MINISTRY OF GENDER, LABOUR AND SOCIAL DEVELOPMENT

better life chances for all

EXPANDING SOCIAL PROTECTION

Expanding Social Protection to Informal Sector Workers in Uganda

By Carmen de Paz, Mark Wheeler, Jean John Barya.

October 2014

A report of research carried out by Carmen de Paz, Mark Wheeler, Jean John Barya on behalf of the Expanding Social Protection Programme- Ministry of Gender, Labour and Social Development.

This report is also available on our website at: **www.socialprotection.go.ug**

FOREWORD

The Government of Uganda is engaged in the process of improving the existing social protection system in the country. The Ministry of Gender, Labour, and Social Development (MGLSD) is leading on this role, through the Social Protection Sub-Committee, and the Expanding Social Protection program. The five-year program launched in 2010 is implemented under the MGLSD with technical and financial support from GoU, DfID, IrishAid and UNICEF. It has two main components: (1) policy support provision through the development of a social protection policy and the generation of evidence of the impacts of social protection, towards building the GoU´s commitment and investments in this area; and (2) implementing a pilot cash transfer program, Social Assistance Grants for Empowerment (SAGE).

The Social Protection Policy Framework proposes a social protection sub-sector composed of two core pillars: social security and social care services. The social security pillar is comprised of non-contributory Direct Income Support (which provides regular and predictable transfers in cash or in kind to poor and vulnerable households and individuals) and social insurance which provides income support on the basis of previous individual and / or employer contributions to mitigate the impacts of income shocks such as unemployment, retirement, ill-health etc. The formal social insurance system in Uganda remains very limited, with only about 5% of the population able to benefit – largely those working in formal employment. This leaves informal sector workers out of coverage of the formal social protection especially because they are often not registered making it hard to identify and reach out to them.

The objective of the social insurance study was therefore to gather information about the situation of the informal sector workers in Uganda and to assess their vulnerability, to learn about the existing risk management and coping strategies(both formal and informal) available to them and to conduct a basic mapping of relevant initiatives in this regard as well as identifying knowledge gaps to be covered.This report presents the research findings that provide a basis for new legislation or new programmatic and policy innovations/interventions that could help increase the coverage of the current social and health insurance systems to the large majority of the population that is not formally employed and therefore remains out of reach of the existing formal instruments.

Findings of the study clearly indicate that a majority of the Ugandan population remain vulnerable to a variety of relevant risks including ill-health, work related hazards, exploitation and abuse, lack of access to finance and education/training, natural disasters and food insecurity. When faced with shocks, households and individuals can resort to different coping strategies depending on their situation and possibilities. Some of the most common include assets and savings depletion, external assistance and production adjustments.

We note that awareness and knowledge levels about social insurance schemes and the benefits of joining remain low among informal sector workers, therefore requiring special efforts which could be channelled through existing informal sector organisations. We also note that the contribution of Government to schemes by the informal sector through non-contributory benefits is particularly critical for rural and low-wage workers who do not have the capacity to ensure access to health or social insurance if not subsidised.

As a ministry, it would be good to advocate for the development of specific efforts through encouraging existing informal schemes that prove to be working effectively. This can be done by including some degree of subsidization in those that are considered promising and through official recognition and support in areas of sensitisation and information campaigns.

Pius Bigirimana
Permanent Secretary

Table of contents

Figures

Boxes

Abbreviations

CBHI	Community Based Health Insurance
CIDR	Centre for International Development and Research
COFTU	Central Organisation of Free Trade Unions
DFID	Department for International Development
ECD	Early Child Development
ESP	Expanding Social Protection Program
GoU	GoU of Uganda
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
ICTs	Information and Communication Technologies
IE	Impact Evaluation
LRA	Lord's Resistance Army
M&E	Monitoring and Evaluation
MGLSD	Ministry of Gender, Labour, and Social Development
MoF	Ministry of Finance
MoFPED	Ministry of Finance Planning and Economic Development
NDP	National Development Plan
NGOs	Non Government Organisations
NHIS	National Health Insurance Scheme
NOTU	National Organisation of Trade Unions
NRM	National Resistance Movement
NSSF	National Social Security Fund
PAYE	Pay as You Earn
PNFP	Private Not-For-Profit
PSPS	Public Service Pension Scheme
PWD	Person With Disabilities
RDCs	Resident District Commissioners
RSSB	Rwanda Social Security Board
ROSCA	Rotating Savings and Credit Associations
RoU	Republic of Uganda
SACCOs	Savings and Credit Cooperatives
SAGE	Social Assistance Grants for Empowerment
SPARCS	Social Protection Assessment of Results and Country Systems
STDs	Sexually Transmitted Diseases
UBOS	Uganda Bureau of Statistics
UCBHFA	Uganda Community Based Health Financing Association
UK	United Kingdom
UPDF	Uganda Peoples' Defence Forces
URBRA	Uganda Retirement Benefits Regulatory Authority
USA	United States of America
VSLAs	Village Savings and Loans Associations
WHO	World Health Organization

EXECUTIVE SUMMARY

Background and introduction

The Government of Uganda is engaged in the process of improving the existing social protection system in the country. The Ministry of Gender, Labour, and Social Development (MGLSD) is leading on this role, through the Social Protection Sub-Committee, and the Expanding Social Protection program. The five-year program launched in 2010 is implemented under the MGLSD with technical and financial support from GoU, DfID, IrishAid and UNICEF. One of the main components of the programme is the development of a social protection policy. The Social Protection Policy Framework proposes a social protection sub-sector composed of two core pillars: social security and social care services. The social security pillar is comprised of non-contributory Direct Income Support (which provides regular and predictable transfers in cash or in kind to poor and vulnerable households and individuals) and social insurance which provides income support on the basis of previous individual and / or employer contributions to mitigate the impacts of income shocks such as unemployment, retirement, ill-health etc. The formal social insurance system in Uganda remains limited, with only about 5% of the population able to benefit – largely those working in formal employment. This leaves informal sector workers out of coverage of the formal social protection especially because they are often not registered making it hard to identify and reach out to them.

The objective of this study was to gather information about the situation of the informal sector workers in Uganda and to assess their vulnerability, to learn about the existing risk management and coping strategies (both formal and informal) available to them and to conduct a basic mapping of relevant initiatives in this regard as well as identifying knowledge gaps to be covered. This report presents the research findings that provide a basis for new legislation or new programmatic and policy innovations/ interventions that could help increase the coverage of the current social and health insurance systems to the large majority of the population that is not formally employed and therefore remains out of reach of the existing formal instruments.

The report is based on two different consultation processes conducted over March-April 2014. Consultations were carried out using non structured interviews and focus group discussions with key informants covering relevant sectors. The health insurance related consultation process was conducted by a team comprising of an international consultant, a local consultant and an ESP staff member. It was conducted in Kampala and in the sites of selected community health insurance schemes. The social insurance related consultation process was conducted by an international and local consultant. It was conducted among stakeholders in Kampala and Mukono.

Importance of social insurance

Individuals and families around the world are faced with different risks, which can often and easily push them into poverty, depending on their particular circumstances. The main objective of social protection, and social security systems within it, is to mitigate those risks by providing a certain degree of financial security to individuals and families. In addition to providing financial protection to households, social protection can play a transformative role, as it allows them to make further productive investments, for instance in children´s education or business expansions.

Sickness, unemployment or disability benefits cover foregone income in the period over which the individual is not able to work due to these different conditions. Child benefits or family allowances are central to the prevention of child poverty and vulnerability, and of child work and exploitation, as they

offer additional income to families faced with higher needs and expenditures. Old age and survivors' pensions are crucial to prevent poverty in old age, which is common across countries, and all death-related expenditures. Old age pensions can also help release some of the time and health related burden on women taking care of the elderly in the household.

Importance of health insurance

Ill health interrupts the income stream of the family concerned, either directly when it is an income earner who cannot perform normal activities as a result of illness, or indirectly when care of a sick child or other family member takes precedence over income earning activities hence the need for some form of income maintenance. Illness in any family member gives rise to expenditure on medical care especially for serious and chronic illnesses requiring long term treatment.Numerous studies identify ill health as a prominent cause of a family falling into poverty. Health insurance is therefore a potential mechanism to deal with effects of illness. The functions of insurance can be performed by other kinds of institutions. In some of the richer countries, where health services are largely funded out of general taxation, the costs of medical care do not fall on the individuals who are sick but on the whole population who contribute to the tax base.

Risks and vulnerability in the informal sector

Findings of the study indicate that a majority of the Ugandan population remain vulnerable to a variety of relevant risks including ill-health, work related hazards, exploitation and abuse, lack of access to finance and education/training, natural disasters and food insecurity. When faced with shocks, households and individuals can resort to different coping strategies depending on their situation and possibilities. Some of the most common include assets and savings depletion, external assistance and production adjustments. Leaving the working population out of reach of existing social protection systems may not only translate into heightened vulnerability to poverty, but also into substantial economic losses in the long run. Extending the coverage of social security to the informal sector has thus also turned into a central concern in recent years.

SP policy and legislation

The constitutional provisions with respect to social security and social protection in Uganda are found in both the National Objectives and Directive Principles of State Policy and in the main substantive part of the constitution. Relevant provisions in the national objectives related to social security and social protection are crafted in terms including; protection of the aged, fulfilment of fundamental rights of all Ugandans to social justice and economic development, promotion of free and compulsory basic education, protection of the family, medical services ensuring food security and nutrition among others.The Uganda vision 2040 and the National Development plan (NDP 2010-2015 all propose social protection and view it as one of the key strategies to transform Uganda to a modern and developed country. Other policies relevant to social protection include the National Orphans and Vulnerable Children's Policy (2004), National Child Labour Policy (2006), National Policy on Disability (2009), National Policy for Older Persons (2009) the National Employment Policy (2010), the Uganda Gender Policy and the National Policy for Disaster Preparedness and Management (2010).

Community based health insurance

Community Based Health Insurance (CBHI) schemes were started in Uganda in 1990s when government health facilities were almost non-functional because of underfunding, lack of trained manpower and limited drugs and medical supplies.To date CBHI schemes have continued to grow with 22 members in the association from 10 in 2002 and 13 in 2006. Active schemes were noted to be 21 in 17 districts with

a total of 138,000 members. Schemes are however concentrated mostly in Masaka, Luweero and the south west and are all in rural areas.

Existing social insurance in Uganda and their potential for expansion to informal sector workers

Uganda has several social insurance schemes including; the public service pension scheme (PSPS), the National Social Security Fund (NSSF), other provisions and schemes are provided for in the Workers compensation Act (Cap 225) providing for compensation to workers in case of injuries at work or to and from work, the Occupational Safety and Health Act No 9 regulating the health and safety of workers, The Employment Act No 6 which provides for rights of workers and employers obligations and other private and non-statutory social protection schemes managed by insurers and some large companies. Non-statutoryschemes are however not regulated without minimum standards governing eligibility and conditions. They also operate side by side with the statutory NSSF arrangements.

A central constraint to expanding social insurance products to informal sector workers in Uganda is the incapacity of formal institutions to identify and reach out to them, and the high costs that this endeavour would entail; in addition, informal sector workers appear to be particularly wary of formal or GoU institutions that may request further contributions from them. Therefore, existing informal or semi-formal organizations offer potential to reach out to informal sector workers in a more effective and inexpensive way.

Conclusions and recommendations

Children - especially orphans , women - especially widows , the elderly and people with disabilities are among the most vulnerable groups in Uganda.Vulnerable populations are generally engaged in informal work in Uganda, and therefore remain out of coverage of the existing embryonic health and social insurance systems.

In trying to expand the coverage of the formal instruments to informal sector workers, lack of financial capacity of a significant proportion of urban and mostly rural workers to contribute to any kind of scheme and low awareness and knowledge levels about insurance schemes and the benefits of joining among informal sector workers were highlighted.

In order for government to promote the expansion of social insurance to informal sector workers it may either support these institutions to widen their capacity and the range of products they offer or to establish partnerships with them, following existing international examples, for the management and/or provision of some form of social insurance.

1 Introduction

1.1 Background and objectives

The GoU of Uganda (GoU) has recently engaged in the process of improving the existing social protection system in the country. The Ministry of Gender, Labour, and Social Development (MGLSD) has played a key role in this endeavour, through the Social Protection Sub-Committee, and the Expanding Social Protection program (ESP) (see box 1). A central output of this process is the Social Protection Policy, which is expected to define the new strategic approach and inform the future social protection policies of the GoU.

Box 1: The Expanding Social Protection Program

This five-year program launched in 2010 is implemented under the MGLSD with technical and financial support from GoU, DfID, IrishAid and UNICEF. It has two main components: (1) policy support provision through the development of a social protection policy and the generation of evidence of the impacts of social protection, towards building the GoU´s commitment and investments in this area; and (2) implementing a pilot cash transfer program, Social Assistance Grants for Empowerment (SAGE). A Social Protection Secretariat has been established under the Directorate of Social Protection within MGLSD, responsible for the management of the program.

This report, commissioned by the ESP to the UK-based consultancy firm Development Pathways, is an input to the Social Protection Policy, and aims to provide the basis for new legislation or new programmatic and policy innovation/interventions that could help **increase the coverage of the current social and health insurance systems to the large majority of the population that is not formally employed** and therefore remains out of reach of the existing formal instruments.

Chapter 1 offers the introduction and background to the report; chapter 2 outlines the most common sources of risk and vulnerability in Uganda; chapter 3 provides a description of the main social protection legislation and policies in the country; chapter 4 presents the past and existing community based health insurance schemes and discusses their potential to reach out to the informal sector; chapter 5 details the existing social insurance mechanisms and related programs and identifies key challenges to the expansion of social insurance to the informal sector; chapter 6 concludes, offering some policy recommendations to the ESP.

1.2 Methodology

This report is mostly **based on the conclusions of two different consultative processes conducted over March-April 2014.** Consultations were carried out through **non-structured interviews and focus group discussions with key informants** covering all potentially relevant sectors (GoU, employers and employees associations and Unions, academia, NGOs, hospitals/health service providers, informal sector associations). The report additionally draws upon different secondary sources, which have been used to confirm and complete the information provided by stakeholders.

Health Insurance Component

The health insurance related consultation process was conducted by a team comprised of an international consultant, a local consultant and a member of the ESP staff between March 3rd and 14th in Kampala and the sites of a sample of community health insurance schemes. Stakeholders consulted included:

- Ministry of Health
- Uganda Community Based Health Financing Association
- The World Bank
- Save for Health, Luwero
- Kabale Catholic Diocese
- Bwindi Community Hospital and e-Quality Health Insurance Scheme
- Ministry of Gender, Labour and Social Development
- World Health Organization
- Informal Sector Association
- National Social Security Fund
- Ministry of Finance
- International Labour Organization
- Confederation of Free Trade Unions (COFTU)
- National Organization of Trade Unions (NOTU)

It had originally been intended that two workshops would be held in the course of this study visit, but the schedule was rearranged and eventually the two workshops were merged into one. Field visits to three CBHI schemes were undertaken between May 5th and 9th, when in addition to reviewing the insurance scheme arrangements and obtaining the views of providers, focused discussions with groups of scheme members and non-members were held.

Social insurance component

The social insurance-related consultation process was conducted by a team comprised of an international and a local consultant between March 26th and April 7th in Kampala. Stakeholders consulted included:

- Ministry of Finance, Planning and Economic Development;
- Ministry of Gender, Labour and Social Development;
- Uganda Retirement Benefits Regulatory Authority (URBRA);
- National Social Security Fund (NSSF);
- Makerere University, Department of Sociology;
- Informal Sector Association;
- Uganda Workers Education Association;
- Union Federations: Central Organisation of Free Trade Unions (COFTU) and National Organisation of Trade Unions (NOTU);
- Uganda Markets Workers Union;
- Build Africa, Care International;
- Federation of Uganda Employers;
- St. Balikuddembe Youth Forum;
- St. Balikuddembe market's zone leaders, SACCOs and women representatives;
- Drivers, Cyclists and Allied Workers Union and taxi drivers;
- Boda-boda Drivers Association;
- Mukono Market Vendor´s Association.

The study visit aimed to: (1) gather information about the situation of the informal sector workers in Uganda, and conduct a preliminary vulnerability assessment; (2) learn about the existing risk management and coping strategies, both formal and informal, available to them; (3) conduct a basic mapping of relevant initiatives in this regard; and (4) identify knowledge gaps to be covered.

The consultation process additionally included two workshops, held in Kampala: an inception workshop at the outset, where the methodology and main consultation lines and stakeholders were identified, and a validation workshop at the end, where the results of the consultation were discussed and validated and the next steps defined.

1.3 The importance of social insurance

Individuals and families around the world are faced with different risks, which can often and easily push them into poverty, depending on their particular circumstances. These risks are normally classified into covariate (e.g., climatic events such as floods or national economic crisis), and individual (e.g., unemployment, death of a family member, or illness).

The main objective of social protection, and social security systems within it, **is to mitigate those risks by providing a certain degree of financial security to individuals and families.** In addition to providing financial protection to households, social protection can play a transformative role, as it allows them to make further productive investments, for instance in children´s education or business expansions.

Sickness, unemployment or disability benefits, for instance intend to partly cover foregone income in the period over which the individual is not able to work due to these different conditions. All these risks, if prolonged, could otherwise easily push a vulnerable household into poverty. **Child benefits or family allowances,** in turn, are central to the prevention of child poverty and vulnerability, and of child work and exploitation, as they offer additional income to families faced with higher needs and expenditures.

Old age and survivors' pensions are crucial to prevent poverty in old age, which is common across countries, and all death-related expenditures. In addition, and oftentimes, they represent a supplementary income to extended families that allows further relevant investments, for instance in children´s education. Old age pensions can also help release some of the time and health related burden on women taking care of the elderly in the household.

Appropriate **social assistance mechanisms,** in turn, provide temporary relief to families faced with food insecurity and natural disasters, preventing them from falling into the poverty cycle, while agricultural insurance products can also help mitigate the negative consequences of these unpredictable events for the household´s economy.

Governments and international organizations around the world have increasingly acknowledged the relevance of social protection for sustainable development in recent years. This is especially the case in view of the emerging global challenges generated by climate change, demographic changes, migration flows and growing economic and financial interconnectedness and instability, among others (World Bank, 2012).

Social protection systems have shown to be **crucial to prevent the negative consequences of shocks related to the former trends,** in particular after the last global financial and economic crisis. This partly explains the fact that building adequate and comprehensive social protection systems has gradually become a central priority across countries, and also accounts for the recent upsurge of international initiatives in this area (see box 2).

