BUSINESS MONITOR international

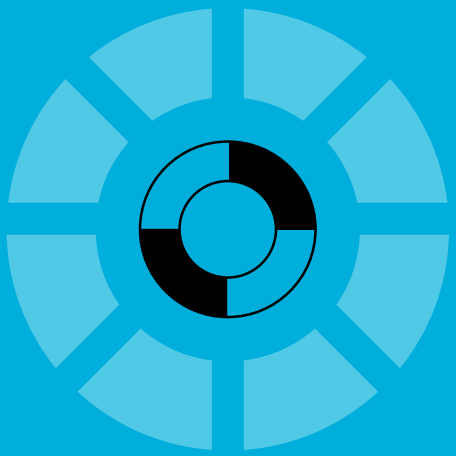
Q1 2012

www.businessmonitor.com

KENYA

INSURANCE REPORT

INCLUDES BMI'S FORECASTS



ISSN 2044-561X

Published by Business Monitor International Ltd.

KENYA INSURANCE REPORT Q1 2012

INCLUDES 5-YEAR FORECASTS TO 2016

Part of BMI's Industry Report & Forecasts Series

Published by: **Business Monitor International**

Copy deadline: December 2011

Business Monitor International
85 Queen Victoria Street
London
EC4V 4AB
UK
Tel: +44 (0) 20 7248 0468
Fax: +44 (0) 20 7248 0467
Email: subs@businessmonitor.com
Web: http://www.businessmonitor.com

Contents

Executive Summary

Table: Total Premiums, 2009-2016

	2009	2010	2011e	2012f	2013f	2014f	2015f	2016f
Total premiums, KESmn	64,470	79,060	90,233	108,281	127,669	148,459	170,904	195,318
Total premiums, KES , % change y-o-y	16.8	22.6	14.1	20.0	17.9	16.3	15.1	14.3
Total premiums, KES per capita	1,634	1,951	2,169	2,533	2,907	3,290	3,689	4,107
Total premiums, % of GDP	2.7	3.1	3.2	3.0	3.1	3.1	3.1	3.1
Total premiums, US$mn	835	998	1,003	1,237	1,395	1,571	1,753	1,943
Total premiums, US$, % change y-o-y	5.4	19.5	0.5	23.4	12.8	12.6	11.6	10.9
Total premiums, US$ per capita	21	25	24	29	32	35	38	41
Total premiums, EURmn	597	752	701	897	1,073	1,257	1,402	1,555
Total premiums, EUR, % change y-o-y	10.7	26.1	-6.8	27.9	19.7	17.1	11.6	10.9
Total premiums, EUR per capita	15	19	17	21	24	28	30	33

e/f = BMI estimate/forecast. Source: Insurance Regulatory Authority (IRA), Association of Kenyan Insurers (AKI)

Key Insights And Key Risks

The long-term achievements of the various protagonists – the trade association, the regulator and the insurance companies themselves – are real and substantial. In spite of Kenya's well publicised economic, social and political problems, non-life insurance penetration has risen to around 2% of GDP – a remarkably high figure given the overall income level in Kenya. We think this is a reflection of the innovativeness of many of Kenya's indigenous non-life insurers, most of which are small organisations by most standards. The insurers understand the needs of the clients and are responding accordingly. Examples that have been publicised in recent months include agricultural risk products that cover farmers against the impact of natural disaster, facilities to pay premiums via mobile phones and *takaful*. Another indicator of the potential for the non-life segment is that Kenya is one of only four countries in Africa (the others being South Africa, Egypt and Uganda) in which global property and casualty insurance giant **Chartis** has an on-the-ground presence.

In a country where many households are too poor to consider saving for the future, Kenya's life insurers have still managed to develop a segment that accounts for about a third of all premiums written in the insurance sector as a whole. In other words, they have collectively built sufficient trust among those

Kenyans who can save for the long-term. Given the country's tendency for high(ish) inflation, this is very much to their credit. Unlike in some Eastern European countries, the development of the segment has not been driven entirely by multinational giants. South Africa's **Metropolitan Life** has a subsidiary in Kenya. **Sanlam**, another South African major, has a strategic relationship with **Pan Africa**, as well as its own subsidiary in **African Insurance**. However, the local life companies have also been key players in the segment's evolution. Life density is low by many standards but is clearly growing rapidly.

We remain optimistic about the prospects for Kenya's insurance sector, including in our projections through to 2016.

SWOT Analysis

Kenya Insurance Industry SWOT	
Strengths	▪ Kenya's insurance industry is resilient. Despite the country's various economic and political problems, the industry has shown it can survive and thrive. ▪ Particularly encouraging is the development of a local life insurance industry, which accounts for about a third of total premiums. ▪ Local groups are engaged in insurance, as are foreign insurers to a lesser extent. ▪ The industry is represented by a well organised trade body and overseen by a relatively new and empowered regulator (at least in theory). ▪ The non-life segment has moved beyond motor insurance. ▪ Micro-insurance products are developing and are ready for the regulatory and economic environment to improve their selling potential. ▪ Insurance companies are grouping themselves together in an effort to build economies of scale.
Weaknesses	▪ No insurer is large, except in a local context, and there are few actual economies of scale. ▪ Past restrictions and a generally challenging business environment in a small economy have limited the involvement of foreign insurers. ▪ Poverty and lack of awareness appear to be major constraints. ▪ State-owned enterprises, potentially substantial users of insurance, have financial problems. ▪ HIV/AIDS limits the potential for health insurance and life insurance. ▪ Insurers have been overly dependent on traditional products and distribution channels ▪ According to the Insurance Regulatory Authority, fraud and corruption have been significant problems. ▪ The regulatory structure has limited the sales of micro-insurance and this needs to be rectified.
Opportunities	▪ It seems reasonable to expect a continuation of double-digit growth in both segments. ▪ Some insurers may boost economies of scale through further consolidation. ▪ Investment by and partnerships with Indian and South African insurers indicate that Kenyan insurers have access to foreign capital and know-how. ▪ The East African Community (EAC) common market, which came into effect in July 2010, may provide opportunities for Kenyan insurers. ▪ Kenyan insurers have demonstrated that they understand micro-insurance, are innovative and can receive payments through mobile phone-based networks. ▪ The development of *takaful* products may open up a previously untapped market. ▪ Agricultural insurance may develop rapidly off an extremely low base.
Threats	▪ Deterioration of political conditions could hamper the development of the insurance sector. ▪ High inflation represents a challenge to the long-term development of the life segment.

Kenya Political SWOT	
Strengths	▪ The government is credibly committed to market-based economic reform. ▪ Allied with the US in the strategically important Horn of Africa region.
Weaknesses	▪ Perceptions of corruption are a hindrance to the government's image at home and abroad. ▪ The ethnic backdrop to Kenya's political scene is a major source of tension, as demonstrated by the post-election violence in early 2008.
Opportunities	▪ Growing ties with China could give Kenya greater influence on the global stage. ▪ Constitutional reform is pending.
Threats	▪ Security risks presented by its border with Somalia, where instability could prompt further refugee inflows and drain government resources. ▪ The structure of the coalition government augurs for political infighting, which could ultimately prompt a break-up of the coalition before the 2012 elections.

Kenya Economic SWOT	
Strengths	▪ Increasing diversification away from the agricultural sector is making the country less sensitive to exogenous shocks. ▪ Kenya benefits from a strategically advantageous location in the EAC. ▪ Increasing ties with China bode well for trade and investment.
Weaknesses	▪ Entrenched perceptions of corruption make for a substandard business environment. ▪ Unemployment and crime levels are rising.
Opportunities	▪ Amid the economic recovery, there is an opportunity and challenge to increase capacity in order to accelerate growth. ▪ Kenya can benefit from the increasing integration of the EAC, primarily through growing intra-regional trade.
Threats	▪ The risk of drought is a constant threat to the economy, affecting inflation and export revenue, as well as the humanitarian consequences. ▪ Kenya's lacklustre productivity gains mean the country risk losing its export competitiveness. ▪ Ethnic tensions highlighted by unrest surrounding the December 2007 presidential election could deter international investors for some time.

Kenya Business Environment SWOT	
Strengths	▪ The government has demonstrated its commitment to prudent and business-friendly economic policy. ▪ Kenya is one of the most diversified economies in Sub-Saharan Africa, making the country less susceptible to shocks. ▪ The deepening financial markets in the country make it easier for companies to hedge risk and prevent asset-liability mismatches.
Weaknesses	▪ Widespread international and domestic perceptions of corruption make for a less than ideal environment in which to conduct business. ▪ The propensity for droughts in the region is a key weakness and can prompt spikes in inflation, given the importance of food prices to headline consumer price inflation.
Opportunities	▪ Kenya's hitherto economic strength and location with regards to key shipping routes to the Indian subcontinent, make it a suitable launching pad for firms looking to expand into Africa. Kenya could attract more significant foreign direct investment as a result, if it markets itself appropriately. ▪ Issuance of external tradable debt would help fund long-term investment projects but also provide foreign investors with a mechanism through which to assess risk with greater clarity.
Threats	▪ Instability in neighbouring Somalia brings multiple risks, through refugee flows across the porous border and security threats with the potential for the conflict to spread. ▪ An inclement climate for investment in the aftermath of the global financial crisis could derail the government's plans to upgrade infrastructure. ▪ Violence in the aftermath of the December 2007 presidential election illustrated the security risk stemming from social instability and ethnic tensions.

