INSURANCE REGULATORY AUTHORITY OF UGANDA

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Baseline Survey on the Insurance Industry in Uganda

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EXECUTIVE SUMMARY

The Insurance Regulatory Authority of Uganda is working towards enabling the development of the insurance market, maintain its safety and sound operation, protect the interests of Insureds and their beneficiaries, and ensure the supply of high quality and transparent insurance services and products.

Existing industry data and information are fragmented and refer to different time periods. Without some baseline status, it would be hard to estimate, let alone appreciate, the changes taking place in the industry.

As part of its five-year strategic plan, the Authority undertook a Baseline survey as part of a comprehensive review of the current market and industrial status, the internal strengths and weaknesses of the industry and the opportunities and threats that the industry faces.

Because of the urban concentration of the insurance activity, the survey was conducted in the areas of Kampala City, Gulu Municipality, Mbarara Municipality and Jinja Municipality. Interviews were held with both the players on the supply side of the Insurance Industry and buyers of insurance in the said areas.

Survey findings point to the fact that lack of trust, limited awareness, distribution challenges and limited response to market demands by the players are major limitations to insurance demand. On the supply side, limited innovations, market conduct and regulatory challenges were identified as key limitations to sustainable insurance industry development.

This survey took a comprehensive view of the industry and market aspects that can guide the development of strategies that address challenges facing the insurance industry in Uganda. It is hoped that this report will inform identification of major challenges and solutions as the industry looks to streamline the regulatory environment to take advantage of the opportunities that lie ahead.

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1. INTRODUCTION AND BACKGROUND

1.1 Introduction

The Insurance Regulatory Authority of Uganda (Authority) was established under Section 14 of the Insurance Statute, 1996 (Statute) [now, The Insurance Act, (Cap 213) Laws of Uganda, 2000] as amended. Its main objective is to ensure effective administration, supervision, regulation and control of the business of insurance in Uganda.

The function of the Authority is to increase insurers' operational efficiency to develop the industry and assure customers of the quality of insurance. Its mission is to ensure a sound and stable insurance industry by maintaining its safety and sound operation, protecting the interests of insureds and their beneficiaries, and ensuring the supply of high quality and transparent insurance services and products.

This baseline falls within strategic objective (i) and (iv) of the Authority's Strategic Plan 2012/13-2016/17. The goal is to examine the current regulatory and supervisory environment to improve operational efficiency, create cultural transformation within the industry, and enhance management controls and accountability.

1.2 Objectives of the Baseline Survey

The objectives of the survey were to:

I. Undertake a situational analysis on the insurance sector in the context of the strengths and weaknesses on one hand and opportunities and threats on the other;
II. Identify the prevalent perceptions, knowledge and values regarding accessibility and quality of insurance services;
III. Assess the existing support infrastructure and the respective gaps;
IV. Identify the key market and other challenges;
V. Recommend critical interventions required at various levels of industrial, and by various stakeholders.

1.3 Scope of the Survey

The findings that are presented in the subsequent sections are limited to the baseline information. This is not a diagnostic study and has not attempted to examine or analyse the data collected beyond the objectives of the study. We however expect the key stakeholders to identify the underlying issues that have contributed to the results of the baseline survey. We did not attempt to compare the data for each of the four areas. We believe that this is not the objective of the baseline study and is outside the scope considered.

1.4 Organisation of the report

Chapters 1 and 2 of the report set out the introduction and methodology of the study, followed by an overview of the market in Chapter 3. The details of the findings and recommendations of the survey are presented in the subsequent chapters.

2. METHODOLOGY

2.1 Methodology

The study was purely qualitative and Key Informant Interview (KII) guides were used to enlist responses from selected insurance industry players on agreed areas ranging from business environment to the legal and regulatory issues. With leads from the interviewed players, face to face interviews were conducted with insurance service consumers about their service experience with their respective providers and the challenges they faced. The detailed discussions were able to give us insights which are discussed in detail in the report.

2.1 Desk study and field study

The baseline was conducted mainly by way of a field study, which was supported by a desk study. The desk study was conducted to analyse policy documents and implementation guidelines as well as reports.

2.2 Selection of respondents

The selection of key stakeholders was done in a consultative way within the insurance industry after a preliminary stock take of existing players. The research teams met with key stakeholders including insurance companies; insurance brokers; loss assessors; agents and the general public. The breakdown of the sample is shown in the table below.