Box 2: Growing recognition of the central role of Social Protection for development

As a result of recent developments, different international organisations as well as governments around the world have increasingly prioritised efforts for the promotion and strengthening of social protection systems.

As an example, the Social Protection Inter-Agency Cooperation Board (SPIAC) was established in 2012 at the request of the G-20 Group to enhance global advocacy and coordination on social protection. Additionally, different common frameworks for the promotion and assessment of social protection have been developed in the last years.

One of such initiatives is the Assessment Based National Dialogue, linked to the ILO Social Protection Floor (SPF), which provides an opportunity for all the stakeholders to analyze and discuss the social security situation and formulate priority policy options.

SPARCS, led by the World Bank, is a multi-year, programmatic platform for global collaboration on social security and labour, aimed at the establishment of strong links across governments, donor agencies, experts and key stakeholders working on social security operations and policy.

Another example is provided by the ADB Social Protection Index, which aims to help evaluate the success of countries in expanding coverage to intended beneficiaries (breadth) and in providing them with adequate benefits (depth).

Sources: World Bank (2013); ADB (2012); ILO (2012); ECA, ILO, UNCTAD, UNDESA, UNICEF (2012)

Leaving the working population out of reach of existing social protection systems may not only translate into heightened vulnerability to poverty, but also into substantial economic losses in the long run. **Extending the coverage of social security to the informal sector has thus also turned into a central concern in recent years.**

This is especially the case in developing countries, where the informal sector represents a large and growing share of the economy and labour force. In Africa in particular, 90% of the new jobs created over the last decade were in the informal sector (MacKellar, 2009).

In line with this pressing reality, the Social Policy Framework for Africa (Windhoek, October 2008) mandates under the Employment and Labour Strategies to: "Give the informal sector the necessary support by removing administrative, legal, fiscal and other obstacles to its growth, and facilitate its employment creation functions with access to training, credit…appropriate legislation, productive inputs, social protection, and improved technology", and to "Develop and extension of social security and social protection to cover rural and informal workers as well as their families"

Despite the general agreement among all stakeholders consulted in Uganda about the relevance of social protection, it must be noted that a certain degree of **confusion with regards to concepts related to social protection and social security exists in the country.**

The lack of a clear and common understanding of what social protection is was particularly prevalent among informal sector workers themselves, for whom these ideas appeared to be completely new. Although the Social Policy will provide clarity in this regard, **reaching and promoting a consensus on what social protection and social security mean in the Ugandan context would therefore be a central priority** moving forward (see Box 3).

Box 3: What is social protection?

Social security according to international standards includes social assistance and social insurance programs. Social assistance refers generally to cash transfers that are not contributory and aims to protect the most vulnerable groups in society; social insurance in turn refers to contributory arrangements that entail risk pooling and some degree of solidarity. Social protection is a broader and varying concept, which for instance includes employment policies.

There has been a recent movement across countries and organizations, especially in the developing world, towards comprehensive social security systems based on three main tiers: public non-contributory basic benefits, which can be universal or targeted to the most vulnerable, normally financed through tax-revenues; a second tier of mandatory and contributory social insurance for formal and if possible informal workers, which can be managed publicly or privately; and a third tier of voluntary contributory social insurance generally managed by the private sector (see Figure 1 below).

Figure 1: Three-tiered approach to social protection

Tier 1: Public non-contributory basic benefits, both universal or targeted to most vulnerable – e.g., SAGE in Uganda.

Tier 2: Mandatory contributory social insurance for formal and if possible informal sector workers, usually public – e.g., NSSF in Uganda.

Tier 3: Voluntary contributory social insurance (supplementary) managed by the private sector – e.g., private sector funds in Uganda.

Source: based on Barr and Diamond (2008)

For instance, **although the existing social protection system in Uganda is referred to as ¨social insurance¨, it is actually based on a provident fund.** The key functions of insurance are risk pooling and time shifting. In the case of health insurance, for instance, risk pooling shifts the burden of payment for medical care from the specific individuals who benefit from it (the sick and injured) to the wider body of all exposed to the risk; while time shifting means that contributions collected out of the income of those who are well can be used to provide benefits for those contributors when sick.

Provident funds are not to be regarded as ¨social insurance¨ mechanisms in strict terms, as they are just saving schemes in essence. Additionally, these savings are withdrawn at a certain point in time as lump sums, and not in the form of periodic pensions, which can defeat one of the primary purposes of old-age insurance mechanisms: to provide financial security over the entire period where the beneficiary is not able to continue generating income.

1.4 The importance of health insurance

Ill health generates two problems for social protection. The first is that an episode of **illness often interrupts the income stream of the family concerned,** either directly when it is an income earner who cannot perform normal activities as a result of illness, or indirectly when care of a sick child or other family member takes precedence over income earning activities. For this situation, there is a need for some form of income maintenance.

The second problem is that illness in any family member **typically gives rise to expenditure on medical care,** since in developing countries virtually all health care providers are financed, in whole or part, by user fees. In the case of minor or transient illness, the costs of care may be easily absorbed, but for serious accident or illness requiring hospitalisation, or for chronic conditions requiring long-term treatment, the costs of medical care can overwhelm the family budget.

Numerous studies identify ill health as a prominent cause of a family falling into poverty. The situation is often exacerbated when the sale of assets such as land or livestock to pay for medical care costs reduces the permanent income of the family, rendering them more susceptible to future shocks.

Insurance is a potential mechanism to deal with both adverse effects of illness. However, the term "health insurance" is often used in the context of the second problem only, where it is equivalent to "insurance against medical care expenses". It is this usage that is almost universal in discussions on health financing, and in particular in Uganda.

Insurance functions are not equally well performed by all types of health insurance. Social insurance schemes on the Bismarck model that are mandatory perform very well; **private insurance and community health insurance perform less well**, because they are forced by their voluntary status into operating practices that limit their protection function, leaving their members exposed to higher levels of risk of out of pocket payment.

In this context, it is important to note that the functions of insurance can be performed by other kinds of institutions. In some of the richer countries, where health services are largely funded out of general taxation, **the costs of medical care do not fall on the individuals who are sick but on the whole population who contribute to the tax base.** The provision of services that are largely free at the point of use is one of the achievements of the British National Health Service and a few other countries that use the tax finance model. Similar outcomes are achieved in continental European countries, which use social insurance mechanisms.

There are examples of developing countries that have attempted to rely on tax finance as the main means of financing at least the public provider system. The problem with this approach is that **in poor countries with a narrow tax base, insufficient resources can be mobilised by the tax system to adequately finance universal high quality services for the population.** The Uganda coverage is not universal, because PNFP facilities are not adequately funded to dispense with user fees, and because of insufficient funding, GoU facilities lack the drugs, equipment and personnel to provide good quality services.

There are some countries where even though the public provider system is financed by a combination of tax finance and user fees paid by the majority of patients, fee exemption schemes seek to protect the most vulnerable sections of the population. Exemptions on the grounds of poverty are common, but the experience is that poverty is usually defined in a restrictive fashion, and only a small proportion of the population qualify for the benefit of free treatment.

The determination of poverty is usually made by health workers, and it is often against their personal interest to grant exemptions as user fee income is often used in part for salary supplementation. More successful are categorical exemptions based on age, pregnancy or the treatment of communicable diseases.

1.5 Social protection and informal sector workers: the case of Africa

I**nformal sector workers normally remain out of coverage of formal social protection throughout the world.** This is due to a variety of reasons. Since informal sector workers are not registered and do not

pay taxes, it is difficult for the authorities to identify and reach out to them. This is even more challenging given that informal workers tend to be scattered, especially in rural areas, and very mobile.

In addition, informal sector workers generally have low and irregular incomes, which, together with their general preference for liquidity in order to be able of facing unexpected emergencies, prevent them from engaging in formal saving instruments. Distrust of formal institutions and low awareness and financial literacy levels further contribute to this trend (MacKellar, 2009).

Different **countries have attempted to include informal sector workers under social protection formal schemes over the last years.** Based on those experiences, potential strategies to attain that objective include: (1) extending or adjusting existing mechanisms, (2) designing and implementing specially tailored schemes, (3) introducing tax-revenue based universal or targeted schemes, and (4) encouraging special voluntary and mutual formulas.

Social security systems were generally introduced over the colonial period in Africa and are still evolving. Some of the main common features are the lack of comprehensive frameworks and a preference for contributory defined benefits schemes, the existence of separate programs for civil servants and private sector workers, the low coverage of existing programs (average 10% in Sub-Saharan Africa), limited benefits (most of them only provide survivor, disability and old age), and serious administrative and financial challenges (Nyarko Otoo, K, and Osei-Boateng, C., 2012).

Many of these features are actually related to the importance that the informal sector has in these countries, which have not managed to incorporate it under their social security systems yet. However, some countries have been recently developing interesting initiatives in this regard:

- Introducing tiered schemes that serve different groups (Ghana);
- Changing financing - from contributory to non-contributory (Lesotho);
- Introducing unified schemes for all workers (Zambia and Ghana).

Informal coping and traditional savings mechanisms are widespread across countries, and unions are playing a central role in advocating for the extension of social security to the informal sector (Nyarko Otoo, K, and Osei-Boateng, C., 2012).

The health sector is no different in the general exclusion of the informal sector from contributory insurance schemes. **Those health insurance schemes which do exist are generally restricted to first, public sector employees, and second, less frequently, the employees of large formal sector enterprises.**

Informal sector workers can be members of **community health insurance schemes, but these are typically small schemes with low coverage of the eligible population and strictly limited benefits.** The only known exceptions to this generalisation are found in Rwanda, which now claims virtually 100% coverage of the population through community based health insurance schemes, and in Ghana where the level of coverage is disputed.

In **most African countries, there are private enterprises that provide health insurance benefits to their employees,** especially the more senior, typically by contracting with private insurance companies, which in turn pay the fees of private practitioners and hospitals. In southern Africa, membership of medical aid societies is an automatic privilege of employment for senior employees.

In many countries, there is legislation that requires private sector employers to provide health services to employees especially in mining and plantation employment. This legislation is widely ignored or observed only by the token appointment of medical and nursing staff, but in some cases employer provided health services can be excellent.

In Botswana, the mines at Jwaneng and Orapa provide at their expense high quality services, not only to employees and their dependants but also to the populations of the surrounding districts in the absence of alternative provision. Unfortunately, these are rare examples, where the high profitability of the diamond mines makes the performance of these social obligations a financially negligible consideration.

I**n general, lower earners even in formal sector employment are not adequately protected by membership of health insurance schemes** or direct employer-financed provision, and are forced to rely on the same fee-charging and/or low quality services that the great majority of the population in the informal sector uses. Both low-income earners and informal sector workers frequently resort to low cost providers, including unlicensed drug sellers and traditional practitioners.

2 Vulnerability Analysis: Most common sources of risk and vulnerability for informal sector workers in Uganda

Uganda has made significant progress in poverty reduction efforts in the last two decades, as poverty rates were cut by 32% (from 56% to 24%) between 1992 and 2009/2010. However, the number of poor people has continued increasing with population growth, and relevant socio-economic challenges remain to be addressed (World Food Program and UBOS, 2013).

Around 7.5 million people still live below the poverty line, especially in rural areas, illiteracy is prevalent among a quarter of the population, over 1 million people live with HIV/AIDS and millions have been affected by the ongoing conflict in Northern Uganda driven by the Lord's Resistance Army (LRA) led by Joseph Kony (World Food Program and UBOS, 2013).

A large share of poor people in Uganda, especially the extreme poor, do not have a ¨financial buffer to protect them from shocks¨, including illness or death of a family member, or failed harvest in connection with environmental risks. When faced with such situations, households often make use of negative coping strategies (e.g., reducing food intake or removing children from school), which can reinforce the poverty and vulnerability cycle (World Food Program and UBOS, 2013).

Based on the consultation process and some additional secondary sources, this chapter provides an account of the main sources of vulnerability for informal sector workers in Uganda. As presented in Box 2 above, most of the common risks faced by individuals and families can be addressed through adequate social protection tools across countries, including unemployment insurance, old-age, disability and survivors pensions, or family and child benefits.

2.1 Sources of risk and vulnerability

Poor working conditions and ill health

Poor working conditions and ill health and its negative impacts (both through catastrophic health expenditure or limitations on the individual and household´s capacity to generate income) was generally highlighted as a central source of risk and vulnerability in interviews with stakeholders. Hazardous working conditions, for instance in the rainy season, were cited as an important source of risk for market vendors, while the high risk of traffic accidents and related injury was one central concern for boda-boda and taxi drivers.

The so called ¨sugar mummy¨ and ¨sugar daddy¨ practices and the increased risk of the spread of STDs as a result was particularly highlighted as a common practice in markets (e.g., Owino) by young people´s organizations. Different sources additionally reported the high prevalence of sexual and other types of harassment at the work place among the most vulnerable informal sector workers.

Secondary sources of information confirm the **high prevalence of poor working and health conditions among informal sector workers in Uganda**. In Buganda and Ankole, an assessment of vulnerability and

coping strategies identified death, illness, loss of assets and drought as the main risks faced for the very poor (De Coninck, J. and Drani, E., 2009).

In addition, a HIV/AIDS vulnerability assessment among young people and women in the informal sector in Lira and Iganga districts found that most of the informal workers (56% and 44.3%) **had no protection from the weather while at work, 45% and 55% did not have adequate washing facilities, 68.2% and 49.8% did not have access to toilet facilities and 94% and 81% worked seven days a week.**

In Iganga, district, 75.7% of the participants in the study suffered from at least one health condition in the three months prior to the interview, 58% in Lira. Workers did not have access to health insurance coverage and mostly used private health care facilities. Despite the high risk of HIV/AIDS, most had never taken an HIV/AIDS test (Platform for Labour Action, 2010).

Harassment, food insecurity and natural disasters

In the same study in Iganga and Lira districts, around **26.5% of the informal sector workers interviewed in Lira reported harassment from other workers,** and 10% of women reported sexual harassment (Platform for Labor Action, 2010). Other studies have **highlighted the prevalence of mental, physical and sexual violence among domestic workers,** which are employed under exploitative conditions, or the poor health conditions of children engaged in the tobacco growing industry (Platform for Labor Action, 2007; Obwuhinya, A., B., 2012).

Given that most of the informal sectors and organizations interviewed were based in urban areas (Kampala), climate-related risks were not generally reported as a central concern over the consultation. However, there is evidence that these are central for agricultural workers and rural populations. As an example, a study in Masindi, Dokolo and Moroto concluded that **¨high prices for goods¨ (80.2%), drought (69.5%), floods (52.3%) and ¨low prices for farm products¨(41.3%) were the main sources of risk identified by participants (Matovu and Birungi, 2014).**

Access to assets and financial resources, education and skills

Informal sector workers themselves appeared to be primarily concerned about their lack of access to funding for business improvements and development, partly associated with high interest rates of commercial loans and unavailability of collateral in connection with their lack of ownership over the resources they use for carrying out their economic activities.

This was especially the case with regards to market vendors and taxi drivers. In order to deal with this issue, **boda-boda drivers reported the existence of informal lending mechanisms instituted by their own organizations and based on members´ contributions that allowed them to buy new motorcycles.**

This finding is aligned with the main difficulties reported by informal sector workers in setting up a business based on the last Household Survey Report (2010): lack of start up capital was the major problem (33%), followed by access to market (16%) and raw materials (14%). In addition, 11% of the households reported that their own savings were the main source of income for starting a business followed by loans obtained from relatives/friends (4%). Interestingly, **the most cited problem in expanding business was insecurity (33%), followed by profitability (16%) (UBOS, 2010).**

Many of the interviewed workers indicated that they were highly taxed, which restricted their financial capacity, and were occasionally subject to abuse by illicit organizations requesting contributions from them. This may worsen the disposition of informal sector workers towards any request for further contributions for insurance-related mechanisms, especially if they have no control over those resources.

Most of the informal sector workers reported that they would like to improve their skills and be trained if this option was available to them. Their lack of adequate skills for business management and improvement, such as accounting and book-keeping, was additionally highlighted as a main source of vulnerability by other stakeholders. Women market vendors also reported that the high costs of their children´s education beyond the primary level represented a high burden for them.

Other sources of vulnerability and risks

Death and burial expenses for survivors was among the most cited source of vulnerability by informal sector workers consulted. In fact, these are the risks that are primarily covered by their organizations or through informal associations such as burial societies, or the so-called and widespread ¨munno mu kabi¨ informal schemes (see box 6).

On the contrary, other common sources of vulnerability traditionally covered by social protection, including old age and disability, were not reported up-front and were only recognized as such by informal sector workers when directly asked about them. This may be related to the fact that people affected by old age and disability were not adequately represented in the consultation process.

Central institutional and GoU related vulnerabilities were also reported over the consultation process. The lack of work stability in connection with regulation changes (e.g., taxi drivers), no involvement and participation of the informal sector workers in GoU decisions that affect them, deficient access to the limited number of social protection or related GoU programs for informal sector workers and the feeling of manipulation by authorities in electoral periods were cited as central constraints by various stakeholders.

In addition, different sources indicated that the lack of adequate organizations for informal sector workers was a key obstacle to furthering their interests. In particular, the deficient leadership and inadequate capacity of existing organizations, the prevalence of governance issues, adverse incentives, the common misuse of institutions (e.g., SACCOs), and the lack of knowledge and legal protection of workers' rights were seriously hampering any effort towards the improvement of their conditions.

2.2 Vulnerable groups

Women, especially widows, were recognized as one of the most vulnerable groups among informal sector workers. Women represent a large share of informal sector workers in Uganda (e.g., over 60% vendors in markets are women), and are confronted with the double burden of child and household care and work.

In addition, women generally face limited rights in practice compared to men, for instance with regards to inheritance in rural areas or ownership and decision capacity over the resources they generate in urban areas, they lack access to childcare facilities, and have special health needs that remain largely unaddressed in the country.

The total population of widows was about 874,000 in 2010, which represents about 11% of the total female population aged 15 years and above. Subsistence farming remains the main economic activity for this group (79%) while 8% were living in single person households. Around 80% of all the widows were household heads (UBOS, 2010). A quarter of households headed by women register inadequate food consumption compared to a fifth in the case of men (World Food Program and UBOS, 2013).