Life Sector

Africa Life Sector Overview

Table: Middle East And Africa Life Premiums, 2008-2016 (US$mn)

	2008	2009	2010	2011e	2012f	2013f	2014f	2015f	2016f
Algeria	73.30	76.72	94.87	101.05	107.60	114.52	121.84	129.57	137.73
Egypt	1,063.11	1,077.21	1,229.04	1,155.51	1,175.42	1,255.06	1,339.57	1,429.09	1,523.85
Kenya	**262.81**	**276.69**	**337.07**	**374.49**	**427.49**	**483.16**	**541.45**	**602.32**	**665.78**
Libya	7.36	8.77	10.67	0.77	0.78	0.78	0.79	1.11	1.57
Morocco	852.44	830.15	790.55	798.50	806.56	814.65	822.69	830.60	838.37
Nigeria	247.36	262.02	310.12	365.75	375.11	384.73	394.60	404.74	415.14
South Africa	22,695.77	21,814.15	28,220.08	36,230.26	40,073.07	44,291.34	45,822.36	47,403.11	49,039.28
Tunisia	92.66	99.97	113.18	114.40	115.60	116.77	117.92	119.06	120.19
Bahrain	137.93	152.21	135.28	225.00	258.85	293.70	331.75	375.50	426.37
Iran	220.25	323.81	361.93	420.86	489.25	568.55	660.42	766.73	889.70
Israel	5,154.13	5,035.30	5,799.29	6,579.11	7,096.02	7,643.19	8,227.04	8,853.84	9,527.42
Jordan	50.65	49.41	53.62	55.96	58.23	60.45	62.71	65.04	67.46
Kuwait	152.45	152.43	185.25	190.76	195.73	200.30	204.66	208.96	213.23
Oman	106.50	101.30	106.49	108.93	111.15	113.19	115.14	117.06	118.96
Qatar	58.25	58.09	59.58	53.69	56.11	58.57	61.05	63.57	66.08
Saudi Arabia	158.61	267.82	259.55	318.65	390.86	479.07	586.85	718.54	732.86
UAE	724.21	890.95	1,089.18	1,200.93	1,286.58	1,377.52	1,474.07	1,576.53	1,685.07

e/f = BMI estimate/forecast. Source: BMI, national insurance regulators/associations

Across Sub-Saharan Africa (SSA), it is useful to consider South Africa separately from the other countries. South Africa has developed a substantial life insurance segment of world class sophistication. This is because, for all its problems in the past decades, there has been sufficient economic and financial stability (together with law enforcement and competent regulators) for households to trust local financial institutions with their long-term savings. Separately, life insurance has been boosted by the presence of a sufficiently large and wealthy minority in the country who have been able to recognise the benefits of life insurance and afford to pay for it. One of the opportunities for the South African life insurance segment is the products that it offers for first-time users.

For a long-time, South Africa's financial institutions were hard pressed to gain capital except from each other because of political sanctions. As a result, the life segment is dominated by four large financial services complexes – each of which includes a bank and a life company. Nevertheless, there are other substantial life companies that are not affiliated with one of the majors. The cross shareholdings and corporate relationships in general have been beneficial in that they have facilitated the use of bank networks to sell insurance products in South Africa.

Outside South Africa, life insurance is very underdeveloped. In this respect, SSA is not dissimilar to the Middle East and North Africa (MENA). However, there is a crucial difference. In the MENA region, life insurance is often shunned because adequate social security is available from generous government programmes. Not coincidentally, life insurance is a more important part of the overall life sector in countries such as Morocco and Egypt than it is in the wealthy Gulf Cooperation Council states. In SSA, life insurance has failed to flourish because people are too poor to be able to worry about long-term savings and/or because they do not trust local institutions.

Partly for this reason, SSA has not been a priority area for most multinational companies. If there is an exception, it is the South African majors, which have sufficient appetite for risk, an understanding of how to develop life insurance markets from scratch and access to global capital markets.

Kenya Life Sector Update

Kenya's life insurance sector is quite unusual. In terms of absolute premiums written, it is tiny. Density (ie: premiums per capita) is low by all standards other than those of Africa (except South Africa). Transparently, a sizeable percentage of all households are too poor to be able to consider saving for their long-term futures via life insurance. Nevertheless, the rapid growth in density, and the fact that the segment accounts for a significant portion (approximately a third) of all activity in the insurance sector, is very encouraging.

As of late 2011, there are several other reasons for confidence in relation to the life segment in Kenya. The first is that the country is of interest to foreign majors. **Pan Africa Life** has a strategic relationship with South African giant **Sanlam**. **Metropolitan Life**, another major South African firm, has set up a subsidiary in Kenya. A second reason is that, as is the case in the non-life segment, Kenyan companies are innovative. Kenyan consumers are able insurance premium payments from their 'virtual wallets' on their mobile phones through platforms such as Kilimo Salama. Third, the Association of Kenya Insurers (AKI) has published a strategic plan to promote the development of the overall insurance sector. Given the structure of the industry, this is likely to have greater benefit to providers of non-life insurance than life insurers but the latter should also benefit.

Most importantly, there is net investment in the industry. In mid-2011, **LeapFrog Investments** invested KES1.15bn (US$14mn) in **Apollo Investment**, which includes **APA Insurance**, **Apollo Life Assurance**, **Apollo Asset Management** and **Gordon Court.** LeapFrog is the world's largest investment fund focused

on insurance to underserved people and markets. Its capital and global insurance expertise should help Apollo become a pre-eminent regional player in insurance in East Africa, including in micro-insurance. Around the same time, Apollo said it had exercised its pre-emptive rights to buy the 39.97% stake in APA that had previously owned by Pan Africa Insurance Holdings.

Life Industry Forecast Scenario

Table: Life Premiums, 2009-2016

	2009	2010	2011e	2012	2013f	2014f	2015f	2016f
Total life premiums, KESmn	21,360	26,710	33,704	37,406	44,209	51,167	58,726	66,911
Total life premiums, KES, % change y-o-y	16.7	25.0	26.2	11.0	18.2	15.7	14.8	13.9
Total life premiums, KES per capita	541	659	810	875	1,007	1,134	1,268	1,407
Total life premiums, % of GDP	1	1	1	1	1	1	1	1
Total life premiums, % of total premiums	33	34	37	35	35	34	34	34
Total life premiums, US$mn	277	337	374	427	483	541	602	666
Total life premiums, US$, % change y-o-y	5.3	21.8	11.1	14.2	13.0	12.1	11.2	10.5
Total life premiums, US$ per capita	7	8	9	10	11	12	13	14
Total life premiums, EURmn	198	254	262	310	372	433	482	533
Total life premiums, EUR, % change y-o-y	10.5	28.6	3.1	18.3	20.0	16.5	11.2	10.6
Total life premiums, EUR per capita	5	6	6	7	8	10	10	11

e/f = BMI estimate/forecast. Source: IRA, AKI

According to the AKI, life premiums rose from KES21,360mn in 2009 to KES26,710mn in 2010. This implies that density is continuing to grow quite rapidly from a low base. By most standards, life density of around US$8 per capita would normally be very low. However, for a country with the overall income level and economic challenges of Kenya, we regard this outcome as more than respectable.

We highlight the absolute size of the segment relativeto the premiums written in the entire insurance sector as significant. In contrast to Nigeria, for example, the life companies have – in some cases with assistance from South African majors – developed business that its substantial relative to the non-life segment. There are Kenyan consumers who have sufficient faith in indigenous life insurance companies that they entrust their long-term savings to them.

Looking forward, our forecasts are based on further steady growth in density as insurers reach first-time users and/or develop innovative new products. Our projections for the medium term are marginally more optimistic than are those of the AKI.

Growth Drivers And Risk Management Projections

Population

Population data is a crucial growth indicator for the life insurance sector: key demographic trends show not only specific areas of growth potential, but can also highlight liability imbalances, and reveal impending growth limitations when viewed in conjunction with penetration figures. Favourable demographics, such as a large youth population, are indicative of promising growth potential, whereas an ageing population or dwindling birth rate can signal curtailment of growth momentum for the sector.

Table: Insurance Key Drivers – Demographics, 2009-2016

	2009	2010	2011e	2012f	2013f	2014f	2015f	2016f
Population, mn	39.46	40.51	41.61	42.75	43.92	45.12	46.33	47.56
Population, % change y-o-y	2.6	2.7	2.7	2.7	2.7	2.7	2.7	2.6
Population, total, male, '000	19,708	20,234	20,827	21,395	21,981	22,577	23,182	23,792
Population, total, female, '000	19,754	20,279	20,783	21,354	21,943	22,544	23,151	23,763
Population by age group, total, '000								
Population, 0-4 yrs, total, '000	6,516	6,664	6,805	6,967	7,141	7,310	7,460	7,620
Population, 5-9 yrs, total, '000	5,548	5,715	5,888	6,049	6,196	6,334	6,473	6,632
Population, 10-14 yrs, total, '000	4,699	4,821	4,960	5,117	5,287	5,462	5,629	5,785
Population, 15-19 yrs, total, '000	4,281	4,314	4,362	4,431	4,519	4,627	4,751	4,887
Population, 20-24 yrs, total, '000	4,077	4,137	4,172	4,185	4,189	4,203	4,238	4,285
Population, 25-29 yrs, total, '000	3,448	3,563	3,675	3,784	3,886	3,971	4,035	4,069
Population, 30-34 yrs, total, '000	2,701	2,823	2,949	3,074	3,198	3,320	3,440	3,550
Population, 35-39 yrs, total, '000	2,001	2,095	2,203	2,318	2,439	2,564	2,691	2,815
Population, 40-44 yrs, total, '000	1,503	1,553	1,620	1,695	1,778	1,869	1,969	2,075
Population, 45-49 yrs, total, '000	1,221	1,247	1,278	1,312	1,350	1,396	1,450	1,512
Population, 50-54 yrs, total, '000	1,018	1,039	1,062	1,085	1,110	1,136	1,163	1,192
Population, 55-59 yrs, total, '000	822	853	880	904	925	946	968	987
Population, 60-64 yrs, total, '000	577	614	648	684	719	752	783	806
Population, 65-69 yrs, total, '000	385	400	419	445	476	509	542	572
Population, 70-74 yrs, total, '000	304	307	307	306	308	315	329	346
Population, 75+, total, '000	361	367	382	394	403	409	411	422