SAMPLE	
Informants	No
Insurers	6
Brokers	6
Loss Assessors	4
HMOs	4
Policyholders	827

2.3 Survey tools

Several tools were developed to collect qualitative data to assess the current industry situation. The tools were shared with the study partners before the first field visit and revised and adapted. The following tools were used in this review:

- interview guides for insurers
- interview guide for Brokers and Loss assessors
- questionnaire for the general public

These tools aimed at capturing information in six main areas discussed in subsequent chapters.

3. MARKET ANALYSIS

The insurance market in Uganda has exhibited positive trends in growth over the past decade with noted stability in terms of industrial composition. The market is crowded and increasingly competitive. This phenomenon has motivated the industry players to invest in the development of new products to enhance their customer base in response to the changing market demands.

Unlike the matured markets that have composite insurance revenue, Uganda is about 90% short term insurance contract markets. Individual life and other personal insurances that constitute the basis of the developed world's market revenue and investment are still very low in Uganda. Long term insurance contracts and the critical mass individual insurance (micro insurance) are practically non-existent.

Dependence on the short term underwriting businesses is affected by adverse market conditions. Key concerns in the market include the fact that insurance penetration within the critical mass market is very low. This is because the supply chain to capture that critical mass is under-developed. In addition, the supply of qualified insurance agents is inadequate, which undermines marketing of insurance at micro level.

Apart from the issue of penetration, a poor compliance culture and low awareness by the public have created a huge public confidence deficit. In addition, suspicion that claims would not be paid limits growth of the insurance market in Uganda.

The Insurance Regulatory Authority therefore has the obligation to ensure that players exercise absolute good faith in the transactional process. Policyholders should have thorough understanding of the risks and place them in the proper manner. Premiums must be put in the right investments to ensure that claims are paid when the need arise, both from the primary and re-insurance ends.

4. SUPERVISION

4.1 Onsite Inspections

The base line focused on the Procedure, Planning and Preparation, Fieldwork as well as Assessment and Reporting. The current process stems from the analysis of the financial and statistical information sent by the companies. Thereafter, the supervisor develops a program, based upon a systematic analysis of the records of respective companies for on-site inspections which are to be carried out.

Players reported that inspections are not focused enough to define the nature and scope of inspections that are performed. However, one of the most identified limitations reported by Authority inspectors is the lack of consistent and, timely data available to the Authority.

More often than not inspectors spend onsite inspection time requesting for information that ought to have been submitted by players. At the end of inspections, inspectors do not discuss findings with the insurance company based on risk profile but to secure commitments on when information needed should be provided. In the end the process becomes a cumbersome exercise that delays identification of problems and follow up to ensure corrective action.

Considering that insurers collect funds and take on contractual liabilities, submission of financial and statistical information to the Authority according to agreed templates, timetables and definitions to permit offsite analysis is important. If an insurer cannot accomplish this there are good reasons to question their ability to be in business.

On the Other hand, players reported that the inspection exercise takes a lot of staff time as inspectors do not focus on the purpose of inspection during field visits. Players also raised questions about the quality of preparation by inspectors and observed that there are weaknesses in follow-up on concerns raised after onsite inspections.

It was also reported that upcountry inspection to agencies and branch offices offices were merely composed of inspectors collecting information without any debriefing. Thereafter fines are imposed without clarification from offices concerned.

4.2 Offsite Examination

Offsite inspections are extremely important for tracking performance and financial health of players. Unfortunately, the Authority is constrained by financial reporting problems in including inconsistent, inaccurate and delayed submission of statistical, financial and reinsurance information from players.

It was reported that inspectors are unable to fully undertake offsite analysis because about 70% of companies submit incomplete information way after the period within which the information is required.

4.2.1 Insurance Companies

It was noted that liquidity is a major challenge in the sector since it affects timely settlement of claims. Clearing liabilities is dependent on how well assets are valued and managed because insurers are exposed to various forms of risks such as credit, investment, market, operational, etc which calls for proper matching of assets and liabilities

In addition, large amounts are reported in the financials of insurance and brokerage companies as outstanding premiums. The implication is that the reported solvency margins of many ***companies are lower than they ought to be because premiums outstanding for more than 3 months*** (according to the amended Act) are disregarded in the determination of solvency margin.

The capacity of insurers and brokers to meet their obligations to clients is constrained: the insurance industry is exposed to the contagious impact of the possible failure of major debtors. It was established that there are substantive lengths of credit periods and no attempt to lapse cover due to non payment.