Children, especially orphans, were also reported to be among the most vulnerable groups in the informal sector. The children of informal sector workers are often raised in unhealthy conditions (e.g., markets), working from an early age (e.g., Owino market), they lack access to early child development (ECD) and education opportunities, and are exposed to abuse and exploitation.

Around 38% of the children aged 0-17 years in Uganda were considered especially vulnerable, including orphans, children who were not attending school, child labourers, idle children, children living in child-headed households, children with adult responsibilities and children with a disability (UBOS, 2010).

The last Uganda Household Survey data available (2010) found that **12% of children in Uganda are orphans, and 18% of the households in the country had an orphan (UBOS, 2010).** Orphan children without their two parents appear to be more involved in employment than other orphan children, and school attendance was relatively higher for children with both parents alive (UBOS, 2013).

Different sources indicate that child labour is still widespread in Uganda, for instance in markets and in agricultural industries such as tobacco growing (Obwuhinya, A., B., 2012). Around 42% of children in rural areas were in employment, 17% in urban areas based on data from the National Labour Force Survey 2011/12. Overall about 1.5 million children in the age group 5-11 years were involved in work. In the 12-13 years age group, 252,000 children aged 12-14 worked in non-light economic activities and in the 14-17 years old group an additional 307,000 were at work in hazardous employment (UBOS, 2013).

The fact that old age and disability were not considered as special sources of vulnerability by most of the informal sector workers consulted suggests that **people with disabilities and the elderly may be not only among the most vulnerable but also the least vocal groups in Uganda.** In this regard, the ongoing disintegration of the traditional extended family social support networks was reported to be generating further hurdles for these highly dependent individuals.

The disability rate in Uganda is 16% based on the last Uganda Household Survey Report (2012-2013). Around 14% of the PWDs aged 6–24 years were limited by their difficulties to attend school while 40% of the PWDs aged 14–64 reported that they were affected all the time in their ability to work (UBOS, 2010). Although the share of elderly people living alone and without any income may still be low for international standards, it is expected to increase in the future.

3 Social Protection Policy And Legislation

3.1 Constitutional and General Legal Framework

The constitutional provisions with respect to social security and social protection in Uganda are found in both the **National Objectives and Directive Principles of State Policy and in the main substantive part of the constitution.** It should however be noted that the 1995 Constitution as amended in 2005 provides, among other things, that Uganda shall be governed based on principles of national interest and common good enshrined in the National Objectives and Directive Principles of State Policy.

The relevant provisions in the National Objectives related to social security and social protection are crafted in the following terms:

- Protection of the aged: The state shall make reasonable provision for the welfare and maintenance of the aged.
- General social and economic objectives: The state shall endeavour to fulfil the fundamental rights of all Ugandans to social justice and economic development and shall in particular ensure that: (a) all developmental efforts are directed at ensuring the maximum social and cultural well-being of the people; and (b) all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, decent shelter, adequate clothing, food security and pension and retirement benefits.
- Educational objectives: (a) The state shall promote free and compulsory basic education; and (b) the State shall take appropriate measures to afford every citizen equal opportunity to attain the highest educational standard possible.
- Protection of the family: The family is the natural and basic unit of society and is entitled to protection by society and the state.
- Medical services: The state shall take all practical measures to ensure the provision of basic medical services to the population.
- Clean and safe water: The state shall take all practical measures to promote a good water management system at all levels.
- Food security and nutrition: The state shall: (a) take appropriate steps to encourage people to grow and store adequate food; (b) establish national food reserves; and (c) encourage and promote proper nutrition through mass education and other appropriate means in order to build a healthy state.
- Natural disasters: The State shall institute effective machinery for dealing with any hazard or disaster arising out of natural calamities or nay situation resulting in general displacement of people or services disruption of their normal life.

The provisions reflected in the substantive part of the constitution in this regard are much narrower, as they only refer to public servants. Under Article 254, "… a public officer, shall, on retirement, receive such pension as is commensurate with his or her rank, salary and length of service." In addition, "… the pension payable to any person shall be exempt from tax and shall be subject subject to periodic review to take account of changes in the value of money." Finally, "… the payment of pension shall be prompt and regular and easily accessible to pensioners."

Some areas in the constitution that also deal with social protection-related aspects are those addressing education, women and workers' rights:

- Article 30 states that "… all persons have a right to education", while Article 34(2) provides that "… a child is entitled to basic education which shall be the responsibility of the state and the parents of the child".
- Article 33(2) in turn provides that "… the state shall provide the facilities and opportunities necessary to enhance the welfare of women to enable them realize their full potential and advancement". Article 33 (3) provides that "… the state shall protect women and their rights, taking into account their unique status and natural maternal functions in society."
- A worker's rights are to some extent recognised and protected with regards to the right to form and join trade unions, "… for the promotion and protection of his or her economic and social interests". The rights to collective bargaining and to strike are also established.
- In addition, the Parliament is enjoined to develop legislation to ensure the population works " … under satisfactory, safe and healthy conditions" and also regarding " … payment for equal work without discrimination", and that " … every worker is accorded rest and reasonable working hours and periods of holidays with pay as well as remuneration for public holidays."
- For women employees, "… the employer of every woman worker shall accord her protection during pregnancy and after birth, in accordance with the law". Thus, maternity leave is at least constitutionally guaranteed.

In light of the above, it may be argued that while the National Objectives and Directive Principles of State Policy clearly recognise the right to social protection with regards to almost all aspects, the substantive part of the constitution only clearly guarantees one aspect of social protection (e.g., old age pension) and only for public officers.

This is mainly explained by the fact that at the time the Ugandan constitution was put into place, social protection was not a familiar concept in the country and barely any formal instrument for its provision existed. However, and in the current context, the development of new legislation may allow making the National Objectives operational moving forward across all relevant areas.

3.2 Political Processes, Proposed Bills, Trade Union Influence and Policy on Social Security

From independence (1962) to 1985, the colonial system of social security operated in Uganda. The NSSF Act was passed in 1985 but due to political instability it did not become operational until 1986, under the National Resistance Movement (NRM). As a result, the PSPS, the NSSF and different private schemes were developed in Uganda only recently. The emerging social security debate led to the proposal for a social security/pensions regulator and the Uganda Retirement Benefits Regulatory Authority (URBRA) was set up.

The Uganda Retirement Benefits Regulatory Authority Act 2011 established an independent regulatory authority that is responsible for regulating the establishment and operation of retirement benefit schemes in Uganda in both the private and public sectors, protecting the funds of retirement benefit schemes, supervising institutions that provide retirement benefit products and services and ensuring the stability of the financial sector through the stability of the retirement benefits sector as a whole with a view of promoting long term capital developments.

It is hoped that the authority will help promote transparency, accountability and ensure the integrity of retirement benefits schemes and the retirement benefits sector as a whole, while protecting the interests of members and beneficiaries of these schemes and preventing contingent fiscal liabilities incurred

by the GoU. The Act also provides for the licensing of custodians, trustees, administrators and fund managers.

In March 2011, the Ministry of Finance, Planning and Economic Development (MoFPED) drafted **the bill for the Liberalisation of the Retirement Benefits Sector,** which is currently under discussion. The draft bill aims at liberalizing "the retirement benefit sector" to:

(1) remove monopoly over mandatory contributions;
(2) provide for fair competition among licensed retirement benefits schemes;
(3) provide for mandatory contribution and benefits;
(4) consolidate and reform the law relating to retirement benefits;
(5) convert the public service pension scheme into a contributory scheme;
(6) repeal the Pensions Act, Cap 286; and
(7) repeal the National Social Security Fund Act Cap 222."

The proposal to repeal the Pensions Act has however been removed, and it is planned that a separate law will deal with a new contributory pension scheme for public servants – different from the current one, in which pensions are paid from the tax payers' money.

This bill has been quite controversial for a number of reasons. First, the idea of open liberalization without the basic protection of reserving one public institution for mandatory contributions is seen as a big risk to beneficiaries. The bill provides that "the retirement benefits sector in Uganda is hereby liberalized and all licensed retirement benefit schemes shall operate and compete for mandatory contributions in an open market …" (S.3 (1)) and that "a single retirement benefits scheme shall not have monopoly over mandatory contributions made in accordance with this Act" (S. 3 (2) (a)).

Secondly, **the draft bill proposes to repeal both the Pensions Act and the NSSF Act (S. 43 (1)) but without making adequate provisions to cover the existing public service pensioners and public officers with 15 or more years of service. Thirdly, while the GoU proposes to guarantee "the safety of the basic mandatory contributions to encourage contribution towards retirement savings", the draft does not state how this will actually be ensured.**

Due to the strong opposition faced, the GoU has withdrawn the bill in order to take into account the views of trade unions and workers, the NSSF and other stakeholders. **Disagreement especially existed with regards to the planned dismantling of the NSSF and having private companies setting up retirement benefits schemes** through competition in the market. As a result of preliminary discussions, it was indeed proposed that the bill was renamed as the Retirement Benefits Reform Bill 2014 (instead of Liberalization of the Retirement Benefits Sector).

On the other hand there are a number of positive proposals in the draft bill that have generally been well received. First, a mandatory registration with a licensed retirement benefits scheme for every employee in the formal sector (S. 7 (1)) and for every employer in the formal sector irrespective of number of employees to make regular contributions for his employees to a licensed retirement benefits scheme (S. 7 (2)). The proposed rates of contribution remain 10% for the employer and 5% for the employee (S. 10).

Secondly, the number and type of benefits proposed have been increased to include: age, survivors, invalidity, major medical and maternity, unemployment, self-education and home ownership (S. 19). Additional mandatory benefits proposed include: child education and injury at work (S. 20). Voluntary benefits include: additional age benefits and basic health care benefits (S. 21). Midterm access to some benefits has additionally been proposed, including self education, child education, short-term unemployment and acquiring or constructing a house (S. 25).

Moreover, all benefits under the draft Bill are exempt from income tax (S. 37) and indexation of benefits is proposed to be managed by the Uganda Retirement Benefits Authority to ensure that the adjustment of benefits is based on the prevailing economic circumstances – and therefore to ensure that the value of the benefits is not diminished by inflation (S. 38).

3.3 Some Policies Relevant to Social Protection

The Uganda Vision 2040 emphasizes the importance of social protection, which is intended to address risks and vulnerabilities faced by different groups in the population. The state recognises the need to provide assistance to people who are vulnerable either by age, social class, location, disability, gender, disaster or who do not earn any income or the very poor.

The Vision 2040 proposes **a social protection system that includes a universal pension for older persons, public works schemes for vulnerable unemployed persons and social assistance to vulnerable children, persons with disabilities and the destitute.** The Vision also identifies universal health insurance as one of the key strategies for alleviating the high cost of health care incurred by households and enhancing access to affordable health services for all.

The National Development Plan (NDP 2010/2015) additionally views social protection as one of the key strategies for transforming Uganda from an underdeveloped and essentially peasant society to a modern and developed country. Other policies that are relevant to social protection include:

(1) **The National Orphans and Other Vulnerable Children Policy (2004),** which provides for survival, development, participation and protection of vulnerable children and obliges the GoU to design appropriate instruments to achieve this;

(2) **The National Child Labour Policy (2006),** which provides a framework for addressing child labour and actions that need to be taken to deal with it;

(3) **The National Policy on Disability (2006)** that seeks to promote equal opportunities, care and support for the protection for PWDs;

(4) **The National Policy for Older Persons (2009),** which provides for equal treatment, social inclusion and provision of livelihood support for older persons;

(5) **The National Employment Policy (2010),** which supports provision of social security for workers in the formal sector, especially those who are able to contribute to social security schemes such as the NSSF, private pension or health schemes;

(6) **The Uganda Gender Policy (2007),** which promotes gender equality in all spheres and provides guidance for engendering social protection interventions;

(7) **The National Policy for Disaster Preparedness and Management (2010),** which emphasizes the critical importance of restoring and maintaining the quality and overall welfare and development of human beings in their environment.

3.4 The National Health Insurance Bill

Status of the Bill

The Ministry of Health in Uganda has drafted a National Health Insurance Bill, currently under discussion, which would cover formal sector workers and which envisages that all Uganda residents belong to one of the three following schemes:

a. **The Social Health Insurance Scheme;**
b. **Community Health Insurance Schemes;**
c. **Private Commercial Health Insurance Schemes.**

However, the Bill has so far met resistance from employers, trade unions and workers' representatives, who view it as a burden in addition to NSSF contributions and income tax (PAYE-Pay as You Earn), and already represent about 30% of an employee's monthly salary. Both employers and workers also question the GoU capacity and integrity to implement the scheme given previous experiences of corruption and failure to manage public health facilities.

The debate over the bill continues. The current draft is accompanied by a certificate of compliance from the Ministry of Justice and Constitutional Affairs dated 3 December 2012, which states: ¨Cabinet approved the principles for the National Health Insurance Bill in Cabinet Minute 275 (CT 2011) of 14 September 2011.This is to confirm that the National Health Insurance Bill 2012 has been drafted by the Directorate of the First Parliamentary Counsel. The Ministry of Health is to seek further instructions of Cabinet regarding the Bill."

It is understood by ESP that the draft bill was still with the Ministry of Finance for consideration of its financial implications at the time when consultations were carried out. Discussions in the course of the visit suggest that the draft bill may be further modified before its submission to Parliament. It should also be noted that the feasibility of implementing the scheme described in the draft National Health Insurance Bill will be profoundly affected by the draft bill providing for the "liberalisation" of social security, because NSSF is assumed to be the vehicle for collecting health insurance contributions.

Format and content of the Bill

In essence, the draft bill envisages the **establishment of a scheme for the formal sector operating on social insurance principles.** Membership is to be compulsory for employees of the public sector and employees of the private sector when the enterprise has five or more employees. The scheme is to be financed by equal contributions from employees and employers at a rate of 4% each of the net monthly salary.

Membership of the scheme gives entitlement to a reasonably comprehensive benefit package with a few exclusions on the grounds of either high cost or moral hazard. The scheme can be characterised as following the Bismarck model, and would be recognised as familiar by anyone in continental Europe.

Clause 5 lists no less than 11 purposes of the scheme, some expressed in terms of benefits to consumers, some expressed as benefits to the health care industry. The first is "to facilitate access to affordable, acceptable and quality healthcare services". Quality is mentioned or implied several times. The redistribution element of social insurance is captured in (g) "to ensure equitable distribution of costs among the beneficiaries of different income groups". Interestingly, private provision, (i) is "to improve and harness private sector participation in the provision of healthcare services".

Governance is dealt with in what should have been labelled as Part III describing the Board and Part IV, which deals with the staffing of the scheme. The Board is to have five members plus the Managing Director. Three of these are representatives of the ministries of health, finance and public service appointed by their respective Permanent Secretaries, plus one member each representing health providers and scheme members.

The Minister can appoint one among them as Chairman of the Board. Clauses 13 and 14 state the functions of the Board, to determine policies, to ensure their implementation, and to manage the scheme in accordance with the provisions of the Act. It is specifically noted that the Board may pay providers only for the benefits in Schedule 1, and may withhold payment for ineligible claims.

It has already been noted that the expected membership of the scheme is employees of the formal sector, but some interesting refinements must be highlighted. The first is contained in clause 4 (2) which states "A member of the National Health Insurance Scheme shall register with the scheme four dependants who shall be beneficiaries of the Scheme". Apart from the oddity of the language (it does not say "no more than four dependants") this is a departure from common practice in that it does not allow for all members of a nuclear family to be covered.

In a country where the Total Fertility Rate is above 6, there must be many nuclear families with more than 5 members. Nowhere is it indicated what should become of them, but the presumption must be that since they cannot be registered as beneficiaries, their medical care costs must be met out of pocket. On the other hand, the wording does imply that other categories of dependants can be registered, for example aged parents.

There seems to be no provision for pensioners, either those already drawing other social security benefits or those who will retire after the scheme comes into operation. In mature social insurance schemes, pensioners are deemed to be entitled to medical care benefits after retirement by virtue of their contributions during working life. There is possibly a need for transition arrangements in the start up phase to avoid burdening the scheme with the costs of the already retired, but this bill makes no provision for entitlements after ceasing to be a contributor, either in a transition phase or long term.

Clause 8 (instead of clause 4 that defines membership of the scheme) provides that: "(1) A person who does not qualify for membership of the Scheme under section 4 and who is not able to join a private commercial health insurance scheme or a community health insurance scheme under section 7, shall for purposes of this Act, be an indigent person. (2) A person who is certified to be an indigent person shall be a beneficiary of the national health insurance scheme. (3) A person shall be declared to be an indigent person using the procedure under this Act."

The bill thus defines indigence in terms of health insurance status, and not in terms of level and sources of livelihood as has been customary, and it precludes the possibility of anyone not being a member of one of the three types of health insurance recognised ("Every person resident in Uganda who is not a member or a beneficiary of the Scheme as prescribed under section 4 shall be registered as a member of a private commercial insurance scheme or a community health insurance scheme").

In addition, the procedure mentioned in 8 (3) is not specified anywhere else in the draft Bill. It is further stated in clause 10 (1) (b) that contributions to the scheme shall be paid "in case of an indigent person, by the GoU, from funds appropriated by Parliament to the Scheme, for the purpose". Although because of the definitional problem identified above, provision for indigents is not likely to happen, it is potentially advantageous to have the principle of GoU subsidy to the indigent expressed in the legislation.

Part VI of the draft bill provides for the compulsory registration of contributors and beneficiaries, and stipulates an identity card as proof of registered status. It also includes at clause 29 the possibility of voluntary registration: "Any person who is not required by this Act to be registered with the Scheme, may using the procedure to be prescribed, voluntarily join the scheme". Nothing is said further about the conditions for joining, including the critical aspects of the basis for the premium payable and the means of verification of earnings. Presumably all such matters will be dealt with by regulations still to be formulated.

Part V of the draft Bill deals with the financial management provisions, although the contributions from members which are likely to be by far the largest part of the funds available are dealt with under Part II clause 10. Clause 19 defines the funds of the scheme and stipulates banking arrangements. Clause 20 provides for the accumulation of a reserve fund of up to three years future expenditure. The purpose of the reserve fund is not stated, so the possibility that it is intended to meet deferred liabilities of members who are no longer contributing cannot be ruled out, but there is nothing to suggest that this is the motive for having a reserve fund.