Table: Insurance Key Drivers – Demographics, 2009-2016

	2009	2010	2011e	2012f	2013f	2014f	2015f	2016f
Dependent and active population								
Dependent population, total, '000	17,813	18,275	18,761	19,278	19,811	20,338	20,845	21,378
Active population, % of total	55	55	55	55	55	55	55	55
Active population, total, '000	21,649	22,238	22,849	23,472	24,113	24,783	25,488	26,178
Youth population, total, '000	16,764	17,200	17,653	18,133	18,624	19,105	19,562	20,038
Pensionable popn. total, '000	1,050	1,074	1,108	1,145	1,186	1,232	1,283	1,340
Life expectancy								
Life expectancy at birth, male, years		53.96					56.7	
Life expectancy at birth, female, years		55.93					59.16	
Urban/rural split								
Urban popn. % of total	21.9	22.1	22.5	22.8	23.2	23.5	23.9	24.3
Rural popn. % of total	78.2	77.9	77.5	77.2	76.8	76.5	76.1	75.7
Urban popn, total, '000	8,622	8,953	9,346	9,755	10,182	10,621	11,073	11,575
Rural popn, total, '000	30,840	31,559	32,264	32,994	33,742	34,500	35,259	35,981

e/f = BMI estimate/forecast. Source: UN Population Division, BMI

Non-Life Sector

Africa Non-Life Sector Overview

Table: Middle East And Africa Non-Life Premiums, 2008-2016 (US$mn)

	2008	2009	2010	2011e	2012f	2013f	2014f	2015f	2016f
Algeria	1,016.17	993.42	997.15	901.28	1,005.09	1,031.40	1,074.34	1,131.43	1,194.95
Egypt	767.91	855.93	918.09	907.39	864.50	1,085.80	1,398.06	1,687.07	1,999.20
Kenya	**529.68**	**558.44**	**660.63**	**628.10**	**810.00**	**912.12**	**1,029.54**	**1,150.54**	**1,277.68**
Libya	234.86	286.36	381.31	19.85	26.33	33.27	49.92	69.24	95.85
Morocco	1,693.67	1,757.05	1,806.06	1,859.42	2,011.30	2,214.52	2,410.46	2,605.62	2,817.00
Nigeria	1,020.67	1,081.16	1,093.37	816.88	981.48	1,188.69	1,395.25	1,631.27	1,885.44
South Africa	7,470.88	8,090.40	9,302.75	10,377.70	9,611.15	10,482.57	11,500.24	12,631.49	13,865.27
Tunisia	686.75	659.82	672.77	710.47	803.19	889.31	954.91	1,028.21	1,111.67
Bahrain	358.42	379.33	421.75	270.70	283.39	303.54	331.23	357.82	383.16
Iran	4,002.14	4,368.33	4,882.57	5,598.65	6,378.91	7,309.50	8,361.00	8,926.40	9,513.04
Israel	5,198.21	4,910.59	5,229.85	5,755.23	6,080.89	6,540.38	7,016.12	7,538.35	8,110.05
Jordan	419.36	465.87	523.55						
Kuwait	516.86	519.66	610.55	647.92	681.99	704.39	719.95	754.66	796.90
Oman	444.20	516.91	545.46	638.93	695.24	744.38	793.67	840.49	884.42
Qatar	934.19	925.55	957.42	1,061.97	1,265.40	1,482.00	1,675.57	1,877.75	2,030.22
Saudi Arabia	2,757.09	3,633.38	4,116.15	5,537.44	6,068.88	6,632.95	7,285.05	7,960.92	8,635.79
UAE	4,251.33	4,565.28	4,887.68	5,330.30	5,831.97	6,274.66	6,802.77	7,406.17	8,036.47

e/f = BMI estimate/forecast. Source: BMI, national insurance regulators/associations

The insurance markets of SSA are not easily categorised. By far the largest market in the region is South Africa. Decades of relative stability, a well developed financial system and a critical mass of households and businesses that can afford to buy coverage for risks have meant South Africa's non-life segment shares many characteristics with its peers in developed countries – notwithstanding that claims and damages resulting from motor accidents are much higher than they would be in Western Europe or North America. Partly because of the peculiar capital structure of the largest South African financial services groups, which is the consequence of isolation from global capital prior to 1990, South Africa's non-life segment is concentrated.

Most other countries in the region have non-life segments that look very different to those of South Africa. Typically, non-life penetration is very low and the absolute number of people who actually use

non-life insurance is limited by poverty. In a minority of cases, insurance is rendered unavailable or irrelevant because of longstanding economic or political turmoil. As is the case in much of the MENA region, most national non-life markets in SSA are fragmented and are dominated by comparatively large numbers of local companies, almost all of which lack scale by any standards other than those of their own country. Unlike in the Middle East, major multinationals are largely absent from the region. This is sometimes because of legal restrictions on foreign insurers and sometimes because the opportunities are perceived as being too small. The main exception is **Allianz**, which has a presence in Francophone countries that were previously served by its semi-autonomous French-based affiliate **AGF**, which has since been rebranded as Allianz.

Kenya Non-Life Sector Update

Table: Breakdown Of Non-Life Premiums, 2008-2009 (KESmn)

	2008	2009
Motor commercial	9,322.4	11,255.0
Personal accident	7,069.5	8,393.4
Motor private	6,102.7	7,306.8
Fire/industrial	4,322.7	4,419.0
Work Injury Benefits Act/employers' liability	2,145.0	3,092.5
Theft	1,765.0	2,003.8
Marine	1,735.7	1,704.2
Miscellaneous	1,242.6	1,411.2
Engineering	1,274.4	1,317.4
Liability	918.1	940.8
Fire/domestic	672.1	785.0
Aviation	325.0	479.4

Source: AKI

Non-life penetration in Kenya is low in comparison with the developed world but compares favourably with most of Africa. Kenya's penetration in 2009 was 1.8%, whereas Egypt had just 0.4% and Nigeria 0.5%. However, South Africa had 2.6% penetration for the same period.

In April 2011, the AKI released its strategic plan for 2011-2015. The association hopes to work with key stakeholders to promote the industry, with the result that premiums rise to KES200bn by 2015. The AKI advocates: product simplification and innovation; activities to promote the image of the insurance sector; customer education; modernisation of the Insurance Act; further market research; improvement in the processes and systems of member companies. The AKI said that over the previous five years, the entire

industry had been growing by around 16% per annum. A continuation of this expansion would lead to premiums of KES150bn in 2015. The AKI therefore must hope its initiatives will result in the generation of an additional KES50bn in premiums that would otherwise not be written. As of December 2011, **BMI** forecasts for non-life premiums of around KES112bn by 2015.

Looking back at the first 11 months of 2011, we suggest the main trend was the continuation of innovation. The discussion of health insurance products later in this report explains how, over the last few years, Kenyan insurers have developed innovative products, some of which can be described as micro-insurance products. At the end of H111, **APA Insurance** said it had paid claims on an innovative index-based weather insurance (IBWI) product that it had developed in conjunction with the World Bank, the UK's Department for International Development, the Rockefeller Foundation, the Financial Sector Deepening Trust and the Kenyan Meteorological Office. The product covers farmers for the loss of crops as a result of bad weather. As a result, it is much easier for them to access funds from specialist lenders such as the **Agriculture Finance Corporation of Kenya** or from other sources. APA also launched an innovative comprehensive motor cover product. It includes cover for hospitalisation in case of accident and income loss. Premiums can be paid monthly and through electronic platforms such as M-PESA, Airtel Money and PesaPoint.

Takaful Insurance of Africa, the country's first fully fledged *takaful* operator began operations in February 2011 and offers a wide variety of general *takaful* products.

Non-Life Industry Forecast Scenario

Table: Non-Life Premiums, 2009-2016

	2009	2010	2011e	2012f	2013f	2014f	2015f	2016f
Total non-life premiums, KESmn	43,110	52,350	56,529	70,875	83,459	97,292	112,178	128,407
Total non-life premiums, KES, % change y-o-y	16.8	21.4	8.0	25.4	17.8	16.6	15.3	14.5
Total non-life premiums, KES per capita	1,092	1,292	1,359	1,658	1,900	2,156	2,421	2,700
Total non-life premiums, % of GDP	1.8	2.1	2.0	2.0	2.0	2.0	2.0	2.0
Total non-life premiums, % of total premiums	66.9	66.2	62.6	65.5	65.4	65.5	65.6	65.7
Total non-life premiums, US$mn	558	661	628	810	912	1,030	1,151	1,278
Total non-life premiums, US$, % change y-o-y	5.4	18.3	-4.9	29.0	12.6	12.9	11.8	11.1
Total non-life premiums, US$ per capita	14	16	15	19	21	23	25	27
Total non-life premiums, EURmn	399	498	439	587	702	824	920	1,022
Total non-life premiums, EUR, % change y-o-y	10.7	24.9	-11.8	33.6	19.5	17.4	11.8	11.1
Total non-life premiums, EUR per capita	10	12	11	14	16	18	20	21

e/f = BMI estimate/forecast. Source: IRA, AKI

According to the AKI, non-life premiums rose from KES43,110mn in 2009 to KES52,350mn in 2010. This outcome reinforces a trend of fairly steady increases in non-life penetration that has been in place since 2005, if not before. Given that a non-life penetration rate of just under 2% of GDP is high for a country of Kenya's per capita GDP, we suggest this outcome highlights the resilience and, in terms of the development of new products, inventiveness of Kenya's non-life segment.