The current state of affairs with regards to wide difference in the values of premium receivable/payable reported by interfacing parties in the insurance value chain and high level of premium receivable in the financials of insurers has a number of noteworthy implications.

Long standing debts (through brokers and direct business) and challenges in reconciliation of outstanding premium balances implies that admitting 50% of outstanding premiums for not more than one year as an asset may give inaccurate picture of a company's financial position.

It is clear that that some brokers and insurers have unduly overstated or understated premium receivable and/or payable in their records. When the accounts are corrected, the financial position of some operators may be significantly lower than what is currently being reported.

For example, while the Authority continued to demand for quarterly reconciliations and the respective age-wise breakdown of premium balances, many insurers did not comply. Surprisingly, many insurers reported outstanding premiums in respect to Southern Union Insurance Brokers only after the company's licence was suspended.

Observations

(i) Current reconciliation process makes it cumbersome to consolidate broker/insurer supplied information, identify transactions that should be flagged as exceptions, and provide data access to inspectors, thus constraining them in respect to supervision, evaluating licenses and delinking exceptions.

(ii) Companies had differing reconciliation statements (number of companies for which business was transacted, amount and certification) depending on the firm that initiated the reconciliation process.

(iii) The sheer volume of transactions involved and the lack of frequent reconciliation exercises implies that the probability of account balances of affected parties being grossly misstated is high.

(iv) The reconciliation statements submitted to the Authority are manual, paper-based and tied into a quarterly cycle. Lots of avoidable man hours are spent on reconciliation exercises which, in many cases, are never fully concluded; debtors use accounts differences as excuses for not honoring their obligations; it is therefore difficult for the Authority to conclude on the verification of balances indicated as outstanding balances in the statements of parties.

(v) To not reconcile, as the case is for some companies, gives rise to uncertainty which increases credit risks to the industry**.**

4.2.2 Health Membership Organisations (HMOs)

It was noted that some HMOs do not have streamlined management and monitoring instruments. Challenges identifed include inability to :

(i) Keep uptodate financial records according to prescribed standards

(ii) Prepare and submit acceptable reports for revenues and expenses of the scheme

In addition, inferences drawn from accounts submitted show that some HMOs have high opertaing costs and borrowings from related parties with neither payment terms nor gurantees.

5. ENFORCEMENT OF MOTOR THIRD PARTY LIABILITY (MTPL) INSURANCE

5.1 Absence of Effective Enforcement Measures

Players reported absence of effective enforcement measures for MTPL. It was reported that many automobiles do not have insurance coverage and the proportion is much smaller if motorcycles are included. On the other hand, policyholders argued for the introduction of clear compensation guidelines for MTPL claims and implementation of claims settlement practices on the part of the insurers (including decentralisation of the claims management for claims up to a certain limit).

It is important to note that currently there is no scheme to compensate victims of non-insured vehicles. Where court action exists, procedures tend to be costly and slow. As a result, most cases are settled out of court by negotiation.

5.2 The Role of Traffic Police

Traffic Police play an important role in enforcement of MTPL Insurance and carrying out investigation. The survey showcase challenges in enforcing of the Traffic Act and the Motor Insurance (Third Party Risks) Act. The primary focus of the policy when an accident occurs is to determine the cause of the accident and those to blame for the impact as per the stipulations of the Traffic Act. This undermines fast tracking of the claims to third parties.

Traffic police reported limited resources (financial and human resource capacity) for coming up with complete police reports. This undermines the assignment of responsibility yet its one of the most important guiding elements of MTPL insurance.

Some traffic officers also expressed ignorance about the features of genuine MTPL stickers. Yet some insurance companies had already reported circulation of fake stickers in the Market. In addition, traffic officers reported back-dating of stickers after accidents have occurred, that is to say, clients connive with agents to backdate stickers.

Motorists and cyclists reported a number of limitations to accessing compensation:

I. Fading stickers and cases of loss of stickers in the event of accidents.

II. Repudiation of claims on grounds of absence of a driving permit yet a permit is not a requirement at purchase.
III. Difficulty in following up on claims by up-country claimants.
IV. Low liability limits.
V. Hit and run accident cases.
VI. Inconclusive police reports.
VII. High cost of police reports (Ushs.85000 per report and additional informal payments)

6. LIABILITY LIMITS AND STAMP DUTY

Insurers reported low liability limits for motor third party and recommended amendment of the Motor Vehicle Insurance (Third Party Risks) Act and regulations to provide for regular premium rate review based on recent claim expenses and adjustment for inflation, increment of liability limits, and a compensation fund for accident victims resulting from hit and run vehicles.