It is not explicitly stated whether the scheme is to be run on a fully funded basis according to actuarial projections (although these are mentioned in relation to the size of the reserve fund) or on a Pay As You Go basis. Clause 21 exempts the scheme from taxes on contributions; clause 22 governs powers to borrow (although it is difficult to know why the scheme should ever wish to borrow); clause 23 makes the financial year the same as GoU's; clauses 24 and 25 deal with obligations for audit and reporting including laying both before Parliament.

Nowhere is any detail provided about the preferred forms of contract, although Part I contains interpretations of the terms "capitation" and "fee for service". There is no mention of co-payments and deductibles, extra billing, or benefit caps, and thus all the details of provider payments, which are critical to the viability of the scheme, are not visible in the draft bill.

Part VIII stipulates that the scheme shall use only the services of accredited health care providers, and sets up machinery to establish an Accreditation Committee accountable to the Board governing the scheme. It sets out minimum requirements for accreditation, of which the most important is that the health care provider is able to provide the level of care determined by the Board. Other requirements are to comply with quality assurance mechanisms and to supply required information.

These provisions put huge discretion in the hands of the Board and its Accreditation Committee. However, no obligation is placed on the Board to ensure that all members have access to an accredited provider. Accreditation appears to be an all-or-nothing proposition according to the wording of the draft bill, in that there is no mention of provisional or conditional accreditation, and no obligation on the Board to help providers meet the minimum requirements.

Precisely because so much discretionary power is vested in the Board, the bill sets up an Appeals Tribunal to hear complaints from contributors, beneficiaries or providers. Part X deals with the machinery of the Appeals Tribunal, its powers (similar to those of the High Court) and its finances (independent of the Board).

Implications of the draft Bill

In many ways, it could be said that what the bill does not state is as important as what it actually does state. As already observed, there is little reference to the informal sector. Clause 7, which is headed "Other categories of health insurance schemes", establishes that every resident of Uganda has to be

registered under one or other of the three recognised types of schemes (National Health Insurance Scheme, private commercial insurance, or community health insurance).

The bill states that private insurance should be regulated in accordance with the Insurance Act and the Medical and Dental Practitioners Act. Conversely, the three sub-clauses that refer to community health insurance provide that:

- " A group of persons resident in Uganda who so wish may form and operate a community health insurance scheme" (7(3));
- " A community health insurance scheme shall be registered in Uganda as a company without share capital" (at 7(4)); and
- "A community health insurance scheme shall be managed in accordance with regulations made under this Act" (7(5)).

However, the provision that everyone should be registered in a community health insurance scheme if not in the National Health Insurance System (NHIS) or private insurance is unenforceable. Such schemes do not currently exist in most of the country, and there is no description of how schemes ought to operate or what assistance, if any, the GoU would provide for their formation and development. The most that can be claimed is that the draft bill envisages community health insurance to be the vehicle for the informal sector.

As currently worded, the bill makes membership of the NHIS compulsory for the formal sector. It mentions private health insurance as another form, but it says nothing about the terms on which private health insurance could be taken out by formal sector employees.

The draft does not say that individuals or groups of employees have the choice of opting out of the NHIS provided they have equivalent or better coverage under a private scheme, and does not mention the Social Solidarity Fund, which was in the previous draft bill. However, there is a fear, and an explicitly stated intention by the Task Force that designed the bill, to include opt-out provisions in a revision of the present draft.

In addition, the draft bill is silent about the process of collecting premiums. It has been assumed that they would be collected alongside the existing contributions to the NSSF and by the NSSF but the draft neither states this explicitly nor does it specify any other collection modality.

There are two problems with this reticence. The first is that NSSF believes that it currently collects only half (approximately) of the premiums due under other legislation on account of evasion by employers - a problem that would presumably get worse as employers are required to find additional contributions for health insurance. The second is that the very existence of NSSF is threatened by the draft bill to liberalise the social security sector.

There are two great dangers in the present situation. The first great danger is that the scheme goes ahead in its present form. The draft bill is directed at the formal sector (it has been prepared by a Task Force that largely represents the formal sector), and it contains nothing suggesting that there is any grand plan that will admit informal sector participants to comparable benefits in the future. It is in fact poised to create a classic two-tiered structure corresponding to the dualistic nature of the Uganda economy.

Although the bill provides for Community Insurance Schemes, which are supposed to cater for the informal sector both in rural and urban areas, in reality the status quo seems to be maintained because there is no proposal from the GoU to contribute to these schemes. In addition contributions to these

schemes would be voluntary, which potentially makes it difficult for them to operate successfully.
It is very well documented in the literature that to start with schemes for the formal sector in isolation runs the risk of developing a scheme that is too expensive to include the informal sector at a later stage, which may create a vested interest that successfully resists future enlargements. There are two indications that this risk is very real.

The first is that the percentage of salary taken in premiums at 8% combined is very high relative to what is collected in other countries. The second is that it is understood from anecdotal reports that the costing of the scheme was based on the tariff of Nakasero Hospital, a private hospital in Kampala which caters for the relatively affluent.

Starting with such a high cost base almost inevitably means that this scheme cannot be extended to a much larger low-income population. Neither internal cross subsidy nor external subsidy from the GoU would be sufficient to bridge the gap between the cost of proposed benefits and the contributions the informal sector could likely afford.

The second great danger is that the scheme will go ahead in a modified form that allows individuals or groups free choice between the NHIS and private health insurance. This opt-out clause will undermine and eventually produce the collapse of the NHIS.

Because of the practice of risk rating by private health insurers, these companies will seek to attract the good risks (individuals who are likely to make few claims on the insurance funds) by offering low premiums to this group, while leaving the NHIS with the bad risks (those with a past history of illness and the elderly who have a higher propensity to seek medical care).

The accumulation of bad risks, not offset by the contributions of the young and healthy, would plunge the NHIS into a downward cycle of increasing costs, declining income from the departure of the good risks, and increasing premiums, which will induce even more of the good risks to leave the NHIS. Requiring the private insurers to contribute 10% of their premium income to a social solidarity fund is quite insufficient to prevent the initiation of this downward spiral.

This downward cycle can be prevented by making the membership of the NHIS compulsory, and therefore ensuring that it contains both good and bad risks to perpetuity. Indeed, there are only two ways in which private health insurance can co-exist with social health insurance without destroying the latter.

(1) The first is to restrict private insurers to providing benefits that are excluded from the benefit package of social insurance, such as treatment abroad or admission to amenity wards.

(2) The second approach is to allow private insurers to offer the same benefits as social insurance, but not to exempt the privately insured from the standard contributions to the social insurance fund.

4 Community Based Health Insurance (CBHI) in Uganda

4.1 The emergence of provider, community and third party-managed models

Community based health insurance schemes were started in Uganda in the mid 1990s, which was a time when circumstances particularly favoured them. GoU health facilities were almost non-functional because they were severely under-funded, lacked trained manpower, were barely provided with drugs and other medical supplies and poorly maintained and managed.

Meanwhile, the church related or private not-for-profit (PNFP) hospitals and other facilities were providing a high proportion of all health services in the country, financed by a mix of user fees and external donations. **Fees were considered to be high, and as a result, PNFP hospitals were experiencing a considerable problem of absconding patients and unpaid bills.**

Despite the dependence of all providers on income from user fees, the adverse effects of this method of financing health services were becoming increasingly recognized. There was a concern that severe episodes of illness requiring inpatient care were so expensive, especially for the poor and near poor, that families were forced to sell assets such as livestock or land, which would push them into poverty.

The fear of heavy expenses induced many patients to delay seeking care until the condition was advanced, or to seek care from traditional or unqualified practitioners. In these circumstances, **an alternative to direct out of pocket payment was urgently sought. One option was some form of health insurance. It was immediately apparent that neither conventional commercial insurance nor social insurance provided an adequate response given the circumstances of the bulk of the Ugandan population, and since both depended on premium collection by employers.**

However, there was a worldwide interest in trying to adapt insurance principles to small scale schemes designed specifically for the circumstances of low income families engaged in informal sector production, including rural self-employment. Policy makers in Uganda were aware of a growing literature on experiments with small-scale insurance schemes in other African countries, and a readily accessible model existed in the experience of the Chogoria Hospital in neighbouring Kenya.

From these roots came the decision to experiment with community insurance schemes in Uganda. It is probably no accident that the PNFP provider-managed model initially became dominant in Uganda, since there was a shortage of trusted financial intermediaries, and in particular GoU agencies were regarded with suspicion. PNFP providers generally enjoyed, and deserved, a better reputation for the quality of care provided, in particular in relation to the provision of a 24 hour service for emergency care and the constant availability of drugs.

The selection of Kisiizi for the first scheme was fortunate. Not only was the hospital relatively isolated, with no close competition to serve the majority of its catchment population, but it was situated in a locality where the traditional burial societies, known as engozi , were particularly strong, with membership reaching 98% of the district population. Recruitment of these groups, already oriented to collective

action on behalf of their sick members, promised not only to make premium collection relatively simple and cheap, but also provided some limit to the risks of adverse selection.

The motive for establishing the schemes on the part of the sponsors, the Ministry of Health and its donors, in particular DFID, was therefore **to create a system where the costs of falling sick, particularly in the case of catastrophic illness, would be shared among groups and the total membership, thereby reducing the burden on individual households.**

By removing the risk of large out of pocket payments, the aim of increasing accessibility to quality health services would be furthered, and the burden of payment would be shifted from the moment of sickness or injury to predictable dates. If the experiment proved successful, with time it might be expected to develop into a self-sustaining method of financing user fees, which would constitute a model for adoption throughout the country.

From the standpoint of the providers and managers of the scheme, the hope was that over time, the insurance schemes would make a positive contribution to the finances of the hospitals. This would occur if insurance scheme membership became popular, and insurance contributions could be raised to the point where they at least approached the notional fee income foregone. Even at lower levels of cost recovery, the existence of a substantial amount of pre-payment would make the hospital income more predictable, and reduce the extent of unpaid bills.

However, since premiums and co-payments were initially set at low levels, based on affordability rather than cost recovery, and since the balance of costs and benefits was so unpredictable at the outset, **the providers were only prepared to accept the financial risks inherent in the schemes on the understanding that they would be fully compensated against any losses incurred.**

DFID therefore undertook to meet not only the costs of establishing and operating the schemes, but also to underwrite any losses. With this guaranteed level of support, additional schemes were set up, generally based on mission hospitals, mostly in the south west of Uganda.

An umbrella organisation, the Uganda Community Based Health Financing Association (UCBHFA) was established with DFID support to represent schemes and to give guidance in their operation. By 2001, there were eight different schemes in operation on the provider-managed model, and two other schemes using different models, discussed below.

The first schemes established, and all those supported by DFID followed the provider-managed model. In this model, the role of insurer and the role of provider are combined. It is the management of the hospital, which has the ultimate responsibility for determining the benefit package, the premiums and conditions of membership, even though in some schemes there is machinery for, and a process of, consultation with the membership. The provider-managed model is capable of accomplishing the risk pooling and time shifting functions of health insurance, but does relatively little for community empowerment.

The community-managed model was represented by a group of schemes located in seven villages of Luwero district, which were financially sponsored by the Centre for International Development and Research, France (CIDR). Although nominally owned and managed by purpose-created village organisations, CIDR readily acknowledges that it necessarily played a leading role in organising the communities, in proposing the concepts of community health financing, and negotiating for the provision of services, at a 10% discount to the normal price schedule, from Kiwoko Hospital. As in the provider managed schemes, banking services are supplied by the hospital.

Of the seven villages, four did not operate risk pooling mechanisms. In these schemes, short term credit (three months) was provided out of the group subscriptions to help individual scheme members to pay off hospital invoices, so that only the time shifting function, and then to a limited extent, was provided by this design. In both credit and insurance schemes, only inpatient care was financed, keeping the premiums at a low level. Premium income did cover treatment costs, because benefits were suspended unless the scheme maintains a positive balance with the hospital.

The third party payer model was represented by the operations of Microcare, a recently founded NGO, which set out to provide health insurance services to low-income groups in the Kampala-Entebbe area. In this model, it is the third party, which owns, organises and bears the commercial risks of the scheme by means of contractual arrangements with the beneficiary groups on one side and the providers (mostly PNFP hospitals). Microcare originally targeted informal sector microfinance groups, preferring savings to credit groups, but had also begun to investigate low earning formal sector employees, such as security guards and labourers in flower growing enterprises. The total enrolment was around 1000 members in 2002.

Over the second main strand in the development of CBHI in Uganda, schemes were derived from the experience of dairy cooperatives in Minnesota, USA, which developed Health Partners as a means of providing health insurance to the cooperative members and their families. Through initial contacts focused on fostering the growth of dairy cooperatives in Uganda, they spilled over into health insurance. **Finding a parallel need for health insurance coverage, the dairymen asked their colleagues in Health Partners to pilot schemes in Uganda.** An organisation with the same name was established to support the establishment of schemes on the community managed model (cooperative members were already familiar with the concept of elected members managing the business).

Although the price levels of health service provision between USA and Uganda were hugely different, the operating principles of health insurance were very similar. Although Health Partners contributed the basic design, and negotiated with provider institutions, each scheme could decide the balance between premiums and co-payments, and premiums were readily collected by deductions from the milk payments owed to each cooperative member. While the first schemes were based on dairy cooperatives in Bushenyi district, the basic concepts were equally applicable to smallholder tea grower cooperatives.

4.2 How did schemes perform?

Administration costs of these pioneering schemes were high, partly because it was necessary for the hospital to employ a minimum of two people full time, one to encourage and record membership, and one to register scheme members as they accessed hospital services.

Premiums were determined on a trial and error basis. They were initially set with a view to affordability rather than cost recovery, but it proved necessary to raise premiums to limit the extent of losses, sometimes by more than twice the initial amount. Premiums varied between schemes, and within schemes depending on the number of household members enrolled.

Much time was taken in the scheme design to try and reduce the risks to the insurance fund. These risks included adverse selection (whereby the sick and elderly enrol in the scheme disproportionately), which was addressed by the requirement that at least 60% of the members of each engozi join, and that all members of each family are enrolled.

Fraud was addressed by the introduction of photo identity cards, while moral hazard was countered by setting co-payments and certain benefit exclusions. Exposure to high cost individuals was reduced

through the exclusion of treatment for chronic conditions from the benefit package. In effect, the schemes adopted many of the operating principles of commercial health insurance, and for the same reason, membership was voluntary.

In the provider managed schemes, there was some confusion on both sides concerning the location of responsibility and control of the scheme, no doubt stemming from the discrepancy between the rhetoric of community financing and the reality of provider management. At various times, the scheme members and the community at large have been involved in decisions about the scheme, and both members and the hospital management used the rhetoric of a community programme. Nevertheless, at critical moments, such as revision of premiums, the hospital management had the upper hand in decision-making.

Although started in auspicious circumstances, the schemes failed to attract the expected membership. Even at Kisiizi, the numbers peaked at around 6400 or approximately 4% of the estimated catchment population. At all the other schemes, membership was even smaller. Moreover, there was a continuing problem that some families dropped out at each premium renewal.

The willingness to enrol proved to be extremely price sensitive. Focus group discussions discovered that the main reason for non-membership or non-renewal was inability to afford the premiums. There were minor differences within the group of provider-managed CBHI schemes. In some areas the engozi are less prevalent than in the southwest, which has compelled the schemes to recruit groups of other types (cooperative members, microcredit borrowers) or to admit individual subscribers at a higher premium.

The most distinctive variant within this group was and remains the Bushenyi Medical Centre, which specialised in enrolling children in secondary boarding schools. Thanks to the low morbidity and low administrative costs of enrolling this clientele, this was one scheme, which could potentially dispense with external subsidy. It was also distinctive in emphasising preventive measures, including a school nurse employed by each school, to reduce the need for curative care.

As the new millennium unfolded, the policy environment in which CBHI schemes operated deteriorated. Two key events were the decision to end cost sharing in GoU health services, announced in the course of the 2001 Presidential election, and the decision by DFID to end its support for the schemes and the association as from 2001.

The first of these was not quite as disastrous for CBHI schemes as might be supposed, for the reason that abolition of fees did not apply to the PNFP hospitals on which most schemes depended. Even competition from free GoU services was limited by the geographic isolation of many PNFP hospitals, and the perception of low quality of under-funded GoU services.

The second event would have been fatal for almost all the schemes supported by DFID had they not found alternative sponsors. The reasons why DFID, having originally initiated the schemes, decided to withdraw support were not explicitly stated, but it may be speculated that there was by 2001 sufficient evidence that the schemes were not and were unlikely to become financially self-sustaining, that their social benefits were limited, and that insurance was not needed if GoU services were free and adequately funded.

There was also a well-founded concern that the DFID subsidy was itself a perverse incentive, in that it discouraged cost saving measures by the CBHI schemes. The study by Magezi et al concluded that **none of the DFID supported schemes, with the exception of the Bushenyi Medical Centre, was or could become financially self sufficient,** in the sense that it could cover both treatment costs of its members and its own administrative costs. This conclusion is likely to have been valid even though the financial analysis was flawed.

Treatment costs in the Magezi study were measured by the user fees foregone when scheme members were treated, but as providers should have been prepared to heavily discount those fees to the schemes because in the absence of insurance they would have been unable to collect all the fees due, as demonstrated by the experience of absconding patients and bad debts.

As it was, the schemes were so far from self-sufficiency that even adjusting for this conceptual error would have left all (with the exception of Bushenyi Medical Centre) unable to cover costs from revenues. Even Kisiizi, the largest and longest established scheme, was able to cover only 30% of its costs as measured in the study. All the other DFID schemes were worse off.

It is not known whether the Health Partners schemes based on cooperatives had attained financial self-sufficiency, but it is plausible that they might. While Health Partners was clearly bearing the costs of starting schemes and some support functions on a continuing basis, **the higher level of incomes of cooperative members and the universal health insurance membership might well have permitted self sufficiency in respect of continuing costs.**

With regard to the other models, CIRD readily acknowledged that **in Luwero the schemes would not exist in the absence of 100% external subsidy for administration costs,** which were a large multiple of premiums. A similar situation was observed in the case of Microcare, which employed three expatriate staff and had only 1000 premium paying members.

It can therefore be said with considerable confidence that, **with the possible exceptions of the cooperative based schemes and Bushenyi Medical Centre, CBHI schemes were not financially self-sustaining in 2002 or had reasonable prospects of becoming so.** However, financial self sufficiency is a means to an end, not an end it itself. The more important issues are how well CBHI schemes fulfil insurance functions, and for whom.