Predicting how non-life penetration develops from what appears to be quite a high level is problematic. For the time being, we assume non-life penetration will remain broadly unchanged. In the fragmented

Kenyan non-life market, it is more likely that pricing pressures will be downwards rather than upwards. However, premiums should grow as a result of the promotion of micro-insurance, the development of *takaful* and product innovation.

Growth Drivers And Risk Management Projections

Macroeconomic Outlook

Developments in the financial market are of great concern to insurers who are susceptible to risk from the rest of the financial sector. The exposure of insurers to the risks of economy fluctuation – where sensitivities include exchange rates, inflation and interest rates – is manifested in two ways: asset value and subsequent capital base and solvency levels, and commercial product and premium development.

Insurers are major asset managers and as they are exposed to recession, they are also naturally likely to benefit from recovery. Historic data and forecasts illustrate economic trends via labour market and macroeconomic indicators which can highlight areas of growth returns and limitation, as well as contextualised market potential for line diversification. Income protection insurance may well see a rise in demand.

Economic Growth To Ride Out The Storm

BMI View: *Although the Kenyan economy will be adversely affected by the subdued outlook for European demand, we believe brighter prospects in regional trade partners, combined with improving domestic economic conditions, should see the economy expand by 5.0% in 2012, up from an estimated 4.1% in 2011. Major risks come from the weather and the approach of elections scheduled for the second half of the year.*

After slowing to an estimated 4.1% in 2011, we expect that Kenyan real GDP growth will rebound to 5.0% in 2012. We believe that the year will be characterised by improving domestic and regional economic conditions, which will help to bolster growth in the face of deteriorating demand from international trade partners, particularly in Europe.

The major risk to the economy emanates from the weather as poor rains would not only disrupt output in the important agriculture industry, but also keep inflation high and the currency weak, having a negative impact on non-agricultural segments of the economy. Political risk should also not be underestimated. Elections are scheduled to be held in August 2012, although there is a campaign to have these delayed until December, and there are concerns that there could be a repeat of the violence seen following the presidential election in 2007

European Concerns

The latest growth data available from the National Bureau of Statistics (NBS) show the economy grew by 4.1% year-on-year (y-o-y) in the second quarter of 2011, down from 4.8% in Q111.

Looking at a breakdown of the figures, the agricultural sector, which accounts for about 20% of the economy, was major driver, expanding by 5.2%, with horticulture the primary engine of this growth. We doubt horticulture will continue to have such a positive impact on agricultural and headline growth. Much of Kenya's horticulture produce is exported to the eurozone and the UK. **BMI**'s Europe team has downwardly revised 2012 real GDP growth to 1.2% in the EU and 1.6% in the UK, from 1.7% and 2.2% previously. Most of Kenya's tourists come from Europe so we also expect a slowdown in the important tourism sector in 2012.

Light At The End Of The Tunnel

While the bearish outlook for European demand raises questions about certain segments of the Kenyan economy, we expect that improving domestic and regional dynamics should help to offset this. Kenya's main trading partner is Uganda, which absorbs about 14% of exports, while Tanzania accounts for just over 8%. The East African Community (EAC), which also includes Burundi, Rwanda, Tanzania and Uganda, accounts for over a quarter of Kenyan exports. We are generally upbeat about the prospects for EAC economies in 2012, with Uganda and Tanzania expected to grow by 8.8% and 6.5% respectively. This should support demand for manufactured goods in particular.

In addition to an upbeat outlook for regional economies, we believe domestic economic conditions should gradually improve from the start of 2012. In particular, we expect inflation, which surged to 17.3% in September 2011 from a cyclical low of 3.1% in October 2010, topped out in the final months of 2011 and will head lower during of 2012. There are several considerations underpinning our belief that inflation is close to topping out, including base effects, improving weather and much anticipated decisive action on by the Kenyan monetary authorities (*see our online service, October 6 2011, 'Long-Awaited Aggressive Monetary Tightening Is Here'*).

Improving weather and the onset of monetary tightening should also provide support to the Kenyan shilling, which was hammered in 2011 by a perfect storm of adverse trade account dynamics, global risk aversion and an inadequate policy response. Falling inflation and stabilisation of the currency, if not recovery, will improve the environment for domestic producers and consumers and should mean domestic demand slowly regains momentum.

Risks To Outlook

The major risk to our outlook comes from the weather. Meteorologists have warned that there is a strong possibility that La Niña will reoccur in 2012 and this could lead to a resumption of the drought that has been a major factor in rising inflation and a weakening currency. Another risk comes from the health of the global economy. Our forecasts for Kenya already take into account near-stagnation in Europe and the US and a relatively sharp slowdown in Chinese growth. However, if things turn out to be worse in China, the US or Europe than we anticipate, our current growth forecasts for Kenya would be overly optimistic. On the other hand, if the global economy stages a miraculous recovery, our expectations for Kenya could turn out to be too pessimistic.

Risks to our economic forecasts also emanate from the domestic political scene. The new constitution requires that a vote be held on the third Tuesday of August 2012. Some members of the government argue that a vote in August is not practical given the logistical challenges and they want to have the vote delayed to December. Added to the uncertainty about timing, there are fears that there could be a repeat of violence seen at the last election. Thrown into the mix is the fact that several leading politicians are on trial in The Hague for their alleged roles in the violence that followed the 2007 polls, adding further reason to believe political tensions could boil over and hamper domestic and international confidence in the Kenyan economy.

Table: Kenya Economic Activity, 2001-2016

	2011e	2012f	2013f	2014f	2015f	2016f
Nominal GDP, KESbn [1]	2,998.2	3,670.5	4,338.0	5,040.8	5,787.7	6,594.3
Nominal GDP, US$ bn [2]	33.3	39.7	48.2	56.0	64.3	73.3
Nominal GDP Growth, % change y-o-y [1]	4.1	5.0	5.9	5.8	5.6	5.3
GDP per capita, US$ [2]	801	928	1,097	1,241	1,388	1,541
Population, mn [3]	41.6	42.7	43.9	45.1	46.3	47.6

e/f = BMI estimate/forecast. Source: [1] Central Bank of Kenya, [2] Central Bank of Kenya/BMI, [3] World Bank/BMI

Political Stability Outlook

The unprecedented instability in the MENA region during 2011 is likely to signal a change in pricing and appetite for political risk and terrorism insurance, business interruption insurance and other related lines on a global scale.

As perceived need for asset and property protection is likely to increase not only domestically, but also amongst the international commercial and industrial communities; this presents a new challenge and opportunity for insurers to address: not only to satisfy the increased demand for coverage with improved and tailored products; but also for improved risk premium calculation to ensure profitable underwriting.

BMI's security risk ratings and political stability outlook provide a guide to country specific and regional threats, highlighting both potential opportunities and liabilities for the (re) einsurance community.

Political Risks On The Rise

BMI View: *Rising prices, the implementation of the new constitution and the trials of key politicians at the International Criminal Court (ICC) all pose risks to Kenya's political stability. However, we maintain our view that the biggest challenge comes from the approach of elections in 2012.*

We have previously written about the major political challenges facing Kenya (*see 'Assessing The Medium Term Political Risks', July 5 2011*). The major ones are rising prices, the slow implementation of the new constitution, the ICC trials of several influential politicians and the elections scheduled for August 2012. Here, we provide updates on the latest developments in relation to all of these issues and seek to assess whether the threat has grown, receded or is unchanged since July 2011.

Inflation Still On The Up, But Maize Prices Falling

With respect to prices, headline inflation has continued to move higher, coming in at 16.7% y-o-y in August 2011, up from a cyclical low of 3.2% in October 2010. The main drivers of rising headline price growth have been food and fuel, which constitute 36% and 18% of the consumer price basket respectively. There is a contrasting outlook for these two components. Encouragingly, following improved rains in the latter part of the long rains season, food production and prices have begun to improve. Prices of the staple maize in the main urban centres have been decreasing since July 2011. The bulk of the long rains harvest should reach the market in November 2011, auguring for further food price declines.

The outlook for fuel prices is less encouraging. Although global oil prices have moderated in recent weeks (Brent crude was trading at US$106 a barrel (bbl) on September 28 2011, down from US$127/bbl in April), the abysmal performance of the Kenyan currency means oil prices in shilling terms are far higher than they were when oil peaked at US$145/bbl back in 2008. The monetary authorities have been unable and at times seemed unwilling to enact policies to support the currency. Until there are signs that the Central Bank of Kenya (CBK) is committed to supporting the beleaguered shilling, we believe imported inflation will continue to exert upward pressure in the cost of living.

Although Kenya has so far avoided the cost of living-inspired popular protests experienced by neighbours Tanzania and Uganda, we believe the threat is growing. Although a continuation of the fall in staple food prices will help to ease tensions, this will be counteracted by poor policy decisions. Apart from the aforementioned monetary policy failures, the introduction of ill-conceived regulations allowing the government to cap the prices of essential commodities is only likely to lead to shortages, which will exacerbate the tension from rising prices.

Political Risk Threat Level: High and rising.

Constitution Implementation

The passing of laws necessary to implement the new document has been a slow process. There are encouraging signs, such as the agreement on the appointment of a new chief justice, that the rival factions of President Mwai Kibaki and Prime Minister Raila Odinga are starting to work together and this bodes well for the process to continue. However, there have been setbacks. One of the central objectives of the new body of laws, the fight against corruption, appeared to suffer a blow when the controversial head of the anti-corruption agency, Patrick Lumumba, was removed from his post by parliamentary consensus.