Players, vehicle owners and transport associations also indicated that stamp duty (payable by the policyholders) increased from 5,000/- to 35,000/- with effect from 2013 on all non-life premiums is a major deterrent to development of the sector. Players reported a negative impact of stamp duty on Motor Third Party Insurance. Higher premiums may increase non-compliance and dampen the social objectives that underlie MTPL insurance.

In fact, Boda Boda cyclists that were involved in the survey were reluctant to purchase third party insurance because of the increment. Players also reported that the increase in stamp duty had grossly affected the uptake of insurance products meant for low income earners.

7. CLAIMS MANAGEMENT AND SETTLEMENT

Payment of claims assures the insureds of protection in the event of loss. However, it was reported that some insurance companies prey on the ignorance of the insured. In addition to claims against the insured's own insurance provider, members of the public reported wrongful denial of claims in the face of clear liability.

Policyholders believe that insurers tend to employ delay tactics to ensure unfair rescission and claims processing practices. Some of the companies in the country are said to be accepting premiums far lower than actuarially possible to cover a risk and this makes it difficult for them to pay claims in the event of an accident that leads to a claim.

Major violations reported included improper rescissions, failure to pay claims on a timely basis, failure to provide required information when denying a claim and mishandling of clients' appeals. For delayed payment of claims, policy recommended payment of interest on claims in question on a progressive basis.

The view of policyholders is that insurance firms do not provide their insured with utmost good faith claims conduct. To them, the emphasis is often placed on controlling claims severities, rather than paying each individual claimant the full amount deserved, without concern for the bottom line.

It was reported that insurers treat clients well during the process of acquiring the policy. Once the policies have been issued no feedback is provided about risk mitigation. Some insurers also prolong the claims management process by paying amounts due to clients in small instalments. By holding onto money longer, insurers can invest the float and often frustrate clients into shutting up.

Policyholders also reported high costs associated with the claims process and ignorance about the claim handling process. Client's upcountry reported the requirement to report to Kampala for assessment and second opinion from head offices of respective companies.

Coverage is extended at sub-market rates just to get as much of the market as the practice would allow. Undercutting practices expose insurers to the strong likelihood of not meeting the reserve balance required by regulation to be set aside at all times to answer for precisely the claims for which premiums have been paid.

Policyholders identified the following as ways in which insurance companies routinely breach their utmost good faith duties:

I. Failure to thoroughly investigate - An insurer cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for a denial of payment in whole or in part.
II. Exploiting the financial vulnerability of the policyholder to obtain a favourable settlement of a coverage dispute.
III. Making unreasonable demands on the policyholder during claims investigation, amounting to harassment.
IV. Claims "extortion" – for example, accusing the policyholder, without reasonable basis, of wrongdoing, or using abusive or coercive practices to compel the compromise of a claim.
V. Refusal to compromise claims until litigation is threatened or commenced.
VI. Unreasonably low counter offer in negotiating the settlement of an underlying claim.
VII. Failure to pay the full value of a claim.
VIII. Failing to inform the policyholder of its rights under the policy.
IX. Failing to advise the policyholder of a right to arbitration.

Policyholders made the following conclusions about industry failure to pay claims

I. Companies consistently put profits over policyholders.
II. Companies continually deny, delay and defend so as to pay fewer claims
III. High administrative and management costs
IV. Contractors (performance bonds) reported identified the following drawbacks:
    a) Insurers always try to establish that the owner did not comply with the technical conditions of a bond to avoid paying the compensation.
    b) High costs incurred by owner in quantification of losses that might have been suffered when a trader or contractor fails in their performance.
    c) Difficulty in recovering shortfall, If the owner underestimates the losses and the future cost of the completion of the project.

On the contrary, insurers indicated that some claims are not payable due to either one, or a combination, of the following:

I. Claim not payable as per the terms and conditions in the policy.
II. The receipts submitted in support of the claim not being genuine.
III. Medical assessment not submitted in support of disability claims.
IV. The complainant not the right representative of the deceased and the insurer advises that the right representative pursues the claim.
V. The policy was misinterpreted.