The functions of health insurance are financial risk protection by means of risk pooling, and time shifting, allowing the insured to contribute when fit and well in order to benefit when sick. All the insurance schemes ensured a degree of risk pooling, which enabled some individuals to benefit from treatments costing hundreds of thousands of shillings for a modest premium.

Compared with a fully fledged health insurance scheme the benefits of CBHI schemes were limited by a number of design features, including co-payments, benefit caps, exclusions and above all by the small size of the risk pools. The credit schemes that operated in Luwero provided no risk pooling, and only limited time shifting since the loans were to be fully repaid in three months. The time shifting aspect of CBHI schemes was limited by the need to renew premiums at annual or shorter intervals, as in commercial insurance but in contrast to social or health insurance where there is in effect a lifetime contract.

There is some ambiguity around the issue of whether CBHI schemes serve the poor. From one perspective, they are a service to poor communities; it is clear that cash is scarce in rural Uganda, and the need to find cash to meet medical care costs is a considerable burden. There appears to be no systematic evidence on the socio-economic status of CBHI members vis-à-vis the surrounding communities, but the anecdotal evidence indicates that it is not the poorest members of each community who enrol. This is supported by the previous observations of extreme sensitivity to the cost of premiums.

The preceding pages have described the origins of CBHI in Uganda and the situation found in the first years of the current millennium. A study published in 2009 shows the situation in 2006, when there were 13 active schemes in Uganda. The authors note the small size of individual schemes, typically less than 1000 members, the small proportion of the national population covered, and in the case of Uganda, the

geographic concentration of schemes in the south west. The study includes a brief description of the scheme based on the Ishaka Adventist Hospital, at that time typical of the provider-managed model. The current situation of CBHI schemes is discussed in the next section.

4.3 Existing schemes

The number of CBHI schemes has continued to grow. The Association now lists 22 members, up from 10 in 2002 and 13 in 2006, although in the consultation process it was stated that there were 21 currently active schemes in 17 districts with 138,000 members. Despite doubts regarding the exact number, it is clear that it has increased, a somewhat surprising finding in the light of the conclusion reached in 2002 that the majority of schemes were not financially viable.

It was initially assumed that these schemes had found new sources of subsidy, although it was claimed that the majority were not donor funded. In some cases the losses were absorbed by the provider institution, presumably in a trade-off against the bad debts incurred by the uninsured. **There were external donors to all of the schemes visited, and the Association itself could not exist without the support received from Cordaid and Health Partners, which is in turn supported by US foundations.**

There has clearly been some turnover among sources of support. Microcare, the one exponent of the third party model of CBHI, had apparently collapsed because of financial difficulties arising in its microcredit rather than health insurance functions. The French CIRD withdrew from their heavily subsidised operations in Luwero, and some new players have come into the picture, including the German NGO Bread for the World and the Bwindi Development Foundation.

There has been a progressive switch from the provider-managed to the community-managed model. An example is the scheme at Ishaka Adventist Hospital. The Save for Health schemes in Luwero had always been community-managed, while the schemes under the Roman Catholic Kabale Diocese switched to community-managed in 2010.In addition, schemes are increasingly becoming combined under an umbrella organisation, which is able to provide professional management services to the individual schemes. This is true both of the Save for Health schemes and the Kabale Diocese schemes.

Despite these developments, some constants exist:

- **The schemes remain confined to their original geographic areas of concentration** around Luwero, Masaka and the south west, and they all are in rural locations.
- **Total membership remains low,** at less than half of one per cent of the national population, although there are some large individual schemes (Bwindi e Quality had 23,000 members at the time of the visit, down from 29,000 at its peak, while the groupings at Luwero claimed 21,836 members in 42 separate schemes and at Kabale 15,480 members in 11 separate schemes).
- **Health insurance remains a hard sell,** as evidenced by the low renewal rates encountered and the preference of members for raising co-payments rather than premiums.

Save for Health, Luwero

When CIRD withdrew from Luwero in 2002, its former staff registered Save for Health as an NGO and have gone on to develop 42 (only 7 under CIRD) community-managed schemes in 9 sub-counties within the three successor districts to the original Luwero District (Nakasongola, Nakaseke and Luwero).

When there was a sufficient consensus to proceed, five representatives from each village would meet as a general assembly to select the five office holders who run each scheme. These office holders have the responsibility for collecting premiums, banking, and membership cards issuance. Each family has

one card with photos, which is intended to last for three years. There is a single enrolment period each year.

Villages can choose between three different models of payments and benefits. In the pure credit model, members make an initial payment of 5,700/- per person, and make co-payments at the rate of 3,000/- for each episode of treatment. This gives entitlement to a loan up to 80,000/- repayable in 1 month if for outpatient treatment, 3 months for inpatient treatment.

In the pure insurance model, members must co-pay 5,000/- per episode of treatment, and can enjoy benefits up to 200,000/- without further payment. Of this amount, 80,000/- is paid from the individual scheme account, and the balance up to 200,000/- is paid by the union, see further below.

There is a third scheme that combines elements of the credit and insurance models. **In the mixed scheme,** the loan amount has a maximum of 30,000/-. The next amount up to 80,000/- falls on the individual scheme, and from 80.000/- to 200,000/- is paid from the union fund. Insurance premiums, which are determined by Save for Health, fall in the range of 7,000-11,000/- per person per year.

To put these figures into perspective, the average outpatient consultation fee is 7,000/- (4,000/- if seen by a clinical officer, 10,000/- if seen by a doctor) excluding drug and laboratory costs. The total cost for a Caesarean section is around 400,000/- of which the theatre fee is 100,000/-. Since the maximum that can be funded by credit and insurance is 200,000/- it is clear that for very expensive procedures the individual insured patient is still at risk to pay large sums out of pocket. This is an important limit to social solidarity.

The schemes all used Kiwoko Hospital as the provider unit in the early days, but there are now two additional units in the area, the Bishop Caesar Asili Hospital and the Franciscan Health Centre. A Memorandum of Understanding negotiated by Save for Health allows any scheme member to use any of the three provider units and referral between them.

There is a union of schemes called Mbuso founded in 2006 that has five fulltime employees and provides management services such as claims handling and production of membership cards and as noted above reinsurance for claims between 80,000/- and 200,000/-.

Individual schemes pay a fee to the union for these management and reinsurance services. The union has extended the range of services which it offers to the individual schemes, and now also functions as a credit union. The union is governed by a general assembly consisting of one representative from each of the 42 individual schemes.

Save for Health gets a grant from the German NGO Bread for the World, which covers the salaries of three full time staff and the costs of their promotional activities. Save for Health is still expanding its geographic reach into additional sub-counties, but is also struggling to retain members already recruited. For the last renewal period in 2013, the renewal rate was 77.6%, although this was regarded as exceptionally low.

Kabale RC Diocesan Office

As a result of an evaluation funded by Cordaid it was decided to reorganise the schemes based on hospitals owned by the RC Diocese as from 2006, putting them all under the control of the Diocesan Office. In 2010 the schemes were shifted from the provider-managed to the community-managed model.

Although all the early schemes were based on hospitals, by 2014 some schemes used HC3 and HC2 facilities, all PNFP. Premiums ranged from 11,600/- to 28,000/- per person per year, usually collected twice per year to coincide with the potato harvest, and co-payments were in the range of 500/- to 3000/- per episode.

As elsewhere, retaining the membership was a perpetual struggle. The renewal rate, which had previously been 85% fell to 76% in 2012 and 69% in 2013. A special case was the Batwa, an indigenous group of originally hunter-gatherers in the Bwindi Impenetrable Forest who had been expelled by the Uganda Army and dispersed in a number of small settlements in Kabale and Kisoro districts. Care had undertaken to pay a special premium of 16,500/- for Batwa in certain sub-counties.

As in Luwero, the umbrella organisation provided a number of services to the individual schemes, including handling of insurance claims and maintenance of membership records. In an interesting example of the progression towards more professional management, the Kabale Diocesan office went beyond these basic functions, and carried out utilisation review. It also commissioned special studies of prescribing behaviour and conformity with treatment protocols, and of consumer satisfaction with the services of the provider institutions.

Bwindi Community Hospital

This hospital proved to be a new well endowed facility, which was built specifically as a service to the dispossessed Batwa (though they were a very small part of the clientele). The CBHI scheme is called eQuality, the e signifying the extensive use of electronic data collection and use. It is essentially a provider-managed scheme derived from the Kisiizi experience, but it has village groups based on the bataka (the local equivalent of engozi).

There were 178 active groups with a total of 23,000 members at the time of the visit. Before a recent hike in the insurance premium, there had been 29,000 members. Relative to the catchment population, these are exceptionally high figures, but then Bwindi Community Hospital is exceptionally well endowed with 6 regular doctors on the staff and visiting expatriate specialists, which is evidently able to offer high quality services.

The hospital is located right on the edge of the Bwindi Impenetrable Forest National Park, on the border with the Congo, and is the sole provider of hospital services for the three sub-counties making up its core catchment area with a population of 60,000. Its total catchment population is estimated to be 100,000 with some overlap with two GoU HC4 facilities, located approximately 40km and 50km away. There are also GoU HC3 facilities in each sub-county.

The premium is a uniform 10,200/- per person per year, and co-payments range up to 20,000/- for a normal delivery (50,000/- for a Caesarean section), but is only 2,000/- for an outpatient visit or admission to the general wards (1,000/- for under fives). Expensive antibiotics, asthma inhalers, and referrals to any other facility are excluded from the benefit package. The Bwindi Development Trust pays premiums at a special rate for 780 Batwa families, who turn out to be infrequent users of medical care.

The purpose of the hospital in establishing eQuality was to improve the financial sustainability of the hospital and to provide improved access to quality care. The scheme contributes 8% of the total revenue of the hospital (the highest encountered) with the balance coming from user fees paid by the uninsured and donations; however, 80% of the total is from donations. The hospital has a diverse donor base, with contributions from the Elton John Foundation, Comic Relief and the US based Kellerman Foundation. It also receives significant individual donations from foreign tourists visiting the National Park.

4.4 Potential for expansion of population coverage with CBHI and recent developments

Virtually all stakeholders consulted highlighted that **the GoU would need to get behind the schemes and give them recognition and approval at the minimum in order for CBHI schemes to become much more prevalent.** Most participants also stressed the importance of sustained sensitisation of communities to the benefits of membership, which they thought was the type of material support that the GoU should give.

The **main impediment to membership repeatedly expressed was the cost of premiums** (one FGD participant also mentioned the difficulty of finding cash for co-payments). The idea of GoU subsidising those who could not afford premiums was widely acceptable, even if it implied that existing members would be expected to go on paying premiums. It was pointed out that those who currently find premiums unaffordable are the relatives of those who are members.

Community based health insurance schemes have been established across the developing world, using a variety of implementation models and units of social organisation as a base. A paper prepared for WHO identified 26 countries in Africa and Asia which had CBHI schemes, but the literature suggests that schemes exist or are being developed in several additional countries.

CBHI schemes were assumed to be particularly well suited to those countries with a large informal sector of the national economy, which could not readily be served by the conventional Bismarck style social insurance arrangements common in industrialised countries. The hope of their founders has consistently been that they would relieve the membership of the burden of large out of pocket payments for medical care, and they would generate a stable and predictable source of income to health service providers.

By analogy with the friendly society model found in Europe in the nineteenth century, it was hoped that these schemes would attract a wide membership, and might eventually evolve into the basis for population wide social insurance schemes. The experience in most poor countries has turned out differently. **With very few exceptions, these schemes have not attained financial self-sufficiency;** those that exist do so because some external agency has been willing to provide a continuing subsidy.

The schemes have mostly remained small, attracting only a small percentage of the population theoretically eligible for membership. Because membership is voluntary, they are driven by financial necessity to adopt the operating principles of commercial insurance, as a result of which the degree of financial protection afforded has been limited. Although the schemes are propagated as a service to the poor, it is invariably found that it is not the poorest in each community who join.

Given this rather disappointing experience, **community based health insurance might have been written off as a blind alley were it not for the experience of certain countries, of which Ghana and Rwanda in Africa are the most relevant examples. In these countries, there has been an evolution from the basic model of CBHI** with the drawbacks and limitations described above to an enhanced model, characterised by GoU´s support and financial subsidy to enable wider participation (see Box 4). The enhanced model has served as a staging post towards a system operating on social insurance principles with wide population coverage (see Figure 2).

Box 4: the Rwandan experience

After the genocide in 1994, user fees were re-imposed in public and mission health facilities, prompting the emergence of mutual aid initiatives. Building on these initiatives, the GoU sponsored 54 pilot schemes in three districts, using a community-managed model. The target population was the catchment population of each health centre. Membership was voluntary. Each scheme developed its own rules of operation having regard to issues of adverse selection, moral hazard, cost containment and fraud, and contracted with provider units on a capitation basis. An annual premium of the equivalent of US$7.6 for a family with up to 7 members provided access to a basic care package at the health centre covering all preventive, curative, antenatal and delivery care, essential drugs and laboratory examinations, plus transport to the district hospital. A co-payment equivalent to US 30 cents was required for each health centre visit, but there was no co-payment for referred patients at the hospital level. At the district level, schemes were combined in a federation, which played a re-insurance role for high cost events requiring hospital referral; it also helped negotiate contracts with the providers.

The results from this pilot phase (1998 – 2001) were considered satisfactory, in that 8% of the catchment population had joined the mutuelles de santé and utilisation of services was six times higher for members than non-members, while members paid less per episode of care. This conclusion resulted in an expansion phase (2002 – 2005) with the basic model, which was actively promoted by local GoU´s authorities. In 2003 there were 102 schemes with 7% total population coverage; in 2004 226 schemes with 27% population coverage, and in 2005 354 schemes with 44% of the population covered, nearly 4 million people. Utilisation rates, which had been as low as 0.28 contacts per person per year prior to the pilot phase, rose to 0.42 in 2004 and according to one source, 0.65 in 2005. An alternative estimate for utilisation in 2005 is closer to 0.47, which is more credible because it is consistent with results for subsequent years.

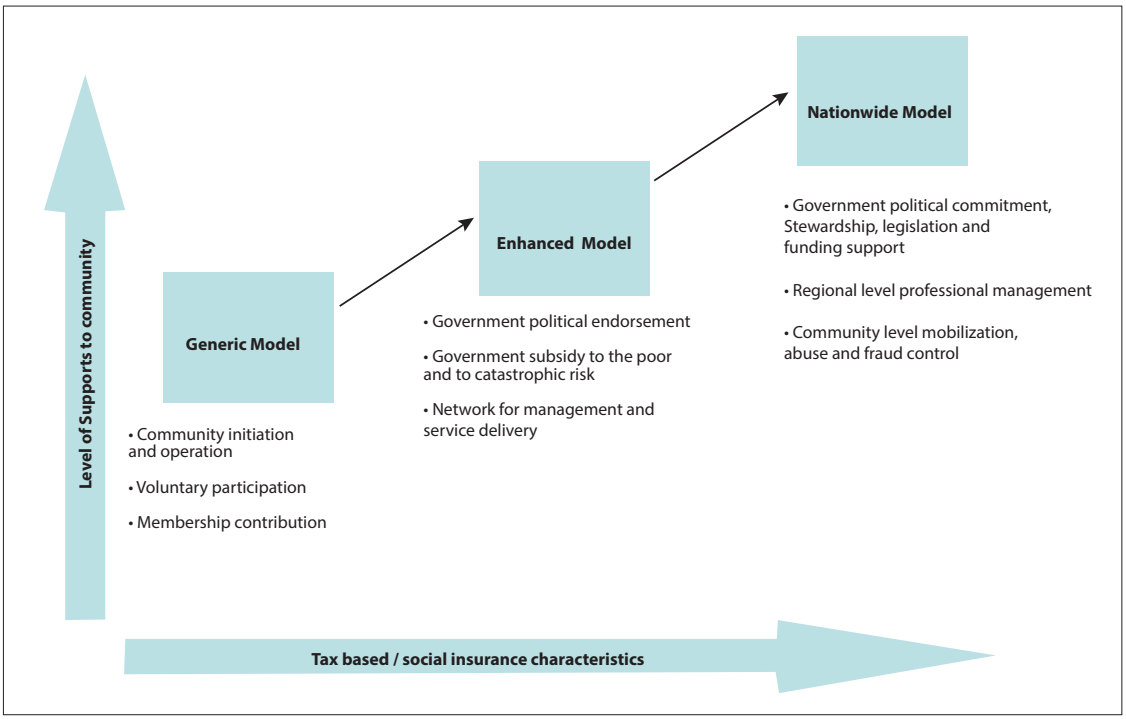
In 2006 the GoU began a series of reforms to the design. These innovations included the introduction of a GoU subsidy for the extreme poor. In 2008 membership of the schemes was made mandatory in law, although this remained an unenforceable provision. Some Global Fund money was channelled into the schemes, and performance based financing of providers was initiated. In 2006 coverage was 73% and utilisation 0.61 contacts per person per year. In 2007, coverage reached 75% and utilisation 0.72 contacts per person per year. In 2008, the figures were 85% for population coverage and 0.86 for the contact rate.

By 2010, population coverage exceeded 90%, and service use increased to 1.8 contacts per person per year. The main structural change reported is the widespread adoption of a wealth categorisation program (Ubehede), which enables communities to assess the socioeconomic status of each citizen. This is then used to determine placement in a tiered premium collection system that includes full subsidies of the two poorest sub-categories. These elements of compulsory membership and income related contributions, allied to insurance of a family group for a fixed premium and entitlement to a common benefit package, move the design much closer to the principles of social health insurance.

Despite these impressive results in terms of population coverage, the impact on financial protection is more erratic. Out of pocket expenditure as a share of private expenditure actually increased from 40.7% in 2000 to 44.4% in 2007, which is hard to interpret. There are some other reservations about the Rwanda program. There was still no integration of the Mutuelles de Sante with the Rwandaise d'assurance maladie (RAMA), which provides for civil servants. The financial stability of the schemes is not fully assured, and monitoring of implementation is a huge challenge. Perhaps the biggest concern is the quality limitations of the predominant providers, the health centres responsible for 95% of all contacts. This, combined with the disparity in the regional distribution of health service capacity, suggests that while Rwanda has made impressive gains in two dimensions of the UC cube (population coverage and financial protection) there is still far to go in the third dimension of adequate service provision.