Lumumba's fiery rhetoric against allegedly corrupt officials was seen by some as a diversion from getting the job done and this seems to be the justification for his removal. However, critics of his sacking argue that his bold oration was an indication that he was willing to take on the political elite and his removal was really about politicians protecting themselves.

Political Risk Threat Level: Moderate and stable.

ICC Trials

The pre-trial hearings of the people accused of organising and encouraging post-election violence in 2008 started in The Hague in September 2011 after the Kenyan government failed in its attempt to have the process suspended and replaced by domestic arbitration. Broadly, Kenyans appear in favour of the trials being handled internationally so the process does not present real risks to stability. Furthermore, we have argued in the past that because the suspects are from across Kenya's political and ethnic spectrum, there has been little risk that the process would fan ethnic or political tension due to perceptions that one group had been singled out. However, all of this could change when verdicts are reached. If some of the suspects are found guilty while others are set free, that would risk fanning tensions, especially if the guilty/innocent outcome is split along political or ethnic lines. Guilty verdicts would also test the authorities' commitment to cooperate with the ICC as it would require Kenya, as a signatory of the Rome Treaty, to make arrests.

Political Risk Threat Level: Moderate-high and rising.

Elections Are Still Key

Topping the list of threats to Kenya's political stability is the next election. For one thing, there is a lack of consensus on when the vote will actually take place. Some MPs argue that this should happen exactly five years after they were sworn in January 2008, as opposed to the constitutional requirement to hold an election every five years that would mean that elections would have to take place before the end of 2012. Many of the issues outlined above are underpinned by electoral motivations. Price controls, for example, are seen as a means of gaining short-term favour ahead of the vote. Also, much of the controversy surrounding the ICC trials emanates from the fact that two of the men, William Ruto and Uhuru Kenyatta, plan to run in the 2012 elections.

As we have highlighted previously, the attempt to move the trials to Kenya was seen by some as an effort to protect potential presidential candidates who may have damaged reputations or be prevented from running at all by the ICC process (*see 'Political Tensions To Arise As Elections Approach', February 24 2011*). Much will depend on yet-to-be-agreed alliances (*see 'Presidential Jostling Begins', August 25 2011*). The formation of these coalitions will involve horse trading and posturing, which is likely to raise tensions further. At this early stage, opinion polls suggest that Odinga is favourite to win and we concur that the balance looks to be tipped in his favour. However, with so many variables and the negative precedent set by the violence in 2007, this could easily change.

Political Risk Threat Level: High and rising.

Healthcare

Private health insurance is a key area of growth for the industry due to universal demand and need for coverage. Economic developments have a major impact upon the provision of healthcare and the availability of health insurance. Hospitalisation remains a major cause of indebtedness across all socio-economic sectors of society where a robust public health insurance system is not in place, therefore perceived need is also very much on the rise.

As the cost of healthcare rises, so does the need for coverage. Mapping the progress of public healthcare developments is a vital indicator for the private health insurance sector as emerging, frontier and developed markets each have their own growth opportunities and risk management rationale.

The Ministry of Health operates approximately 50% of health facilities, with the remainder run by the private sector, missionary organisations or the Ministry of Local Government. Rural health centres were to be given greater autonomy in 2008-2009, with direct funding and greater community involvement in rural healthcare provision.

The quality of healthcare infrastructure suffers major disparities between regions. Only 30% of the rural population have access to health facilities within 4km of their home, compared with 70% of the urban population. Residents of the capital, Nairobi, visit hospitals an average of 17.7 times a year, whereas in coastal provinces, the average is just 7.8 visits a year. This regional disparity is unsurprising given the uneven distribution of health infrastructure. It is estimated that 25% of households live more than 8km from any form of health facility, while drug allocation favours larger hospitals. District hospitals are allocated 38% of the Ministry of Health's drug procurement budget, provincial hospitals 18% and rural health facilities 18%. The drug procurement budget itself was only 10.5% of the Ministry of Health's total budget for 2005-2006.

Meanwhile, the Kenya National Health Accounts survey, conducted in 2002, found that those in the poorer income quartiles are more than twice as likely to seek healthcare when ill. The public health insurance consultation also revealed that those from the lowest social groups made the highest number of visits to hospitals (an average of 16 a year) but spent the least on healthcare, at just KES1,637 (US$26.60) a year. This can be explained by the fact that those in low income groups tend to have the poorest health, but can afford to devote little to treatment, meaning that they are less likely to cure the underlying cause of their ill health and simply treat symptoms. In contrast, the highest income groups made the fewest hospital visits (an average of 9.6 a year).

In September 2008, The Nation reported that the Kenya Medical Association (KMA) was worried about the pace at which the government was moving to act on the problems being faced by the public hospitals.

The KMA added that immediate steps need to be taken to improve the service delivery in public healthcare institutions and to provide adequate access to care.

On a positive note, in June 2009, it was revealed that the Kenyan government plans to construct a state-of-the-art health facility in the country in order to reduce the burden associated with the country's citizens seeking treatment abroad. Odinga suggested that the funds for such an institution could easily be realized via public-private partnership arrangement.

Furthermore, in June 2010, it was revealed that 3,000 nurses have been hired as part of a public healthcare reform programme (part of the Economic Stimulus Programme) in Kenya, expected to cost KES4bn (US$48mn). Under the stimulus programme, the ministry of health has been authorised to recruit 4,200 nurses, 20 for each of the 210 constituencies. According to the Ministry of Public Health and Sanitation, the hiring of an additional 700 nurses has been delayed due to issues with applicants' academic and identity documents.

BMI welcomes the employment drive. Like many other African countries, Kenya suffers from inadequate numbers of healthcare workers, especially in less accessible areas. Kenya currently has around 5,000 doctors, which equates to around one doctor per 6,000 people. Additionally, in October 2009, the National Nurses Association said that Kenya lags behind the recommended ratio of one nurse per thousand patients and requires about 24,000 nurses to tackle the shortage.

At present levels, SSA accounts for only 3% of the world's medical workforce, yet has the highest rates of HIV/AIDS infection in the world, with some 24.5mn registered cases. Over the years, Kenya has experienced a brain drain of health workers due to poor pay and poor working conditions, many ending up in western countries. **BMI** has believed for some time that while the UK has introduced new laws that could slow the reported 'brain drain' of medical workers from SSA, the Kenyan government also needs to address the situation. Under the legislation, the UK will grant work permits for foreign nurses only if no British or EU candidates can be found.

We are therefore positive over the government's recognition of the fact that in order to provide the country's citizens with sufficient care, it needs to hire more staff as well as incentivise medical workers to work locally. According to the Human Resource Development Sector Report 2010, the new programme will create 24,000 jobs for health professionals and the government aims to provide doctors, nurses, medical lab technologists and community health workers with incentives similar to those in the private sector to enhance morale, productivity and staff retention rates.

In addition to monetary incentives, schemes such as the Health Professionals of the Year Awards, a nationwide excellence award scheme that recognises various categories of healthcare professionals in the country, are part of the Human Resources for Health Strategic Plan for 2009-2012 which is looking for ways to retain health workers.

Health Insurance

It is our view that the increasing cost of medical care in Kenya has forced health insurance companies operating in the country to alter their business models to maintain revenues. In addition to pushing up insurance premiums, health insurance providers are increasingly focusing on the micro-insurance sector to create a new income stream. Additionally, there are increasing partnerships between companies in order to provide low cost services.

In September 2010, it was revealed that over a period of three years, medical costs in Kenya had risen at an average rate of 20% per annum, with the increase attributed to a steep rise in doctors' fees after the pricing guidelines developed by the Medical Practitioners and Dentists Board collapsed. Consultation fees for general practitioners stood at KES1,200 (US$14.823), up from KES900 (US$11.12) in 2009. Fees for specialists such as gynaecologists, dentists and oncologists were between KES2,000 (US$24.71) and KES3,000 (US$37.06), up from KES1,500 (US$18.53) in 2009.

In 2011, hit by rising inflation and the increase in the price of medicines and medical devices, the majority of which are imported, and the subsequent increase in the cost of operations, Kenya's top hospitals raised bed and consultation charges. This translates into a 10-40% increase in charges in the last four months of the year.

According to the Association of Kenya Insurers, only five out of the 16 medical insurance providers in Kenya made an underwriting profit in 2009, with the loss reaching KES235.8mn (US$3.1mn). Highlighting continuing operational challenges, the association's report for 2010 said the medical insurance sector had the highest loss ratio in the industry of 81.5%. Net earned premiums reached KES5.9bn (US$74.5mn) and net incurred claims reached KES4.8bn (US$60.6mn). It was followed by private motor insurance at 74.9% and commercial motor insurance at 58.8%. The loss ratio is the ratio of what an insurance company pays in benefits and associated expenses (such as adjustments) against what is collected in premiums, expressed as a percentage.

Referring to the inflationary climate in 2011, Peter Nduati, chief executive of insurance provider **Resolution Health East Africa**, said: 'We are being hit by costs of diagnostic procedures and medicines that have increased by 40% and 30%. Medical insurance premiums are bound to go up on renewal and we, in the mean time, expect very high loss ratios for insurers.' Insurance companies that have been forced to bear the immediate costs in healthcare have said the cost of health premiums could rise by up to 22%, in line with the pace at which the cost of medical services is rising.

The increase in healthcare costs has forced companies to hike up insurance premiums to maintain revenues. Firms have also introduced co-payment systems, which require patients to pay for a portion of their treatment costs.