VI. Claim not payable because the complainant paid premium after an accident had occurred.

Statistics from the Authority including accounts, returns, and information on claims outstanding and increasing number of complaints in 2012 however corroborate the policyholders' concerns. The industry non life average claims ratio reduced from 42.57% in 2011 to 40.30% in 2012.

Notwithstanding the low average claims ratios, further analysis shows that 14 out of 20 companies paid less than the industry average. Conversely, non life management expenses increased from 21.59% in 2011 to 23.62% in 2012 with 13 out of 20 companies spending above the industry average.

In respect to the life segment, there was a sharp reduction in claims ratio from 55.81% in 2011 to 34.85% in 2012 and management expense ratio reduced from 46.39% in 2011 to 37.86% in 2012.

8. UNLICENSED COMPANIES OFFERING INSURANCE SERVICES

Insurers reported that the requirement for borrowers to insure cars and other goods purchased with personal loans is increasingly becoming a driver of the insurance industry. However, they were concerned about self insurance by savings and credit cooperatives (SACCOs) such as Uganda Co-operative Saving and Credit Union (UCSCU).

They also identified unlicensed health service providers (such as Vanbreda, Resolution Health) as well as non government organisations that make insurance arrangements from the respective countries of origin.

9. COMPETITION AMONG SERVICE PROVIDERS

9.1 Undercutting

Most players reported that their competitors charge premiums below the approved minimum premium rates mainly in the non-life industry segment. They were concerned about lack of underwriting discipline reflected in heavy discounts, and failure of the Regulator to sanction companies engaged in the practice.

There are allegations that informal payments to inspectors have allowed the problem to continue unabated. Already, the image of the insurance industry in the country is not the best because of the allegations of the refusal of companies to honour their obligations and rather hide behind legalities and clauses in the policies, which they normally do not explain from the point of selling an insurance product.

Responses from the survey show that competition has prompted underwriters to reduce or cut rates to survive. Undercutting was reported as a survival strategy, not withstanding its implications to the industry.

This shortfall has undermined the provision of quality insurance. For instance, ccontractors reported that undercutting by insurers undermines assurance for project completion and makes owners incur additional costs.

Regulation and competition should reinforce each other in the interest of the consumer, with competition being the prime factor for allocating resources to and within the industry and regulation the main factor for assuring fair competition.

10. FEEDBACK FROM OTHER STAKEHOLDERS

Insurers	I.	Unclear communication of changes in policy, regulations and inadequate or no consultation on policy issues by the Authority
	II.	Regulator has not encouraged and supported a desired level of self-regulation.
	III.	The volume of communication from the regulator and fines imposed affect business transactions (A lot of staff time is spent on compliance related activities.
	IV.	Some loss assessors are induced by the claimants to compromise and work against the interest of the insurer.
	V.	High incidence of fraud in the medical segment that have created delays due to the need for scrutiny, including more stringent reviews of services provided.
Brokers	I.	Brokers expressed optimism about the growth opportunities in the insurance industry albeit the low percentage of the total industry premium currently written through brokerage firms. Whereas opportunities presented by the fast growing agricultural sector, services sector, oil and gas, energy, mining and micro-insurance, the extent of progress in likely to be thwarted my limited innovation in both products development and distributive channels.
	II.	Regulatory requirements for acquiring a licence as an agent particularly corporate agents are minimal yet there are no limitations to the volume and nature of business they can place. This gives them an unfair advantage.
	III.	Policyholders delays in respect to payment of premiums (or sometimes not paying premiums)
	IV.	Insurance companies engaging in unethical market conduct practices such as delayed settlement of claims, luring clients to deal directly with them especially at renewal and undercutting which has created uncertainty in the market to detriment of the sector as a whole.
Agents	Long delays in the communication of policy changes and directives from insurance firm head offices.	
Loss Assessors/ Adjusters	Both insufficient knowledge and unethical conduct were reported amongst some loss assessors/adjusters. There is an inherent tendency of many assessors to act unprofessionally by favouring insurers at the expense of policyholders. This bias has caused unnecessary delays as the reports are quiet often challenged. Agents create false expectations among policyholders because they lack sufficient skills to differentiate between payable and non-payable claims. Delays in payment for technical services provided (claims investigation, pre insurance risk surveys and valuation) and undue influence by insurers to alter outcomes of investigations and assessments.	