Source: Binagwaho et al. (2012); Diop and Butera (2005); Makaka et al. (2012)

Figure 2: Evolution of community-based health insurance



Source: Wang and Pielmeier (2012)

There is no published policy document that suggests that Uganda intends to follow this evolution. Indeed Uganda has already embarked on a course that would, in theory, make health insurance redundant, as the President announced the abolition of user fees in GoU facilities in 2001. If health services are available free at the point of use, then there is no need to contribute to insurance funds in order to access them.

Unfortunately, the GoU is unable to provide sufficient finance to make a reality of free health services. GoU health facilities discourage potential patients because they have inadequate drug supplies, few diagnostic facilities and insufficient trained staff. Low salaries have driven many health workers into the private sector, where there is a thriving market in clinical and diagnostic services and pharmaceuticals, even in smaller settlements.

It is instructive to note the response of the private not-for-profit (PNFP) providers, mostly mission hospitals and clinics, to the advent of free services. Whereas there were those who argued that GoU should provide subsidies that would allow PNFP providers to dispense with fee income, it was the PNFP providers themselves who resisted this proposal.

While they did accept extremely modest GoU grants for public health services, they preferred to retain user fees for curative care in order to guarantee a source of income with which to purchase drugs and equipment and pay salaries. In effect, mindful of long experience of irregular disbursement in the previous two decades, they feared that the GoU would be unwilling to provide subsidies at a level that would enable them to dispense with user fees.

While there is no published evidence of the GoU intent to develop from a CBHI base, and only a passing reference in the current draft of the National Health Insurance Bill, senior officials in the Ministry of

Health indicated that **the Ministry does have a concept note in preparation that envisages reliance on insurance coverage rather than tax finance to reach universal health coverage.**

The Ministry additionally appears to favour a model of private provision and public finance; that coverage of the formal sector is simply the first step, and there is a vision that from the outset encompasses inclusion of the informal sector. However, caution is advised until a document is published which sets out this vision.

The first obstacle to be overcome is achieving a reversal of the current policy of free health services. Although there have been some calls from some public figures, to date it still represents a major impediment to publicly adopting a new strategy. In short, it is assumed that health insurance will bring in more revenue, enabling the provision of more and better services; conversely, if insurance coverage is less than universal, introducing user fees for the uninsured will impose hardship, especially on the poorest. It is most likely that the transition to insurance coverage will be piecemeal, with the current draft bill for the formal sector or something close to it as the first and only visible instalment, which poses some extreme dangers.

5 Existing Social Insurance In Uganda: potential for expansion to informal sector workers

5.1 The Public Service Pension Scheme (PSPS)

The public service pension scheme (PSPS) is a government scheme managed by the Ministry of Public Service, which covers a number of public servants. **The Pensions Act covers public servants of central and local governments.** S.9 in particular provides that "… every officer employed in the public service who has qualified for a pension shall be entitled to it". The minimum qualifying age is 45, having worked for at least 10 years, or compulsory retirement at the age of 60. Provision has now also been made for pension and gratuities for the army.

All the pension and gratuity schemes for central government public officers, some local government staff, teachers, medical workers, the army, the police and prisons officers are managed and operated by the Ministry of Public Service. However, due to decentralisation, all the personnel that have been recruited by District Service Commissions are a responsibility of those districts. Under the Constitution "the terms and conditions of local government staff shall conform to those prescribed by the Public Service Commission for the public service generally." (Article 200: 2).

In addition to the PSPS, **members and staff of parliament are now provided with pension and gratuity under the Parliamentary Pensions Act 2007 (**No. 6/2007). The scheme covers all members of' Parliament whether elected or ex-officio except the Prime Minister and Vice-President. Both the current and the former 7th Parliament members are covered (S. 5 (3)), as the membership of the 7th Parliament (2001-2006) was made retroactive.

Contribution by members of parliament is 15% of their pensionable emoluments while the government contributes 30% monthly. In addition, the government must guarantee the solvency of the scheme (Parliamentary Pension Scheme) "… for any payment that may be required under it" in the short and medium term (S. 21).

Apart from the above elements of the PSPS there are a number of additional laws covering some other public servants namely: local government staff, police and prison officers, judges, magistrates, intelligence officers and some public bodies, authorities and enterprises. Their social security arrangements vary and are subject to decisions of boards of public bodies.

For Judges of the High Court, Justices of the Court of Appeal and Supreme Court provision was made in 1996 under the Judicature Act (Cap. 13) to the effect that once they are appointed on pensionable terms they are eligible "for pension on completion of one year of service or in accordance with the Pensions Act, whichever is sooner".

For the local government, the Local Government Act provides that the terms and conditions of service of local GoU staff shall conform with those prescribed by the Public Service Commission for the public service generally (S. 61 (1)). In practice the local government pensionable officers are paid gratuities and pensions by the central government because the local governments cannot afford to pay this pension let alone cover most of their obligations without central government support.

For the Uganda Peoples' Defence Forces (UPDF), the UPDF Act makes provision for pensions and gratuity for both officers and militants (non-officers). The formula used to compute pensions and gratuities under the UPDF Act is similar to that applied to pensions and gratuities of public servants (S. 71). Provision is also made for pensions and gratuities in case of death or disability (S. 78).

For the police officers, the Police Act establishes a police authority, which is empowered to make provisions for the establishment of schemes for pensions, gratuities and other benefits to officers appointed on permanent or temporary terms (S. 62, Police Act). The Prisons Act does not make provision for terms and condition of service and pensions for prison officers.

No separate schemes have been established for the police or the prisons. The central government foots the pension bill of all these institutions. However the Pension Regulations, which are Schedule One to the Pensions Act, provides for gratuities for police officers below the rank of assistant inspector and prison officers below the rank OF principal officer.

The Security Organisations (Terms and Conditions of Service) Regulation made under the Security Organisations Act (Cap 305) provides for compensation for employees of intelligence organisations in case of injury during the normal course of duties (Regulation 24) amounting to not less than one year's salary. On retirement (at 50 years or 25 years of service) however there is no pension but an ex gratia payment "equivalent to 5% of the officer's gross earnings for the period served" as well as transport for the individuals and their family to his or her home village. There is also provision for general gratuity every three years equivalent to 30% of an officers' gross salary earnings for every completed year of service, as well as provision for burial expenses when the officer dies or one of his/her family´s members dies . A death gratuity is payable to the family of the deceased officer.

There are Regulations and terms and conditions specific to every Commission, Authority or public enterprises (the few that were not privatized or that were created in the last two decades) such as the Electoral Commission, Uganda Human Rights Commission, Public Service Commission, Electricity Regulatory Authority, Uganda Revenue Authority, Bank of Uganda or Uganda Investments Authority.

For instance the Bank of Uganda Act (Cap 51) provides that Board members not being employees of the Bank may be paid remuneration or allowances as the Board may in consultation with the Minister determine (S. 12) and the Board itself is empowered to make byelaws to regulate conditions of service of Board members (S. 28 (4)). For the Electoral Commission, officers and employees are employed "upon such terms and conditions as shall be determined by the Commission in consultation with the Public Service Commission" (S. 5 (6)).

The Electricity Act (Cap. 145) also sets up an Electricity Regulatory Authority (S. 4) with powers to appoint "other officers and staff of the secretariat on such terms and conditions as may be specified in the instruments of appointment" (S. 21 (1)) and the Authority must "with the approval of the Minister, make regulations governing the terms and conditions of employment of the staff of the Authority" (S. 21 (2)).

The PSPS has a number of shortcomings that render it unsatisfactory. First of all, it excludes a number of public servants such as those in all public enterprises, support staff in local governments, commissioners of various commissions under the Constitution, Resident District Commissioners (RDCs), and employees of intelligence services as seen above.

Secondly, it is non-contributory and relies on funding from the Consolidated Fund. As a result, pensions have been in arrears beyond Shs. 300 billion (by 2007 - RoU 2008:11). Thirdly, the scheme has a limited range of products/benefits. It does not cover health, education, insurance or invalidity benefits.

In addition, the scheme has no mid-term or work life benefits. One must wait till old age to qualify unless retrenched or going for voluntary early retirement. Above all, accessibility to the benefits is difficult, as many bureaucratic hurdles exist. Therefore, although most public servants are entitled to pension, it is not conceived and managed in a manner that meets the internationally acceptable standards of a good social security system.

5.2 The National Social Security Fund (NSSF)

The NSSF was established in 1985 by the National Social Security Fund Act. Compulsory membership is established for all employees in any firm that has five or more employees. Similarly, any employer with five or more employees must register as a contributing employer. The NSSF provides only five benefits:

(1) Old-age benefit, at 55 years or 50 years and retiring from regular employment;
(2) Withdrawal benefit at 50 years and not being employed for a period of at least one year (S. 21);
(3) Invalidity benefit as a result of physical or mental disability of a permanent nature rendering the worker incapable of earning a reasonable livelihood (S. 22);
(4) Emigration grant for employees migrating permanently from Uganda (S. 23); and
(5) Survivors' benefit for dependent relatives and family members of a deceased employee that was a member of the fund (S. 24).

The NSSF makes lump sum payments at old age or in any of the above situations. Workers contribute 5% and employers 10% of monthly emoluments (S. 11 & 12). The NSSF has about 300,000 members out of a working population of 11 million people (RoU 2007:1). Therefore, most eligible employees and employers are not registered with the NSSF.

There are several conceptual and practical problems with the NSSF scheme. In the first instance, the NSSF is a provident fund (e.g., basically, a savings instrument) and not a pension scheme, and as such the lump sum payment may run out quickly, pushing the beneficiary into destitution. This tends to defeat the purpose of this kind of social protection arrangement: ensuring income security in old age.

Secondly, the benefits available are too limited. Well known risks and social needs like sickness, unemployment and problems such as HIV/AIDS were not anticipated and thus not catered for. Thirdly, the scheme is only compulsory for employees working in companies with 5 or more workers, which leaves the majority of firms in the country out of coverage.

Finally, there is excessive GoU control. For instance, no investment can be made by the Fund before consulting the Minister (S. 30).The Minister also determines the rate of interest on contributors' accounts (S. 35). Declared interest rates have been too low since 1985. It is only recently (July 2008) that the Fund declared it would now grant interest at 14% per annum, but thereafter the NSSF management has since reverted to very low rates (about 4% in 2010) much below the inflation rate. In addition, and as the Fund continued to grow from a few billion shillings to now over a trillion shillings, reports and evidence of misuse and mismanagement have increased.

5.3 Other provision and schemes

The Workers Compensation Act (Cap. 225) provides for compensation to workers for injuries and diseases incurred in the course of their employment. It commits employers to provide compensation to workers in case of injuries at work or to and from work.

The Occupational Safety and Health Act No. 9 of 2006 regulates the safety and health of workers at the workplace and requires employers to put in place measures to ensure the safety of workers and provision of protective gear to avoid injuries or occupational diseases.

The Employment Act No. 6 of 2006 provides for rights of workers and employers' obligations, including the duty to give maternity and paternity leave, and prohibits any kind of work that is dangerous or hazardous to a child's health.

There are a number of private non-statutory social protection schemes managed by insurers and some large companies. Some of the existing schemes are those at Makerere University-Makerere University Staff Retirement Benefits Scheme, British American Tobacco Staff Pension Scheme, Stanbic Bank Staff Pension Fund and Bank of Uganda Staff Pension Scheme.

These schemes are problematic because they are unregulated, and therefore there are no minimum standards governing eligibility and conditions. More interestingly, the schemes usually operate side by side with the statutory NSSF arrangements, covering:

> … individuals whose incomes and standard of living allow them to afford additional contributions for supplementary benefits over and above what is being provided under the basic mandatory arrangement. In a number of organisations, they are provided to senior staff only (RoU 2003: 35-36).

5.4 The informal sector in Uganda and the challenges in expanding the coverage of social security to informal sector workers

The informal sector in Uganda is large, representing around 80% of firms and 92% of active working population according to different sources consulted (e.g., Informal Sector Association). Out of the estimated 6.2 million households covered by the last available Household Survey Report (2010) 1.2 million (21%), had an informal business.

A total of 1.8 million informal businesses exist in the country, mostly in the agricultural sector (27%) followed by trade and services (24%). Around 3.5 million people were engaged in informal businesses, and across all industries, female employees dominated except for agriculture and services in 2010 (UBOS, 2010).

There are relevant differences between the urban, peri-urban and rural informal sector workers. Rural informal sector workers tend to be engaged in occupations including agro and food processing, mining, fishing and related industries, while peri-urban and urban informal sector workers are largely boda-boda and taxi drivers, artisans, market vendors and domestic workers. Their income levels also substantially vary across these groups.

The main characteristics of the informal sector in Uganda based on the consultation process include:

(1) their scattered nature and the difficulties faced for their identification;
(2) their high mobility and dynamic/fluid nature;
(3) their precarious working conditions and the temporality of employment;
(4) the general lack of skills and education;
(5) their distrust of formal institutions; and
(6) the high fluctuation of incomes;

Low awareness and literacy levels and a preference for liquidity are additional features of informal sector workers based on other international experiences.

As of 2009/10 only around 21% of the labour force was engaged in paid employment (UBOS, 2012). Therefore, most of Uganda's working population appears to be out of coverage of any formal social security scheme. Even when accounting for the private arrangements outside the NSSF scheme, formal social security coverage has been estimated to be below 7% of the population in Uganda.

The main challenges in expanding coverage to the informal sector pertain the type of schemes that are adequate for them (e.g., compulsory, voluntary, semi-compulsory), the benefits included (e.g., old age, disability, survivors, etc.), eligibility rules (e.g., by occupation), the need for incentives to encourage participation (e.g., fiscal incentives or GoU matches), the need for flexible arrangements in contributions and withdrawals, the lack of financial literacy and potentially high administrative costs. The responses to all these challenges and its effectiveness vary across countries (see box 5).

Box 5: Increasing the coverage of social security to the informal sector – Lessons from a review of the international literature

Type of schemes: There are some examples of mandatory schemes, such as in the case of Chile, in contexts where there is a high degree of institutional capacity and where the selected strategy is to extend or adjust existing schemes. However, most of them are voluntary, which often result in low take-up rates.

An increasingly common trend is the extension of provision of minimum and non contributory guaranteed incomes (the so called first tier of social insurance), either universally or only to the most vulnerable, combined with some voluntary contributory schemes for the informal sector (third tier of social insurance).

Benefits: The most common benefits offered are old age and survivors benefits, and they are normally small, given that the contribution rates are also normally low.

Incentives for participation: Most of these schemes include special financial incentives to encourage participation. The most common one is matching contributions from the State. For instance in China, local authorities can match voluntary contributions to the new rural and urban pension schemes with at least around 5 US dollars per year. In India, the GoU has granted around 17 US dollars to accounts that increased by more than 17 US dollars per year over the first years of operation of the program. Other incentives are the possibility of using accounts savings as collateral for credit, such as in Ghana, or to secure a mortgage, as in Kenya Mbao.

Eligibility rules: Schemes often have tied eligibility rules. In the cases of India and Brazil, for instance, eligibility is linked with the occupation. China is an exceptional example, since it includes family binding criteria. For old people to be eligible for social pensions, their children must be contributing to the voluntary contributory scheme. This has been however criticized since it leaves a share and arguably vulnerable share of the elderly out of the system.

Flexible contributions: Flexible rules in the schedule and size of contributions are often incorporated to account for the irregularity and low incomes of informal sector workers. India, Ghana or Kenya, offer flexible arrangements, and allow contributions as low as 2 US dollar per month in India or 6 US dollars per month in Kenya.

Flexible withdrawals: Similarly, arrangements that allow early and partial withdrawals are normally introduced, accounting for the potential and unexpected basic needs of

beneficiaries. In this regard, the Ghana scheme is particularly interesting, since it is based on two different accounts: a retirement account, and a personal savings account, from which withdrawals are possible for specific uses including education or business enhancement investments.

Low literacy and awareness: Some schemes have also tried to address the lack of financial literacy and awareness among informal sector workers through training, information and sensitization activities, such as in the case of SEWA in India or Rwanda.

Minimizing the costs: Minimizing the administrative costs is particularly important for informal sector schemes, given the generally low levels of contributions. In order to do that, it is possible to make use of existing infrastructures or institutions for service provision. In Ghana, the GoU established an agreement with micro finance institutions in this regard; while in India, the scheme is operated through a network of licensed aggregators including post offices, insurance companies, and banks.

Building partnerships: In addition, and as shown by the Rwanda case, building partnerships with organizations that have a high degree of penetration in the informal sector, including associations or cooperatives, may be particularly useful.

Coverage is low for most of the schemes. In the case of Sri Lanka, where some of the oldest initiatives can be found, the combined coverage rate of the three main programs is 30%, although effectively coverage is estimated to be half of that amount due to the high levels of default. However some schemes are promising in this regard.

The Chinese Rural and Urban Social Pensions have been particularly successful in expanding coverage, which has reached around 60% (80% in early pilot areas) over a few years. The Brazil social agricultural pensions have also a wide coverage. Other more recent initiatives have shown a certain degree of take up, but it is still too early to assess their effectiveness with regards to coverage.

Regarding the adequacy of benefits, this is generally a key challenge for all schemes. The China Rural Pension offers a low basic benefit of 55 yuan or 35.17 USPPP, which represents only 14% of the national annual per capita net income for rural workers. The Kenya Mbao offers very low benefits when contributions are the lowest (6 USD per month). This is also the case with the Bangladesh and India micro pensions, and Sri Lanka schemes.

As for issues of affordability, sustainability and robustness, there are questions about the confidence in the pension's schemes in China, and also in connection with institutional capacity given its fast expansion. In India, the success of the program will mainly depend on the ability to generate demand for the voluntary scheme. In the Brazil scheme, the GoU has to finance a large share of costs (amounting to 1.3% of GDP in 2009), and in Sri Lanka GoU unfunded liabilities are very large and threaten the sustainability of schemes, especially when the rate of contributors to beneficiaries decreases with population aging.

Sources: Hu and Stewart (2009); MacKellar (2009); Olivier et al. (2012); Samson (2009); Sane and Thomas (2013); HelpAge International (2013); Duarte Barbosa (2011).

5.5 Existing informal coping and risk management mechanisms in Uganda

When faced with shocks, **households can resort to different coping strategies, depending on their situation and possibilities.** Some of the most common include asset and savings depletion, external assistance and production adjustments. The first two, which appear to be widespread in Uganda, are short-term negative strategies that can further push households into poverty. External assistance is also frequent, especially for the poorer households (Matovu and Birungi, 2014).
Informal family networks

Extended family networks are reported to be a central risk management and coping mechanism among informal sector workers in Uganda. The prevalence of family linkages as safety nets is demonstrated by a recent study conducted in Buganda, Ankole and Lango, which found that the clan (ekika) is partly valued for the assistance it provides during hardship. Extended families prove to play a key role as coping mechanisms, especially for widows and orphans. Indeed, around 18% of households reported to be looking after an orphan in Uganda in 2010 (UBOS, 2010).