Historically, companies have targeted the middle and upper classes who could afford to pay for their premiums. However, the rising consultation fees, payments for laboratory tests and for drugs have left many citizens unable to pay the regular and mandatory monthly premiums. In order to retain customers as well as increase subscription rates, another way in which health insurance companies have tackled the rise in medical costs is the launch of the more affordable micro-insurance products.

BMI commends this strategy as it is clear that a large proportion of Kenya's population has extremely low spending power. In 2009, the poorest 20% of the population's per-capita spending amounted to US$166 while the middle 60% amounted to US$486. **BMI** also believes that while micro-insurance products are more affordable, their uptake may still be slow. However, with the country's economy expected to grow and incomes expected to rise, per-capita spending is also forecast to rise, increasing demand.

Examples Of Micro-Insurance Products In Kenya's Health Sector

In August 2008, a micro-insurance package expected to cover around 1mn Kenyans was launched. The scheme is administered by the **Cooperative Insurance Company of Kenya** (CIC) and non-governmatal organisation the Swedish Cooperative Centre. It is being run as a pilot project in Kenya with a view to expanding to other African countries.

In February 2009, the Kenya Women Finance Trust, the CIC and the National Health Insurance Fund launched a medical insurance cover, Afya Card, which costs as little as KES10 (US$0.12) a day or KES3,600 (US$45) a year. The insurance policy underwrites all inpatient expenses for a member's entire family, with no exclusion clauses for chronic illnesses and maternity, and also covers surgery costs above KES15,000 (US$188). The policy restricts payment to expenses incurred in appointed private, public and mission hospitals for up to 180 days. The premiums are seen as affordable, with most group healthcare plans covering up to four members of a family averaging between KES750 (US$9) and KES1,000 (US$13) per month.

Simultaneously, a second affordable insurance product, Safari Bima, was launched by **Kenya Orient Insurance**. The product allows Kenyans to access personal insurance cover for KES30 (US$0.38) a day. The personal insurance covers a maximum of KES100,000 (US$1,235) in compensation for injuries sustained in any accident within 24 hours of payment. Policy holders are required to submit the daily KES30 (US$0.38) premium when they need the cover through a short messaging service on their mobile phones.

CFC Life Assurance has also launched a life insurance product, Life Vest. For a minimum of KES2,500 (US$31) a month, an individual can qualify for a compulsory fixed life cover benefit of at least KES100,000 (US$1,235) and savings benefits, with no strict underwriting or medical examinations. The Life Vest product is different from other products in Kenya as it provides consumers with the opportunity to obtain life insurance as well as acting as a savings vehicle to aid financial planning. The new product

now has two variants, one targeted at middle- and upper-income consumers and the other at lower-income consumers. Consumers have the choice of investing in low-, medium- and high-risk options which include money market, balanced and equity funds.

Launched in 2010, the newest product on the Kenyan market is Changamka, a micro-health cover launched by **Changamka Micro-Health**. Changamka allows members to receive treatment at designated hospitals for as little as KES450 (US$5.56) per visit and uses pre-paid smart card technology to allow its members to access treatment at designated medical outlets. In addition, the Changamka cards can be used by any member of a family and can be bought for third-party beneficiaries such as parents. The use of the smart card technology eliminates paperwork, which would otherwise generate additional costs.

In 2010, **Eagle Africa Insurance Brokers** rolled out Afya Milele, an inpatient and outpatient cover costing KES35 (US$0.43) per day. The cover takes care of maternity costs, doctors' fees, daily hospital charges and drug prescriptions. Eagle Africa allows the members to make payments easily through mobile money transfer services.

A third way in which insurance companies have dealt with rising healthcare costs is to form partnerships with other insurance companies and social welfare groups to lower overall costs and increase subscription rates. For example, the partnership between Changamka Micro-Health and Pumwani Maternity Hospital has lowered the overall cost of delivery, with expectant mothers paying KES3,000 (US$37.06) – one of the lowest child delivery charges in Nairobi.

In the meantime, a July 2008 report by local newspaper Business Daily said Kenyan health management organisations identified collusion between medical personnel and policyholders as the chief cause of medical insurance fraud. According to insurance industry estimates, about a third of all medical claims paid in Kenya in 2006 were fraudulent, raising questions over the viability of the expanded coverage.

Epidemiology

Studying health and illness at the population level is key to highlighting regional and demographic vulnerabilities, opportunities and liabilities in the health insurance sector. Urbanisation, growth in real incomes and the increased prevalence of lifestyle diseases are all factors that are expected to contribute strongly to the demand for healthcare and health insurance in the next decade.

BMI's Burdern of Disease Database (*BoDD*) records the number of disability-adjusted life years (DALYs) lost as a result of having or having had a disease. Therefore, our measure of DALYs is a measure of lost productivity. According to the BoDD the number of DALYs lost to all disease in Kenya is to increase from 12,823,021 in 2009 to 16,900,141 in 2030. Additionally, according to the BoDD, the number of DALYs lost to communicable diseases will increase from 9,013,730 in 2009 to 10,888,077 by

2030. The number of DALYs lost to non-communicable diseases will rise from 2,550,604 in 2009 to 4,116,757 by 2030.

HIV/AIDS

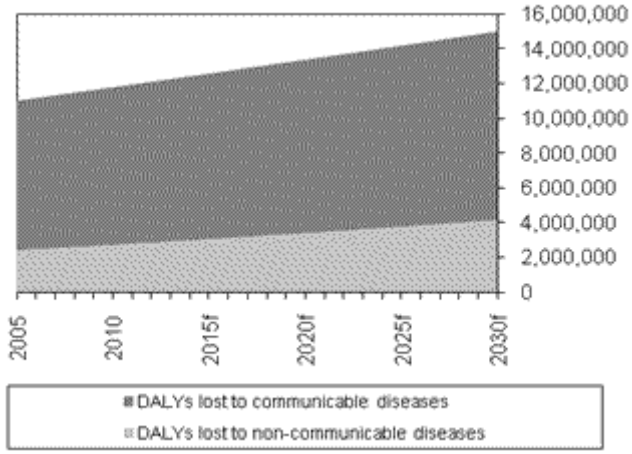
Despite significant disagreement over the number of Kenyans infected by the HIV virus, data from international agencies and the Kenyan government points to HIV/AIDS being the country's most pressing health concern. The UN Development Programme (UNDP) claimed that 16% of adults in Kenya were infected with HIV in 2006. Meanwhile, the Joint UN Programme on HIV/AIDS (UNAIDS) suggests only 6.1% of adults were infected in 2005.

In 1999, former president Daniel Arap Moi declared HIV/AIDS a national disaster. Since then, the death toll from HIV/AIDS has continued to rise, overtaking malaria and tuberculosis. HIV/AIDS is one of the key reasons behind a decline in life expectancy of about 10 years from its peak. That said, the latest indicators from the UN suggest life expectancy at birth rose to 54 years in 2007, up from 53 years in 2006. It was revealed in February 2009 that the country spends more than KES5bn (US$63mn) on ARVs annually, the vast majority of which are sourced from China and India.

In a bid to diagnose cases of HIV early, the Kenyan government is to launch a house-to-house testing service. The project is estimated to cost US$5mn and some funding is to be provided by the US government. Henry Chang, vice president of **Impact Initiatives**, said: 'by offering testing in individual homes, we are more likely to diagnose early disease and provide care that is at once less expensive and more effective at keeping those who are HIV positive from progressing to advanced disease and death.' In December 2009, it was revealed that the US foreign aid programme devoted to single disease, the president's Emergency Plan for AIDS Relief, committed US$2.7bn to help fight HIV infection in Kenya. The money, to be provided over a period of five years, represents a 112% increase in funding for the program in Kenya and will be used to care for more than 555,000 orphans and vulnerable children as well as help to manage related co-infections such as tuberculosis.

Burden Of Disease Projection

2005-2030



f = forecast. Source: BMI's BoDD

In July 2011, it was revealed that the Kenyan government has assigned KES64bn (US$715.48mn) to the implementation of its health service plan, according to Finance Minister Uhuru Kenyatta. Of this total, KES903mn (US$10.1mn) will be directed towards the purchase of anti-retroviral drugs to ensure the availability of medication for people suffering with HIV.

Tuberculosis

There has been notable success in the treatment of tuberculosis (TB) in Kenya. Following the adoption of the Directly Observed Treatment Short-Course (DOTS) into national health policy, the treatment's success rate had improved by around 80% during 2003. In March 2009, the Karel Styblo Award was presented to Public Health and Sanitation Permanent Secretary Mark Bor in Nairobi, for Kenya's efforts in fighting and controlling the spread of TB. Bor said that the award was in recognition of Kenya's achievement of the WHO's target of TB case detection rate of 70% and treatment success rate of 85%.

However, TB still remains a burden to the country's healthcare system. Kenya ranks number 13 out of the 22 TB high-burden countries in the world. There were 116,732 new TB cases reported in 2008, of which 12,839 were in children.

In September 2009, it was reported that there were approximately 401 cases of multiple drug resistant-TB between May 2003 and May 2009. Only three health centres in the country have wards that are able to treat patients with MDR-TB, however, the government aims to equip each provincial hospital with the facilities to treat drug resistant patients.

Malaria

Efforts to reduce the burden of malaria received a boost in November 2008. According to a paper published in The Lancet, a dramatic drop in the prevalence of the disease resulted from the replacement of chloroquine with sulfadoxine-pyrimethamine in treatment regimes. Other interventions including the use of insecticide-treated bednets and artemisinin-based therapies could have contributed, researchers said, but the surge in their use came after the steep fall in transmission of the disease.