	Loss Assessors urged the Authority to: Ensure that insurance companies undertake pre insurance risk surveys and valuation using loss assessors/adjusters/surveyors instead of agents and brokers. Introduce initiatives that will increase their capacity in the oil and gas industry Create incentives for increased capitalization so that the industry reduces on the amount ceded because reinsurers opt for overseas based adjusters due to huge sums paid in reinsurance. Address unreasonable refusals and delays in getting approval from their professional Association. Some loss assessors/adjusters expressed concerns that their professional Association, the Uganda Association of Engineers, Valuers and Loss Assessors (UAEVLA) was deliberately curtailing entry into the market by other interested firms, citing conflict of interest among the members of the executive committee. Examine why some insurers opt for specific loss adjuster company(s) regardless of the expertise of the key personnel in those adjusting firms which delays the claims process.
Health Service Providers:	Insurance Companies and HMOs unnecessarily delay payments (including routinely denying full payment for care provided to policyholders). Low and delayed reimbursement is increasingly compromising patient health. Some facilities have stopped providing services to clients from some insurance companies while others give preference to patients that pay upfront. Service providers urged the Regulator to: I. investigate abusive patterns rejection rates of claims, accounting delays in provider payment II. introduce interest for delays of more than 30 days III. examine and streamline claims management processes IV. delink HMOs from the health facilities With specific reference to HMOs, service providers noted that some existing medical insurance schemes are not financially viable and they do not have suitable monitoring instruments in place to measure financial viability. They are, for example, not aware of their operating expenses as expenses are not

necessarily allocated to the operation of the scheme (i.e., in most cases expenses such as salaries and office rent are provided by the host health facility and are not specifically allocated to the HMO schemes).

Key concerns were however raised about clients' satisfaction including the receipt of courteous attention at the hospital, waiting times and availability of a doctor or nurse. In addition, the following shortfalls were identified:

I. Inconsistent medical services e.g. not working on Sundays and clients are referred to public hospitals that are already overwhelmed by patients.
II. Unclear definitions for exclusions (e.g. sexually transmitted and examination).
III. No inspections for HMOs from Authority and Insurers
IV. Over billing, unnecessary prescriptions
V. Delays in verification
VI. Strict limits
VII. Expiry of covers and no notification is provided to clients

11. CONSUMER AWARENESSAND DISTRIBUTION OF INSURANCE PRODUCTS.

Findings from the survey indicate that insurers have not done enough in terms of quality of advice for choice of product, servicing of policies, post sale and settlement of claims. A considerable gap exists in respect to the low level of awareness on existing insurance products, policyholder rights, and protection.

Policyholders expressed ignorance about the terms of the policies they hold. This has created false expectations which have worsened the existing public confidence deficit. As such there is a wide spread belief that compulsory insurance is a tax. Both potential and existing policyholders think that the purchasing decision is not customer-driven and recommended a deliberate move from selling insurance to marketing an essential financial product.

The view of policyholders is that insurance companies should concentrate more on improving their services. The real growth in insurance will occur when customers realize the true value of insurance.

The distribution of, and access to, insurance services was also reported as a key challenge. Insurance services are concentrated in urban and peri-urban locations limiting the extent to which micro insurance products can be spread to the rural areas. It was also noted that agents in most peri-urban outlets are not knowledgeable enough to explain the rights and obligations of the respective parties under an insurance contract. For instance some of the policyholders (schools) that held standard fire policies at the time did not have fire extinguishers and no advice was provided on risk mitigation by the insurers that provided the policies.

In addition, agencies are not empowered to make decisions in regard to claims payment. In the event of a claim, all claims documentation is sent to the head offices in Kampala. In effect follow up is difficult, resulting into excessive costs, delays in settlement and frustration.

12. RECOMMENDATIONS AND CONCLUSIONS

The growth of the insurance industry is hinged on whether regulation and supervision are based upon an ideal set of policies that attempt to replicate the conditions of a competitive market and maximize social welfare. As the International Association of Insurance Supervisors (IAIS) recommends, the Insurance Core Principles (ICP) should be used to identify areas in the existing system that need to be improved. The Authority should embark on the process of:

1. Address existing regulatory gaps to tackle undercutting, claims payment and unlicensed companies.

2. Consulting with players on the regulatory and policy agenda;
   I. Enlisting proposals for reform from insurers, and dialoguing in a formal systematic and inclusive way on the reform agenda;
   II. Building capacity for identification and analysis of risks for example building underwriting skills, especially in the area of specialized risks e.g. oil, gas & energy, aviation, marine etc
   III. Improving delivery of regulatory services – (licensing, supervision and complaints handling);
   IV. Regulatory house-keeping – (regularly reviewing existing regulations to ensure compliance with International Financial Reporting Standards, Insurance Core Principles, and ensure that they are in compliance);
   V. Harnessing technological developments to facilitate risk based supervision;
   VI. Ensuring best practice in corporate governance.
   VII. Encouraging and supporting players' associations in self regulation of members with clear quality assurance mechanisms;
   VIII. Taking appropriate action for malpractices and misconduct.
   IX. Working with key stakeholders to fast track insurance of government assets and improve compliance with workers' compensation and motor third party insurance.

3. Mechanisms must also be put in place to enhance supervision in respect to:
   I. Improving the process of offsite and onsite supervision;
   II. Tracking capital adequacy;
   III. Asset valuation;
   IV. Related party transactions (loans, outsourcing agreements, investments and technical assistance agreements);
   V. Remittance of collected premiums;
   VI. Adequacy of claims reserves;
   VII. Reinsurance payables and adequacy of reinsurance coverage and tenure;
   VIII. Management of mergers, acquisitions and insurer receiverships;
   IX. Management of insolvency guaranty mechanisms that cover a portion of the claims of insolvent insurers;
   X. The process of revocation, suspension and re-licensing of companies;

XI. Regulation of insurer market practices, such as product design, marketing and claims adjustment; and
XII. Cross border supervision and group wide supervision.

4. Embedding a Pro-Consumer Service Regime

Its important to re-emphasize that customers deserve clear and unambiguous information about their rights and there should be sanctions and penalties if their rights are compromised. All relevant information should be given at point of sale, in policies and during any contract.

Previous assumptions and perceptions about customers may no longer be reliable, and those insurers who anticipate this and are able to respond to what customers need now are most likely to succeed. The demand behaviors, attitudes and preferences of insurance customers are changing.

5. The survey findings suggest that to remain competitive, players must:
   I. Recognize that the consumers are looking for products which offer solutions which are simple to understand and a high level of transparency.
   II. Integrate existing distribution channels with online channels.
   III. Invest in customer service and brand equity, given these factors are as important (if not more so in some regions) than price.
   IV. Determine ways to reward valuable customers to improve retention and cross-selling efforts.
   V. Build brand value, as customers evaluating similarly priced products often revert to secondary buying factors like brand and reputation.
   VI. Improve communication with their customers throughout the product life cycle. In action on the part of players will lead to loss of their customers.
   VII. Invest in corporate social responsibility.
   VIII. Make the claim payment process less tidious, efficient and transparent.
   IX. Adjust their service standards to match those of other players in the service in including decentralisation of claims payment up to a given limit.
   X. Keep pace with the expectations of the consumers which are constantly changing.

APPENDIX I: List of Companies contacted

<table>
<tr><th colspan="3">List of companies visited</th></tr>
<tr><th>Insurers</th><th>Loss Assessors/Adjustors</th><th>Insurance brokers</th></tr>
<tr><td rowspan="2">1) Liberty Life
2) NIC
3) ICEA
4) Sanlam
5) Jubilee
6) Goldstar
7) Lion
8) East Africa Underwriters
9) Rio
10) APA
11) NIKO
12) AIG
13) UAP
14) NOVA
15) PAX
16) Britam
17) Excel
18) TransAfrica</td><td>1) Multiple consult
2) Crown assessors
3) Elit
4) General Adjusters
5) Mclaren Uganda
6) Intertech</td><td>1) Marsh
2) AON
3) Rock
4) Liaison
5) Padre Pio
6) Intercontinental</td></tr>
<tr><td>HMO
1) AAR
2) IHN
3) Case
4) Exceed</td><td>Member Associations
1) UIA
2) IIU
3) UAIB
4) UEVLA</td></tr>
</table>