However, various stakeholders indicated the progressive weakening of such informal safety nets, especially due to the growing lack of employment opportunities and income sources for families, leading to their incapacity to provide support to extended family members. This trend is expected to strengthen in the future, with the on-going changes in lifestyles and increasing mobility. The same study in Buganda, Ankole and Lango concluded that the use of ¨traditional¨ support strategies was declining and in some cases had disappeared due to increased poverty, HIV/AIDS and changing values (De Coninck, J. and Drani, E., 2009).

Microfinance regulated institutions

Savings and borrowing additionally appear to be key coping strategies in Uganda. In particular, borrowing was mentioned by some of the consulted stakeholders as a potential negative strategy leading to reinforced vulnerability when resources were not used productively.

The formal microfinance industry started developing in Uganda in the early 1990's with FINCA and Uganda Finance Trust, Ltd (started as Uganda's Women Finance Trust) began offering microcredit loans. Today, the microfinance sector in Uganda is considered one of the biggest and most dynamic in Africa together with Ethiopia, Kenya and Tanzania, with over 25 years of experience providing financial services to low income households, around 2115 providers, 4,830,583 total accounts, 3,438,269 deposit accounts and 952,331 loans (Mapping Microfinance 2014).

After the policy statement issued by the Bank of Uganda in 1999 on microfinance supervision and regulation, all financial institutions were categorized into (1) commercial banks that offer microfinance services, (2) credit institutions, (3) Micro Deposit-taking Institutions (MDIs) and (4) SACCOs, NGOs, and smaller companies not under the supervision of the Central Bank. However, a proposed bill that has already been presented to the Parliament aims to regulate the activities of financial institutions in a group (4).

Micro-savings and lending products are offered by a plethora of regulated microfinance institutions (e.g., FINCA, Pride Uganda, Opportunity Uganda, Uganda Finance Trust, etc.), for which 90% of the lending portfolio is in the informal sector.

Based on the Association of Microfinance Institutions of Uganda latest report, regulated institutions have the largest number of clients (with the main institutions being Centenary Bank, Equity Bank and

Post Bank followed by PRIDE, Finance Trust & FINCA). Loan and savings portfolios were also the largest among regulated institutions.

Products are diverse, although more so in the case of regulated institutions given their larger capacity, although smaller institutions have been creative in offering products that are suitable and most demanded in their localities such as solar loans, rain water harvest loans, boda-boda loans or house improvement loans.

As an example of microfinance organizations, the GoU-owned Pride Uganda offers savings and lending products to informal sector workers. Savings products require low minimum amounts and offer flexible withdrawal in some cases, and the possibility of using savings as collateral for long term products. Loans are generally restricted to agricultural purposes, group guarantees and school fees.

However, actual insurance products are not normally provided by these organizations, with the exception of agricultural and life insurance products in some cases. Additionally, formal microfinance organizations appear to target the upper-income and more educated informal sector workers. In fact, most of consulted informal sector workers did not refer to them as potential positive coping strategies, and only the Boda-boda Drivers Association mentioned working with Liberty Life for insurance products.

Informal credit and savings associations

Based on the consultations, informal savings and lending schemes are widespread and help cover the existing gap with regards to social insurance for the informal sector. Although an exhaustive account of initiatives is beyond the scope of this report, some examples of such schemes discussed over consultations are detailed below. All the existing informal schemes seem to be based to a certain extent on traditional self-help groups such as the Munno Mukabi further described in box 6 below.

Box 6: Munno Mukabi in Uganda

The most common traditional self-help groups in Uganda are Munno Mukabi, which translates into Friend In Need Associations, which are based on the principles of solidarity and sharing at specific times, especially death, sickness and the celebration of marriage.

Normally at the inception of the group a budget is agreed on and split equally among the members, which make fixed regular contributions at meetings (weekly or monthly). This money is lent to members when required, usually for burials, weddings, children's graduations, baptismal parties, etc. Members also pledge to make their labour available when a member faces a crisis or holds a celebration (CGAP, 2000).

However, there are signs that these groups may be weakening or disappearing in some parts of the country, mainly in connection with administration issues, (Seeley, 2013) but also due to conflict and changing ways of life. In fact, there are signs that some of them have been adjusting, for instance starting income generating activities (De Coninck and Drani, 2009).

Source: CGAP (2000); Seeley (2013); De Coninch and Drani (2009).

1. Savings and Credit Cooperatives, SACCOs (Owino market)

Savings and Credit Cooperatives (SACCOs) are ¨user owned and managed organizations under the Cooperative Act¨, which aim to ease access to credit for members. SACCOs help pull together resources in the form of savings in order to lend them out at lower interest rates to members.

There is large variation in size, from a few to several thousand members. Most are organized around the work place in the case of formal sector workers, but also around specific markets in urban areas (e.g., Owino) or products (e.g., coffee) in rural areas (Okwee, 2008).

There is a widespread network of SACCOs in Uganda, as most sub-counties have one. Membership fees are determined by each respective board (e.g., 10-20,000 shillings in Owino market). Shareholders elect the board, which adopts the central decisions to be ratified by the shareholders assembly, while the executive management, selected by the board, is in charge of day-to-day operations. Every member has a vote, regardless of the size of his/her lending or saving portfolio (Okwee, 2008).

However, many SACCOs have been reported to face serious financial and governance challenges, sometimes leading to their collapse. Exposure to credit and operational risk is reported to be high (Cuevas and Fischer 2006). The lack of transparency with regards to rules, the appropriation of institutions by managers and Boards, complex and often not-enforced accounting systems, and adverse incentives generated by members drive to minimize interest rates charged, are some of the most common problems.

Liquidity management challenges are also prevalent, given that SACCOs often lend out both savings and share capital, and large portfolios in arrears are common due to poorly enforced if existing lending policies and arrear management systems and difficulties in realizing collateral (Carlton et al. 2001).

2. ROSCAs (Rotating Savings and Credit Associations): the case of the Taxi drivers' numberless scheme (Constitutional Square Stage)

ROSCAs are Rotating Savings and Credit Associations in which all members contribute a fixed amount regularly (weekly), with the total being assigned to one of the members each week until all of them have received this amount at least once. Savings therefore do not generate any additional return.

An estimated 2.2 million Ugandans are ROSCA members. The widespread use of ROSCAs in Uganda has been attributed to the lack of availability and accessibility of formal financial institutions for large shares of the population (Peterlechner, 2009).

The taxi drivers' ¨numberless schemes¨ is an example of these common institutions. Numberless schemes are rotating savings and ¨insurance¨ schemes for members present in all permanent and big stages in Kampala. The biggest, with 102 members, is the one of the Constitutional Square Stage, with which the team had contact over the consultation process.

Contributions for the scheme amount to 3,000 shillings per route (it is estimated that there are 120 routes a day in the Constitutional Square Stage), from which 1,600 go into pooled savings for death and sickness benefits. Savings are put into an account in the Centenary Bank, overseen by an elected Committee, and with control mechanisms for withdrawal (e.g., no individual committee members can withdraw money from it, and every time funds are withdrawn members of the group are informed).

The benefits in turn amount to 500,000 shillings for burial expenses, 400,000 shillings to dependents; and varying amounts to ill members depending on the Committees evaluation. In addition, 200,000 are paid out to each member regularly in turns based on a list. The elderly in the group are covered, even when they no longer work.

Despite the weaknesses of the scheme, as funds do not generate significant additional returns, and it only covers a limited number of contingencies to a certain extent, it has proven to be successful in providing security for this group. It represents a promising example for potential scale-up or institutionalization and offers potential for replication.

3. Village savings and loans associations (VSLAs)

Based on ¨munno mu kabi¨ or ROSCA informal arrangements, these schemes are being promoted and supported by different NGOs throughout East Africa and Uganda in particular using a certain simple but clear methodology. In Uganda, VSLAs were started by Care International in 1998, and today exist in 63 districts of the country, serving more than 2.8 million people (CARE).

VSLAs are self-managed savings, insurance and credit groups that aim to reach the most vulnerable (e.g., those who are not in a position to be SACCO members). Community members form themselves into two groups (around 15-30 people) to pull money together and lend among themselves based on their own rules, and choose their own leaders.

Savings range from a minimum 1000 shillings to a maximum 5000 weekly. They additionally include an emergency fund (200-500 shillings a week) that helps members cope with shocks (death, illness, social obligations), provide interest free loans or grants usually to families that lose a member, and request lending interest rates of between 5-20% when borrowing is due to other purposes.

Funds accumulate, and after one year members are encouraged to distribute savings and re-start the scheme. Special provisions are made to adjust the scheme to the particular features of these groups. For instance, shares are represented by stamps to allow illiterate people follow up. Training to use the savings productively is provided to members.

VSLAs appear to have been effective in promoting growth and building local capacity, through the upscale of economic activities, better education opportunities, and general life improvements among members. In particular the insurance component has allowed members not only to cope with shocks but to use their resources more effectively.

It is observed that after the first year of operation, saving and borrowing is increasingly used for entrepreneurship or business development purposes, partly through peer-pressure and role modelling. In addition, and since most members are women, VSLAs have promoted women´s economic and social empowerment in communities. As an example, 95% of female members report improvements in domestic relationships (CARE International).

5.6 Potential for increasing coverage of social insurance to informal sector workers

A central constraint reported by respondents to expand social insurance products to informal sector workers in Uganda is the incapacity of formal institutions to identify and reach out to them, and the high costs that this endeavour would entail; in addition, informal sector workers appear to be particularly wary of formal or GoU institutions that may request further contributions from them. Therefore, **existing informal or semi-formal organizations offer potential to reach out to informal sector workers in a more effective and inexpensive way.**

None of the existing informal schemes described above offered proper social insurance products yet. **A strategy of the GoU to promote the expansion of social insurance to informal sector workers may however be to either support these institutions to widen their capacity and the range of products they offer or to establish partnerships with them,** following existing international examples, for the management and/or provision of some form of social insurance (see Box 7).

Box 7: Building partnerships with existing organizations

The costs associated with setting up and managing pension systems can be high. Informal sector schemes should be designed in a way that costs are minimized, given the likely lower pension balances of participants and the irregularity of contributions. When setting up a new pension system, using existing infrastructure where possible could be an efficient strategy. In addition, the likelihood of engaging informal sector workers in special schemes is challenging and may be improved through linkages with organized groups of workers.

For example, in India, the financial sector infrastructure related to the National Pension Scheme includes banks, post offices, depository agencies, etc. In addition, drawing upon existing financial sector players and institutions which already have a relationship with the target groups outside the pensions realm may also be useful – for example, the Grameen Bank.

In this regard, the Rwanda Social Security Board (RSSB) established partnership with key institutions that work with the informal sector to facilitate sensitization, mobilization and organization, including: Private Sector Federation, Rwanda Cooperative Agency, Rwanda Development Board and District Authorities among others. Coordinated working procedures were developed, including intensive sensitization campaigns and creating an IT interface with these institutions for the exchange of data.

Source: Samson (2009); Hu and Stewart (2009)

Participants in the consultation process highlighted that **GoU support, mainly in the form of matching contributions, would be key for the expansion of social insurance to informal sector workers.** Many responded that existing informal or semi-formal institutions could be helpful in reaching out to them, although governance issues would therefore need to be considered and addressed, especially in the case of SACCOs. However, some of the stakeholders consulted warned that further **GoU interference in the existing successful institutions may in fact compromise their effectiveness,** which is considered to be largely based on independence and self-management principles.

Additionally, the lack of information and sensitization about the importance and use of social insurance was reported as a main barrier for the expansion of any kind of social insurance product to informal sector workers, who were not generally aware of such schemes and their benefits. **Existing informal and semi-formal institutions are particularly well positioned in order to develop any kind of informative or training activity in this regard.**

It cannot be concluded from the interviews with government stakeholders that the GoU (MoF and URBRA) has a specific plan to reach out to informal sector workers. References to expanding coverage of social insurance to informal sector workers are anecdotal in the new legislation, and it appears that this objective will be largely left in the hands of the free market forces that are expected to start operating in the sector. However, and at the same time, it seems that proposals in this area would be welcomed and considered.

Some of the new or old operators may be in the process of developing products and activities to reach out to informal sector workers. NSSF in fact reported having been working on these kinds of schemes for some time now, and to be awaiting the finalization of the reform process for their launch. However, it is not expected that the situation would change dramatically after the reforms if the incentives and costs for the development of such market remain the same for both financial institutions and potential customers.

6 Conclusions And Recommendations

6.1 Conclusions: the role of the GoU

The analysis presented in this report is mostly based on a consultation with stakeholders conducted in Uganda over March-April 2014. **The results of such process indicate that additional and substantive efforts from the GoU will be required to effectively prevent pervasive vulnerability to poverty among the majority of informal sector workers in the country, which otherwise will continue hampering its long term economic and social development.**

Based on the consultation, a majority of the Ugandan population appears to remain vulnerable to a variety of relevant risks, including ill health, work-related hazards, exploitation and abuse, lack of access to finance and education/training, death and burial expenses, natural disasters and food insecurity. Children - especially orphans -, women - especially widows -, the elderly and people with disabilities are among the most vulnerable groups in Uganda.

Vulnerable populations are generally engaged in informal work in Uganda, and therefore remain out of coverage of the existing embryonic health and social insurance systems. Their systematic exclusion from coverage of the formal mechanisms not only has individual negative consequences, since it makes these workers and their families susceptible to falling into poverty, but also entails social costs, as it deters them from investing in productive activities.

Different challenges have been identified in trying to expand the coverage of the formal instruments to informal sector workers. Two key constraints across countries including Uganda are: (1) the lack of financial capacity of a significant proportion of urban and mostly rural workers to contribute to any kind of scheme, which would demand some kind of subsidization; and (2) the low awareness and knowledge levels about insurance schemes and the benefits of joining among informal sector workers.

The GoU has recently embarked in the process of reforming the current social and health insurance legal frameworks through two main instruments: the new National Health Insurance Bill, and the Retirement Benefits Reform Bill. However, the effectiveness of these attempts is at least questionable. This is the case even for the minority of formal sector workers that are covered under social insurance arrangements, as the system continues to be articulated around a provident fund, a mere savings scheme in essence.

The potential for these reforms to increase coverage to informal sector workers is clearly limited. On the one hand, and **although provision had been made for voluntary participation by the informal sector to contribute to the existing schemes, this idea is not elaborated at all in the new Retirement Benefits Reform bill**, and plans for its future development do not seem to exist.

Given the past and current extremely low or absent contribution rates among informal sector workers, nothing indicates that coverage may be increased just as a result of the liberalization of the sector. The high costs and potentially low returns of engaging informal sector workers in existing or adjusted schemes are very likely to discourage private operators to put any special efforts into trying to reach out to them without the assistance of the GoU, especially for the lower income and more isolated groups. On the

other hand, and despite the importance attached to health coverage by informal sector workers, **the National Health Insurance Bill makes no mention to the potential expansion of coverage to that share of the population.**

The new legislation in both the social and health sectors as it stands indeed is likely to lead to further entrenching a dual system where the most vulnerable continue to remain excluded and, in the best case scenario, end up having access to lower quality insurance and/or services, and to the eventual collapse of NHS and the NSSF as contributors opt-out to enrol in the new private schemes and the ¨bad¨ risks concentrate in the public instruments.

It is also worth noticing that these two new laws seem to have reinforced the existing and notable confusion around social protection concepts among stakeholders. As an example, the new Retirement Benefits Reform Bill refers to benefits that are not conventionally included under that category, under the argument that they are targeted at people who ¨retire¨ from the labour market for one reason or another, and some key officials consider social security restricted to social assistance.

Confusion is also prevalent in the realm of health, as contradictory messages from different GoU agencies and officials with regards to the yet absent long term strategy for health care provision are common. Shorter and medium term actions from the GoU should be aligned with and move towards a longer term vision that ensures financial sustainability and access for the majority of the population. Examples of informal and community based provision of some form of social and health insurance exist in the country, especially in the health sector; however, they do not suffice to mitigate risks and help informal sector workers cope with shocks. Indeed, CBHI experiences have shown that a different approach will be necessary for these kinds of initiatives to effectively help expand coverage, one where the GoU plays an active role.

The Ministry of Health does not regard the existing CBHI schemes as a good platform for future expansion on the grounds of the limitations imposed by their rural location and relative poverty of their members, and it favours schemes aimed at higher income informal sector workers in the urban areas. It remains unclear whether any such schemes currently exist.

6.2 Recommendations: Moving towards an effective and comprehensive social protection system

The ESP is well positioned to act as a key focal point and driver in order to generate consensus and clarity about social protection in Uganda, both in terms of the conceptual and policy framework and the long-term strategy. In the area of health, and given that it falls under the direct mandate of the MoH, special efforts will be required to engage with the relevant counterparts and ensure that such clarity is restored, with the objective that all actors work towards the same future vision and objectives for the country.

In the area of social insurance, and although this subject is beyond the scope of the report, **the GoU (through ESP) may wish to conduct an in-depth analysis of the functioning of the current provident fund based schemes and explore the potential advantages of progressively moving towards a proper social insurance system in the country** (see Box 8).

Box 8: Reforming provident funds?

Provident fund systems have been widely criticized across countries in connection with some of their features and key weakness, which indeed and strictly speaking would leave them out of the realm of social insurance (see introduction). The ILO highlights, for instance, that these schemes are not the ¨ideal substitute of pension systems¨, given their innate constraints to alleviate poverty in old age as protection over the whole length of the period is not granted.

The income replacement, investment and inflation risks in provident funds are mainly borne by beneficiaries, which further limit their ability to prevent poverty in the event of any contingency covered (especially old age and survivors). In addition, conservative policies, for instance restricting the international diversification of investment portfolios, often yield the returns of provident funds particularly low (e.g., India, Sri Lanka).

Some countries have thus attempted to transform provident fund- based systems into proper pension schemes over the last decades. However, these reforms have often proved to be challenging (e.g., India, Kenya). Various stakeholders have often opposed reforms on the grounds that they entail higher costs and may be unsustainable in the long run, and have often led to the coexistence of various (and fragmented) schemes.