In March 2009, it was revealed that low-income Kenyans may be able to access the most effective malaria drugs at KES70 per dose, down from KES500, before the end of the year. The medicines will be provided under a highly subsidised programme that aims to ensure anti-malarial drugs are available at all private pharmacies as well as local kiosks. Although the new artemisinin combination therapies are already available without a charge at public health institutions, their intake has been low as their availability has been affected by constant distributions in the supply chain.

As a result, Beth Mugo, Minister of Public Health and Sanitation, called for a meeting between the pharmaceutical industry and medical products distributors to discuss the modalities. It was expected that Mugo would have a difficult time convincing commercial distributors to come on board, mainly because of the government's poor payment record.

Furthermore, in April 2009, it was revealed that an international partnership (backed by the UN) called The Affordable Medicines Facility has been launched to ensure the poor have access to malaria drugs. Prices of ACTs will be reduced from US$6-10 (KES463-KES771) to US$0.20-0.50. (KES15-KES39) The programme was developed through Roll-Back Malaria -- a partnership of public and private organisations that include the Global Fund, the World Bank, the UN Children's Fund, the Dutch government, the Bill and Melinda Gates Foundation and the Clinton Foundation. The scheme will be offered to a number of countries in Africa including Kenya.

In July 2009, it was revealed that despite efforts being made to ensure access to ACTs, just about a third of patients seeking malaria treatment in the country were being provided with the recommended medicines, while some people were still being treated with drugs like chloroquine, which were phased out almost a decade prior. Additionally, it has been reported that at least 61% of Kenyan children do not sleep under insecticide treated nets, which are recommended for preventing malaria. **BMI** believes this highlights the need to raise awareness among the country's citizens as to which drugs are appropriate and how the disease can be prevented.

On a positive note, in October 2009, the US government announced a KES200mn grant towards eradicating malaria in Kenya, which will be channelled through Health Right International (HRI) and Merlin. HealthRight International will implement a three-year US$1.5mn malaria programme targeting more than 200,000 children and pregnant women in the North Rift, while Merlin, with a three-year grant totalling KES112mn will execute a malaria prevention and treatment programme targeting an estimated 220,000 children below five years of age and pregnant women in five malaria epidemic-prone districts of Nyanza Province.

Both programmes will consist of community education and training activities which will promote prevention and care-seeking behaviours by strengthening community access to quality malaria prevention and treatment services. HRI will also build 21 target facilities and five District Health Management Teams to deliver appropriate prevention, diagnosis, and treatment services and distribute long-lasting insecticide treated nets. Additionally, Merlin will work with the Ministry of Health and other health providers to increase community awareness and knowledge on malaria prevention, treatment and management. The project will promote correct and consistent use of insecticide treatment nets as well as increase access to intermittent preventive treatment among pregnant women.

Polio

In February 2009, the Kenyan Health Ministry issued a polio alert after a rare case of the disease was confirmed in a young girl in northern Kenya. It is thought the infection had spread to the country from neighbouring Sudan where cases of polio had been seen.

Many Kenyan children have not been vaccinated against polio due to the political violence that broke out in early 2008 following a disputed election. The unrest left more than 1,000 people dead and 600,000

people displaced from their homes. This had a negative effect on the country's polio immunisation campaign, declining from 100% coverage down to 60% coverage. This is far below the 80% coverage recommended by the WHO.

Shanaz Shariff, director of public health at the Kenyan health ministry, said the government was planning to conduct an immunisation campaign in northern Kenya immediately, targeting all children under the age of five. The project is expected to cost KES5mn (US$63,000) and aims to immunise 96,000 children. Kenya has faced a vaccine shortage since early 2008 and it is reported the country will get doses of the vaccine from the World Health Organization (WHO), which has stocks in the Democratic Republic of Congo. WHO Kenya representative David Okello said the outbreak was a major setback as the WHO, which was planning to certify Kenya as 'polio free' within two years, could no longer do so. The key to stopping polio in its tracks is a comprehensive, coordinated vaccination campaign and cross-border planning. To this end, Kenya will be working in collaboration with Sudan, Ethiopia and Uganda.

In May 2009, the government launched a door-to-door polio vaccination campaign in parts of Nairobi, central and Rift Valley provinces. The first round targeted approximately 2mn children under the age of five. A total of three rounds of vaccinations had taken place by the end of May 2009. Additionally, the Ministry of Public Health and Sanitation in Kenya began a door-to-door anti-polio vaccination campaign on June 4 2011. The programme is aimed at vaccinating 1.2mn children at a cost of approximately KES62mn (US$713.46mn), according to ministry director Shariff Shaanaz. Shaanaz has asked parents of children under the age of five years to ensure their vaccination. The programme will cover children in 22 high-risk districts in the Nyanza, Western and Rift Valley provinces.

Pneumonia

According to a study published by the WHO in September 2009, Kenya has one of the 10 highest proportions of childhood pneumonia in the world, killing approximately 30,000 Kenyan children annually. In areas where malaria is not endemic, pneumonia is the leading killer of children under the age of five, while it comes second in malaria-endemic areas. The high prevalence of the disease is attributed to a lack of pneumonia vaccines, a high prevalence of HIV, poor access to medical care and the large number of undiagnosed and untreated cases of sickle cell anaemia.

BMI therefore welcomed the statement from the national head of immunisation, Dr Tatu Kamau, that by 2010 a pneumonia vaccine would be made available in all public hospitals at no cost. The vaccine is currently available in the private sector for KES12,000; a price that we consider to be unaffordable for the majority of the country's population.

In September 2009, it was revealed that a measles immunisation campaign for children aged below five years old would be extended after the seven-day emergency KES135mn (US$1.8mn) campaign failed to provide the intended coverage. The driver of the vaccination campaign was a measles outbreak in the North Eastern and Rift Valley. **BMI** welcomes the government's focus on and investment in containing

the disease, as no vaccination programmes have been carried out since 2006, when 120 children died due to the disease. According to government statistics, approximately 1.3mn children are yet to be vaccinated despite the 2006 immunisation drive.

In February 2011, UK-based **GlaxoSmithKline** (GSK) announced the incorporation of its pneumococcal vaccine *Synflorix*, which protects against 10 strains of the pneumococcus bacteria responsible for most pneumococcal disease in Kenya and worldwide, into the Kenyan national immunisation programme. Kenya is the first African country to receive pneumococcal vaccines thanks to the Advance Market Commitment (AMC), which aims to bring heavily discounted vaccines to children in the world's poorest countries. Jean Stephenne, chair and president of GSK Biologicals, said: 'The architects of the AMC have delivered on their promise to accelerate access to vaccines for children living in the world's poorest countries. Their vision, Kenya's leadership and the willingness of donors to realise this commitment have resulted in a genuine breakthrough to global public health.'

Cancer

In February 2009, it was reported that health experts at Nairobi's Kenyatta National Hospital were concerned by the increasing number of cancer deaths among the citizens of Kenya. The last recorded figures showed that 18,000 people died of the disease in 2005, with more than 70% of the total aged below 70 years old. The three most common cancers in men are those of the throat, prostate and Kaposi's sarcoma. Meanwhile, breast cancer is the leading cause of death in women, followed by throat and cervical cancer.

Dr Kimani, director of medical services, said that Kenyatta National Hospital was the only public health facility providing comprehensive cancer treatment. He added that this was grossly inadequate as many patients are put on a waiting list of up to six months, and by the time they get attended to, it is too late. On a positive note, he said that plans to set up treatment centres in Mombasa and Nyanza provincial hospitals were in progress.

In October 2009, it was revealed that the Breast Cancer Association and other stakeholders were urging the government to implement a Cancer Control Bill to improve treatment in the country. The association's vice chairman, Newton Siele, said that the Bill would force the government to allocate resources for an autonomous cancer unit that would deal with the treatment, diagnosis and research into cancer. Additionally, the Bill would also create an independent cancer institute, which would not have to rely so heavily on WHO statistics and the Nairobi Council Registry, which collects data only from public hospitals.

In July 2011, the House Budget committee of the Kenyan Parliament was urged to provide funds for the purchase of three radiotherapy machines to be used for cancer treatment. Lawyer Mumbi Ngugi of the Albinism Foundation of East Africa and Kituo Cha Sheria executive director Priscilla Nyokabi presented a petition to the committee in which they also asked the government to provide sunscreen in public

hospitals to help patients with albinism. According to Ngugi, cancer patients were required to travel to Kenyatta National Hospital (KNH) to receive treatment, with most unable to afford it. Ngugi has suggested the installation of the machines in KNH and provincial hospitals in Nyanza and Coast. Committee member Julius Kones revealed that the committee would make amendments to the budget to allocate KES300mn (US$3.37mn) to the purchases

Obesity

A study published in BioMed Central Public Health in December 2009 ('Overweight and obesity and urban Africa: A problem of the rich or poor?') said obesity is on the rise in Africa and may reach epidemic proportions in the near future. The study examined changes (over a period of 10 years) in the prevalence of excess weight and obesity among urban adult women in seven Sub-Saharan African countries (Kenya, Burkina Faso, Ghana, Malawi, Niger, Senegal and Tanzania) and investigated the extent to which these changes vary according to household wealth and education.

The data showed that over the study period the prevalence of overweight/obesity increased by nearly 35.5%. The study also showed that the prevalence of obesity was as high as 38% in urban Kenya compared with 18% in rural Kenya; 35% in urban Niger compared with 7% in rural Niger; 35% in urban Ghana compared with 16% in rural Ghana; 32% in urban Tanzania compared with 12% in rural Tanzania; 29% in urban Senegal compared with 14% in rural Senegal; 28% in urban Burkina Faso compared with 4% in rural Burkina Faso; and 23% in urban in Malawi compared with 12% in rural Malawi.