APPENDIX II: List of Respondents

Stakeholder/Institution	**Person(s) Interviewed**	**Sector/Mandate**	**Office location**
Equator Seeds Limited	Okello Tonny, Managing Director	Agriculture, seed production, sale of chemicals, farm tools, agriculture consultancy	Gulu
Alin	Opira John, Programs Manager	NGO, Enabling Access, creating knowledge, empowering people	Gulu
Mt. Olive Good Shepherd Nursery And Primary School	Mwaka George William, Director	Education	Gulu
UAP Insurance Uganda Limited	Jackie Alobo, Michael Odong	Insurance branch	Gulu
Northern Uganda Development Of Enhanced Local Governance, Infrastructure And Livelihoods (Nudeil) Program	Edith Anderu, Human Resource Assistant	NGO	Gulu
Statewide Insurance Company	Lutara Wilson Willy, Customer Service Executive	Insurance branch	Gulu
Acholi Ber Country Hotel	Opio Mark, Managing Director	Hotel	Gulu
Gulu District	Alobo Betty	Local Government	
Infominds	Mwaka Savio	Consulting, program/project Management consulting, Management Information Systems Consulting, Business Process Outsourcing	Gulu
	Onono Nixon, Mechanic	Dealers in importation of motor vehicles and spare parts	Gulu

APPENDIX II: List of Respondents

Stakeholder/Institution	**Person(s) Interviewed**	**Sector/Mandate**	**Office location**
Sunset Hotel International	Ojok Francis, Financial Controller	Hotel	Jinja
UAP Insurance Uganda Limited	Bbosa Elijah	Insurance branch	Jinja
Uganda Co-Operative Alliance Ltd	Egibwa Proscovia, Regional Coordinator ABU-Busoga Region	Agriculture Co-operative	Jinja
AIG	Rujumba P, Branch Manager	Insurance branch	Jinja
National Insurance Corporation Ltd	Isingoma Dominic, Branch Manager	Insurance branch	Jinja
Statewide Insurance Company	Mateege Denis, Branch Manager & Nabbanja Fatuma, Assistant Supervisor	Insurance branch	Jinja
Leads Insurance	Nawundo Esther, Assistant Supervisor	Insurance branch	Jinja
First Insurance Company Ltd	Kakembo Muhamed, Agent	Insurance agency	Jinja
Pax Insurance	Musoke Samson, Agency Manager	Insurance agency	Jinja
Jubilee Insurance	Abiji Charles, Marketing Manager Life	Insurance branch	Jinja
Excel Insurance	Naima Nakasango, Agent	Insurance agency	Jinja
International Medical Centre	Agasha Carol, Practice Manager	Healthcare provider	Jinja
APA	Anguria Charles, agent & Namasoga Sarah, agent	Insurance agency	Jinja
Insurance Company of East Africa (U) Ltd	Andrew, Branch Manager	Insurance branch	Mbarara

APPENDIX II: List of Respondents

Stakeholder/Institution	**Person(s) Interviewed**	**Sector/Mandate**	**Office location**
GBK Group of Companies	Godwin	Insurance consumer	Mbarara
Tuwereza Bakery	Mutambuka	Insurance consumer	Mbarara
Ours For People with Disabilities	Tweheyo Oscar, Program Director	Insurance consumer	Mbarara
Elizabeth Glaser Paediatric Aids Foundation	Undisclosed	Healthcare provider	Mbarara
UAP Insurance Uganda Limited	Undisclosed	Insurance branch	Mbarara
Statewide Insurance Company	Kyomukama Rose, Branch Manager	Insurance branch	Mbarara
Balya Hardware	Undisclosed	Insurance consumer	Mbarara
New Mugisha Trading Company	Undisclosed	Insurance consumer	Mbarara
Ankole Regional Traders	Undisclosed	Trade Association/Insurance consumer	Mbarara
Liberty Life	Nyabahini Florence, Office Administrator	Insurance branch	Mbarara
APA Insurance	Bahame B. Barack, Sales Agent	Insurance agency	Mbarara
AIG	Muhiire Robert, Administrator	Insurance branch	Mbarara

APPENDIX II: List of Respondents

Stakeholder/Institution	**Person(s) Interviewed**	**Sector/Mandate**	**Office location**
Mayanja Memorial Hospital	Karuhanga John, Administrator	Health	Mbarara
Excel	Tuhairwe Winnie	Insurance Branch	Mbarara
Jubilee Insurance	Mutoni Karake Ritah	Insurance branch	Mbarara
Mbarara High School	Kihimo Robert, Deputy HeadMaster	Education	Mbarara
Leads Insurance	Kagarura Monday Keneth	Insurance Branch	Mbarara
Lion Assurance	Kabyesiza Joachim, Branch Manager	Insurance branch	Mbarara