In addition, further exploring informal sector needs, features and preferences through proper qualitative and quantitative analysis would be desirable. In parallel, improving the knowledge of the functioning of SACCOs and other existing informal or semi-formal financial and self-help organisations would be helpful, for instance in order to identify the ones that may be of interest for the potential provision of social or/and health insurance related products and services (e.g., sensitisation) for informal sector workers.

An economic feasibility and costing (if possible measuring cost effectiveness or costs-to-benefits) exercise of any of the potential alternative measures to adopt would be recommended. In addition, any intervention design should incorporate an impact evaluation study when possible. These analyses would help make informed policy decisions also in terms of costs-to-benefits and estimated impacts (see box 9 below).

Box 9: The relevance of adequate impact evaluation (IE) and M&E

Impact evaluation allows knowing whether the outcomes (e.g., vulnerability, poverty, etc.) actually change as a result of the intervention. Impact evaluations can therefore help build public support for proven programs, encourage program designers to focus more on program results and on the more successful programs, and will provide guidance as to what policy option is more adequate in each context.

Monitoring, which is complementary to impact evaluation, is a continuous process of collecting and analyzing data to compare how well a project, program or policy is performing against expected results.

When evaluating alternative policy interventions, it is important to use a research design that provides credible estimates of the causal impacts of the intervention under consideration.

The central challenge would be to find the right counterfactual: what would have happened without the program or intervention?

Before and after comparisons of the same individuals and comparisons between those who join and those who do not may be affected by unobservable variables that cannot be controlled for, which would require a ¨randomized¨ assignment of the treatment to a large enough sample of in principle similar individuals ¨on average¨.

Randomized experiments are considered the ¨gold-standard¨ for estimating effectiveness. However, a range of political, ethical and practical concerns has limited its use. Quasi-experimental methods often rely on constructed quasi-experiments to estimate causal impacts, including:

1. Difference in differences - Compare the change in outcomes between treatment and comparison groups, assuming that both would have had the same trend without the program.
2. Discontinuity design - Compare outcomes for units just above and below the defined cut-off point.
3. Propensity Score Matching – aims to replicate randomization, matching and comparing pairs of individuals that are assumed to be similar based on observable variables and comparing their evolution with and without treatment.
4. Instrumental variables –it aims to find sources of variation in program participation that are not directly related to program outcomes; a suitable variable (the instrument) provides an exogenous source of variation that allows identifying a causal relationship.

Notwithstanding the results of such studies, **the characteristics of the Ugandan context indicate that developing a zero social protection pillar providing non-contributory tax-financed minimum benefits for all workers that remain unprotected and vulnerable could be the most effective strategy to expand coverage to the informal sector.**

This is especially evident in view of the need for GoU´s financial support for any initiative to succeed in increasing coverage to the most vulnerable informal sector workers, and the likely high costs of identifying informal sector workers. Such pillar could either be universal or introduce some means testing, - although this last option could prove challenging -, and build upon the SAGE pilot for old-age pensions (see figure 4 and box 10).

Box 10: Broadening access to non-contributory systems

The great expectations raised among international and national actors about the potential of tailored-made schemes for the informal sector when these initiatives started being tested have often not been met, especially in contexts of high informality, lack of institutional capacity and widespread poverty. The high required levels of subsidization of these schemes, coupled with the costs they can entail, and the lack of incentives or actual capacity for the target populations to contribute have partly led to the increasing recognition that broadening access to non-contributory social protection for all citizens may be the most effective way to reach the most vulnerable informal sector workers and protect them against certain risks and shocks. This foundational pillar, in time, could be complemented by other voluntary schemes for those informal workers that choose to save and are in a better position to do so.

This has been the case in many countries in Latin America, where informality rates generally amount to 40% of the labor force. The natural response to this gap across countries has been to develop non-contributory insurance programs, mostly through social pensions, or entitlements financed out of general revenues or earmarked taxes and paid out to certain categories of individuals, based purely on age.

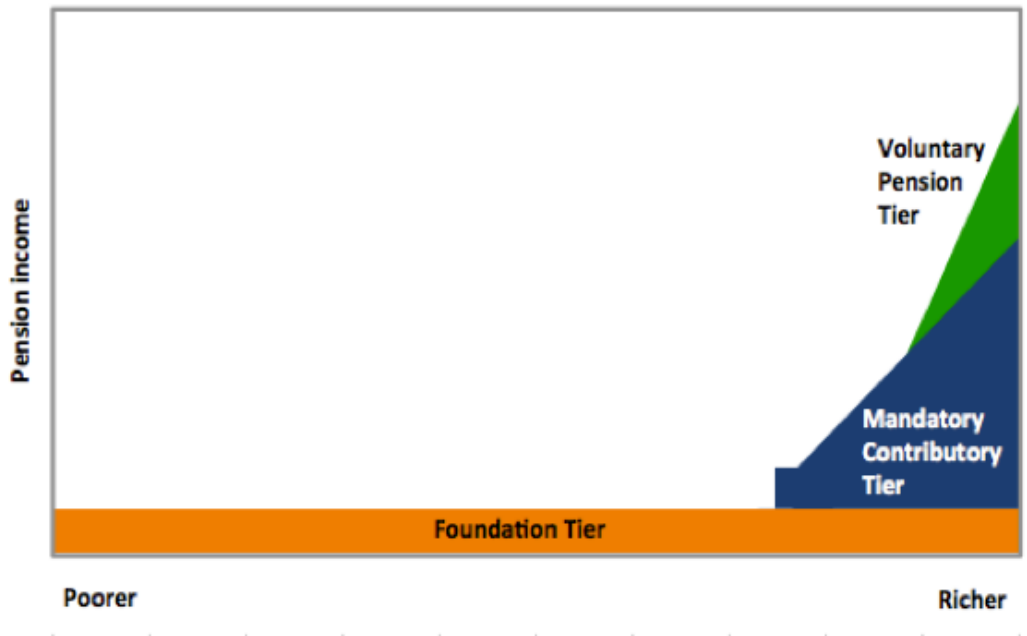
Several countries in Africa have opted to extend coverage more broadly by better integrating tax- financed non-contributory pensions into a multi-pillar retirement system. Mauritius' multi-tier pension system, for instance is well developed and a model for developing countries. Other countries, including Kenya and South Africa, are working in this direction.

The first tier in the Mauritius system is a non-contributory Basic Retirement Pension (BRP) financed through tax revenue providing a minimum benefit in old age; the second tier is comprised by two mandatory pension schemes – the National Pension Fund (NPF) and the National Savings Fund (NSF); the third tier includes diverse smaller-scale voluntary schemes targeted to the population that is not covered by the first two.

In February 2008 Kenya's Retirement Benefit Authority submitted to Cabinet a universal social pension package to provide Kenyans over 55 years old with a monthly minimum guaranteed benefit of 70% of the absolute poverty line (KES 1,600), creating a foundational pillar for a more comprehensive retirement savings system. The scheme was to be financed through a modest tax increase.

Sources: Kidd (2013); Ferreira and Robalino (2010); Samson (2009).

Figure 4: Universal basic pension for all workers



Given the current move towards private sector provision of social insurance benefits, the potential set-up of a separate public scheme for informal sector workers does not seem to be the preferred option by the GoU, and would therefore require special awareness raising and lobbying efforts on the part of ESP. In addition, international experiences so far do not show remarkable results in effectively expanding coverage to informal sector workers through special schemes.

Nevertheless, it could be intrinsically interesting to pilot a scheme specifically aimed at informal sector workers that builds on some of the existing informal experiences described in previous sections, exploring its effectiveness and potential for scale up. Based on international experiences, such pilot program may include the following features:

1. Voluntary although incentivized participation, with for instance fiscal incentives associated. Matching contributions may however entail approximately the same costs as providing fiscal incentives and be seen as a more immediate incentive for potential users, based on discussions with them.
2. Providing flexibility in contributions, through smaller but more regular contributions, and in withdrawals, offering the possibility to use part of the savings for certain purposes (e.g., productive investments) and/or as collateral, following the example of Ghana.
3. Reducing administrative costs making use of existing infrastructure and institutions and ICTs (e.g., mobile money, as in Kenya Mbao), partnering with organizations that are present and have the out-reach capacity in the informal sector for sensitization and/or management/provision of these services, following the example of India or Rwanda.
4. Provide the benefits that are really demanded by informal sector workers, and in the format that is most useful for them, based on a proper exploration of their needs and preferences, maybe per groups defined by levels of income/regularity of income, occupation or rural-urban setting, etc.
5. Based on the consultations process, it would be most effective to start with a pilot in urban areas and among informal sector workers that would have the capacity to contribute to such a scheme.
6. Training and sensitization activities, not only to raise awareness about the importance of social and health insurance products but also to improve the financial literacy of potential users, would be a key stepping stone for any scheme to be successful in reaching out to informal sector workers.

At a minimum, the ESP may want to advocate for the development of specific efforts in this regard through the GoU´s encouragement of existing informal schemes that prove to be working effectively, for instance by including some degree of subsidization (e.g., fiscal incentives) in those that are considered especially promising, and/or through some kind of official recognition and support, (e.g., sensitization and information campaigns) (see Box 11).

Box 11: Maximising opportunities for social protection through existing traditional mechanisms

Despite the limitations found in some of the existing traditional solidarity mechanisms, including their reciprocal nature and exclusion of the very poor, the risk of ¨adverse incorporation¨ or potential co-option, many have shown ¨resilience, adaptability and a degree of inclusiveness that can provide opportunities for future growth¨. Research findings indicate that building on those values and instruments offers important benefits compared to starting externally-inspired systems anew. However, such approaches would need to be based on changed attitudes by policymakers towards ¨cultural resources and values¨ and ¨cultural mainstreaming¨ in GoU structures.

Although both formal and informal mechanisms present advantages and disadvantages, the links between the two could be used effectively to ¨counteract their weaknesses¨ , including: (1) financial links, as tax subsidies, redistribution between them, financial consolidation and joint pooling; (2) operational links, as technical advice, exchange of information, regulation and control; (3) governance links, such as representation on boards and other bodies; (4) health service provision links, including contracting or access to health service delivery providers; and (5) policy links, such as joint participation in the design and implementation of social protection strategies and policies and policy coherence.

Source: Coheur et al. (2008); De Coninck and Drani (2009).

Awareness and knowledge levels about social insurance schemes and the benefits of joining remain low among informal sector workers, therefore requiring special efforts in this regard, which could be channelled through existing informal sector organizations. In addition, the contribution by GoU to schemes for the informal sector or through non-contributory benefits is particularly critical for rural and low-wage workers who do not have the capacity to ensure access to health or social insurance if not subsidized.

In the area of health insurance, and although the MoH plans even for formal sector workers are yet to be clarified, the GoU may wish to consider the implementation of a pilot of urban CBHI aimed at the informal sector, where its central involvement is ensured. Such scheme may show different results from past and current experiences, mainly aimed at rural and low-income informal sector workers. This option would attract support from trade union leaders willing to recruit members from the informal sector and other leaders. It is recommended that:

1. the community-managed model is used for such pilot;
2. the community selected is in the suburbs of Kampala;
3. it builds on existing groups of traders and craftsmen who already have an organizational structure;
4. organizations such as Save for Health are approached to operate the scheme; and
5. unions and informal sector associations are consulted and asked to mobilize support.

7 References

1. ADB (2012); The Social Protection Index: Assessing Results for Asia and the Pacific
2. Barr, N. and Diamond, P. (2008) ; Reforming pensions ; Center for Retirement Research at Boston College.
3. Basaza R et al. (2009) ; What are the emerging features of community health insurance schemes in East Africa? Risk Management and Health Policy, 2009 :2 47-53
4. Binagwaho A et al. (2012); Mutual health insurance and its contribution to improving child health in Rwanda; 2012, Passauer Diskussionspapiere: Volkswirtschaftliche Reihe No V 66 12.
5. Carlton, A., Manndorff, H., Obara, A., Reiter, W., Rhyne, E. (2001) ; Microfinance in Uganda ; OECD.
6. CGAP (2000); Focus: Microfinance and risk management; No17.
7. Coheur, S., Jacquier, C., Schmitt-Diabaté, V., Schremmer, J. (2008) ; Linkages between statutory social security schemes and community-based social protection mechanisms: A new approach ; International Social Security Association.
8. Cuevas, C and Fischer, K (2006). Cooperative Financial Institutions: Issues in Governance, Regulation and Supervision, World Bank Working Paper No 82.
9. De Coninck, J. and Drani, E. (2009) ; Social protection is centuries-old! Culture and social protection for the very poor in Uganda: evidence and policy implications ; Chronic Poverty Research Center, Working Paper number 140.
10. Diop FP. and Butera J.D. (2005); Community Based Health Insurance in Rwanda, Findings; World Bank.
11. Duarte Barbosa, E. (2011); Brazil, in Volume 18: Successful Social Protection Floor Experiences; UNDP and ILO.
12. ECA, ILO, UNCTAD, UNDESA, UNICEF (2012); Social protection: A development priority in the post-2015 UN development agenda. Thematic Think Piece; UN System Task Team on the Post-2015 UN Development Agenda.
13. Ferreira, F.H.G., Robalino, D. (2010); Social Protection in Latin America, Achievements and Limitations; Policy Research Working Paper, The World Bank.
14. Goswami, R. (2001); Indian Pension System: Problems and Prognosis. Paper presented in the IAA Pensions Seminar, Brighton, June 5-7..
15. Halvorson GC, (2007); Health Care Co-ops in Uganda; Permanente Press, Oakland Ca.
16. HelpAge International (2013); Pension coverage in China and the expansion of the New Rural Social Pension ; Pension Watch, Briefings on Social Protection in older age, n°11.
17. ILO (2012); Social Protection Floor for a Fair and Inclusive Globalization; Report of the Advisory Group chaired by Michelle Bachelet with the collaboration of WHO.
18. Magezi A et al, The financial viability of community based health insurance schemes in Uganda, Report for UCBHFA and DFID, 2002.
19. MacKellar, L. (2009); Pension systems for the informal sector in Asia; Social Protection Discussion Papers 47679, The World Bank, Mar. 2009.
20. Makaka A. et al. (2012); Universal Coverage in Rwanda: a report of innovations to increase enrolment in community based health insurance; The Lancet.
21. Mapping Microfinance in Uganda: http://ds.haverford.edu/wp/mappingmicrofinance/country-reports/uganda-intro/distribution-of-microfinance-institutions-in-uganda/

22. Matovu, F., and Birungi, P. (2014); Social Protection and the Vulnerable Communities in East Africa: Implications for Household Welfare in Uganda; International Development Research Centre.
23. Nyarko Otoo, K, and Osei-Boateng, C. in (2012) Social Protection Schemes in Africa, edited by Trywell Kalusopa, Rudi Dicks and Clara Osei-Boateng.
24. Okwee, A. (2008) ; Corporate Governance and Financial Performance of SACCOs in Lango Sub-region ; Makerere University Business School .
25. Obwuhinya, A., B., (2012); Elimination of child labour in tobacco growing : rapid assessment report : Masindi and Kiryandongo Districts; Platform for Labour Action
26. Okwee, A. (2008) ; Corporate governance and financial performance of SACCOs in Lango Subregion ; Makerere University Business School.
27. Olivier, M., Andrianarison, F. and McLaughlin, M. (2012); Study on Social Protection in Sub-Saharan Africa; European Commission.
28. Peterlechner, L. (2009); Roscas in Uganda : Beyond Economic Rationality; African Review of Money Finance and Banking.
29. Platform for Labour Action (2007) ; Adult domestic workers in Uganda, an analysis of human rights and social injustice.
30. Platform for Labour Action (2010); Risks and vulnerabilities of HIV/AIDS in the informal sector: a case study of women and youth in Lira and Iganda districts, Uganda.
31. Samson, M. (2009); Good practice review, Extending social security coverage in Africa; Working Paper number 2, International Social Security Association, Geneva, 2009.
32. Sane, R. and Thomas, S. (2013); In search of inclusion: informal sector participation in a voluntary, defined contribution pension system; Indira Gandhi Institute of Development Research, Mumbai, India.
33. Seeley, J. (2013); HIV and East Africa: Thirty Years in the Shadow of an Epidemic, Routledge Explorations in Development Studies.
34. Soors W et al. (2010) ; Community health insurance and universal coverage: Multiple paths, many rivers to cross. World Health Report 2010 Background Paper 48.
35. Twikirizwe JM and O'Brien C. (2011) ; Why Ugandan rural households are opting to pay community health insurance rather than use the free healthcare services, Int J Soc Welfare 2011.
36. UBOS (2010) ; Uganda National Household Survey : Socioeconomic Module ; Abridged Report.
37. UBOS (2013) ; The National Labour Force and Child Activities Survey 2011/12 : Child Labour Report.
38. Wang H and Pielmeier N. (2012) ; Community-Based Health Insurance: An Evolutionary Approach to Achieving Universal Coverage in Low-Income Countries, Journal of Life Sciences 6 (2012) 320-329.
39. World Bank (2012); 2012-2020 Social Protection and Labor Strategy: Resilience, equity and opportunity.
40. The World Bank (2013); Social Protection Assessment of Results and Country Systems Brief Concept and Invitation to Partner: February 8, 2013.
41. World Food Programme and UBOS (2013); Comprehensive Food Security and Vulnerability Analysis, Uganda.

About this report

This report was produced with funding support from Department for International Development- DFID Uganda, Irish Aid and UNICEF through Maxwell Stamp International PLC

About The Expanding Social Protection Programme

The Expanding Social Protection (ESP) Programme is a Government of Uganda initiative under the Ministry of Gender, Labour and Social Development. The development objective of the 5 year Programme is to embed a national social protection system that benefits Uganda's poorest as a core element of the country's national policy, planning and budgeting process.

ESP Programme is supported by Government of Uganda, DFID/UKaid, Irish Aid and UNICEF

Disclaimer:

The views expressed in this publication are not necessarily those of the expanding social Protection Programme, Ministry of Gender, Labour and Social Development or their partners.

Expanding Social Protection Programme

Ministry of Gender, Labour and Social Development
Plot 9,Lourdel Road , P.O.Box 28240, Kampala
Tel:+2560414534202 |+256312202050

E-mail: esp@socialprotection.go.ug I http://www.socialprotection.go.ug

UKaid
from the British people

Irish Aid
Department of Foreign Affairs
An Roinn Gnóthai Eachtracha

unicef