

Settlement: Payment of the benefits specified in an insurance policy.

Term insurance: A plan of insurance that covers the insured for only a certain period of time (term), not for his or her entire life. The policy pays death benefits only if the insured dies during the term.

Underwriter: (1) A company that receives the premiums and accepts responsibility for the fulfilment of the policy contract. (2) The company employee who decides

whether or not the company should assume a particular risk. (3) The agent who sells the policy.