The findings reinforce the observation that obesity is on the increase in urban areas of Africa, and supports the WHO warning on an impending dual epidemic of communicable and non-communicable diseases on the continent in the near future. Focusing on Kenya, **BMI** notes that our *BoDD* reveals the number of DALYs lost to communicable diseases will increase from 9,013,730 in 2009 to 10,888,077 by 2030, equating to a 21% rise in the DALYs lost. Meanwhile, the number of DALYs lost to non-communicable diseases will rise from 2,613,832 in 2008 to 4,116,757 by 2030, equating to a staggering 57% increase.

Obesity is a widely recognised contributing factor to the development of various chronic diseases such as cardiovascular diseases and diabetes. According to the *BoDD*, 48,043 DALYs were lost to diabetes in Kenya in 2009 and by 2030 this will have increased to 82,064 DALYs -- a 71% increase in the disease burden. Furthermore, 382,854 DALYs were lost to cardiovascular disease in Kenya in 2009 and this is expected to rise to 608,717 DALYs by 2030, a 59% increase. **BMI** believes these figures emphasise the need for the Kenyan government (as well as the governments of other African nations) to educate its population about the seriousness of obesity and its effects. Furthermore, we believe that healthcare services in these nations should prepare themselves for dealing with the changing epidemiological profiles.

The study also showed that women of higher socio-economic status (proxied by household wealth and women's education) were more likely to be overweight or obese than those that were less well-off. Additionally, women who were earning an income were more likely to be overweight or obese. Expanding waistlines are becoming increasingly common in the growing middle and upper classes as people ditch traditional diets (consisting of unrefined carbohydrates and fresh fruits and vegetables) for Western-style foods that are high in saturated fats. This trend is coupled with increasingly sedentary lifestyles.

Table: Insurance Key Drivers – DALYs 2009-2016

	2009	2010	2011	2012f	2013f	2014f	2015f	2016f
All diseases and injuries, total, male,	6,502,941	6,601,828	6,701,127	6,800,530	6,900,103	6,999,899	7,099,964	7,200,081
Communicable, maternal, perinatal and nutritional conditions, total, male	4,303,756	4,347,546	4,391,314	4,434,557	4,477,314	4,519,618	4,561,497	4,602,777
Non-communicable diseases, total, male	1,324,990	1,356,701	1,388,497	1,420,627	1,453,109	1,485,957	1,519,183	1,552,744
All diseases and injuries, 0-4 yrs, male	1,919,539	1,905,410	1,887,748	1,870,043	1,852,228	1,834,251	1,816,075	1,802,265
All diseases and injuries, 5-14 yrs, male	531,825	535,162	538,434	541,970	545,679	549,480	553,296	552,666
All diseases and injuries, 15-29 yrs, male	1,260,844	1,283,551	1,296,400	1,309,212	1,321,950	1,334,581	1,347,076	1,355,834
All diseases and injuries, 30-44 yrs, male	1,652,701	1,708,136	1,775,550	1,842,026	1,907,908	1,973,511	2,039,124	2,108,962
All diseases and injuries, 45-59 yrs, male	800,075	823,722	843,726	865,273	888,179	912,258	937,321	959,434
All diseases and injuries, 60-69 yrs, male	206,145	210,340	220,278	229,781	238,998	248,059	257,071	265,216
All diseases and injuries, 70+ yrs, male	131,812	135,507	138,991	142,226	145,161	147,760	150,000	155,703
All diseases and injuries, total, female	6,320,080	6,407,907	6,496,061	6,584,851	6,674,212	6,764,091	6,854,444	6,945,487
Communicable, maternal, perinatal and nutritional conditions, total, female	4,709,974	4,758,246	4,806,261	4,854,521	4,902,989	4,951,630	5,000,417	5,049,521
Non-communicable diseases, total, female	1,288,841	1,321,111	1,354,051	1,387,410	1,421,174	1,455,327	1,489,860	1,524,816

Table: Insurance Key Drivers – DALYs 2009-2016

	2009	2010	2011	2012f	2013f	2014f	2015f	2016f
All diseases and injuries, 0-4 yrs, female	1,618,034	1,603,062	1,585,327	1,567,557	1,549,674	1,531,618	1,513,342	1,498,478
All diseases and injuries, 5-14 yrs, female	447,421	449,718	451,644	453,676	455,748	457,798	459,772	457,416
All diseases and injuries, 15-29 yrs, female	1,584,066	1,607,845	1,619,194	1,630,776	1,642,555	1,654,494	1,666,560	1,673,507
All diseases and injuries, 30-44 yrs, female	1,649,483	1,695,907	1,757,452	1,818,898	1,880,406	1,942,129	2,004,211	2,073,757
All diseases and injuries, 45-59 yrs, female	652,131	671,683	687,124	703,453	720,561	738,335	756,657	772,711
All diseases and injuries, 60-69 yrs, female	215,183	221,106	232,350	243,233	253,902	264,490	275,113	284,017
All diseases and injuries, 70+ yrs, female	153,762	158,585	162,971	167,259	171,367	175,228	178,788	185,601
All causes	12,823,021	13,009,735	13,197,188	13,385,381	13,574,315	13,763,991	13,954,408	14,145,568
Communicable, maternal, perinatal and nutritional conditions	9,013,730	9,105,792	9,197,575	9,289,079	9,380,303	9,471,248	9,561,914	9,652,298
Non-communicable diseases	2,613,832	2,677,812	2,742,547	2,808,037	2,874,283	2,941,285	3,009,043	3,077,560
All diseases and injuries, 0-4 yrs, total	3,537,573	3,508,473	3,473,075	3,437,600	3,401,901	3,365,868	3,329,417	3,300,743
All diseases and injuries, 15-29 yrs, total,	2,844,909	2,891,396	2,915,594	2,939,988	2,964,505	2,989,075	3,013,637	3,029,341
All diseases and injuries, 30-44 yrs, total	3,302,184	3,404,043	3,533,002	3,660,924	3,788,314	3,915,640	4,043,335	4,182,719
All diseases and injuries, 45-59 yrs, total	1,452,206	1,495,406	1,530,850	1,568,726	1,608,740	1,650,593	1,693,978	1,732,144
All diseases and injuries, 5-14 yrs, total	979,245	984,880	990,078	995,646	1,001,427	1,007,278	1,013,068	1,010,083
All diseases and injuries, 60-69 yrs, total	421,328	431,446	452,627	473,013	492,900	512,549	532,184	549,233
All diseases and injuries, 70+ yrs, total	285,575	294,092	301,962	309,485	316,528	322,987	328,788	341,304

f = forecast. Source: BMI's BoDD

Motor

As demand for vehicles grows, the correlative scope for insurance growth is large. Monitoring key indicators, tightening insurance regulations and domestic purchasing power can be crucial in a market with a short-purchase cycle and high churn rate. Vehicle sales and car ownership statistics are crucial growth indicators for the motor insurance market. Identifying growth trends for these two indicators has the dual advantage of highlighting potential areas of growth and the need for line diversification in both compulsory and non-compulsory motor insurance products.

As growth rates slow in the core private passenger segment, insurance companies look to faster growing specialty segments for expansion, including motorcycles and HGVs; whose domestic sales statistics also offer an insight into the potential of the smaller specialist insurance market potential.

Total new vehicle sales in Kenya rose 8.8% y-o-y in the first nine months of 2011, largely thanks to growth in key industrial sectors, which has driven demand for commercial vehicles. According to data from Kenya Motor Industry (KMI), growth in the agriculture, manufacturing and trade sectors is driving demand for pick-up trucks, which accounted for 35% of total vehicle sales in the nine-month period.

Sales of heavy commercial vehicles still account for 26.8% of the market, behind pick-ups. We also believe that construction projects in the region will fuel sales in the heavier segments over our forecast period. Further growth in Kenya's construction sector is forecast over the next two years by **BMI's** Infrastructure team, supporting the favourable conditions for the commercial vehicle segment. **BMI** expects growth in construction industry value to remain at roughly the same level as 2010 in 2011 and 2012, with industry value reaching KES159bn (US$2.1bn) by 2012. There could also be good news on the pricing front if the CBK's monetary tightening measures result in the shilling's appreciation.

BMI has previously commented on the effects of a weakening Kenyan shilling on the country's used car segment and new data show the extent of the problem, with figures not expected to improve in the short term. Data from the NBS show that used car sales for the eight months to August 2011 were down 20% y-o-y to 33,073 units, from 39,790 in the same period of 2010 previous year.

Dealers have reported a 30% increase since the start of 2011 in the charges associated with importing used cars, including the exchange rate against the yen and US dollar and higher freight costs. The shilling reached a record low of below KES100.0/US$ on September 26, and the Central Bank of Kenya expects sustained currency volatility over the next six months. Inflation has exacerbated the situation and, according to Kwame Owino, chief executive of the Institute of Economic Affairs, this has particularly hit the middle class, which is the biggest customer base for used cars.

Domestic production is one solution to such issues and Kenya is attracting investment, particularly from Chinese companies. Commercial vehicle manufacturer **Foton Motor** launched its first domestically produced trucks in June 2011, after establishing a local subsidiary in the country in late 2010. The Foton

Slip Double Cab pick-up truck was assembled at the **Kenya Vehicle Manufacturers** facility, where it will be assembled until Foton's own plant comes onstream. As part of a growing focus on Africa by Chinese auto companies, the company is building its own vehicle assembly plant, which is scheduled to begin operations in May 2012. **Chery Automobile** will be the next Chinese carmaker to invest in Kenya. According to Justus Nguu, director of Chery's local franchise holder **Stantech Motors**, Chery is now in negotiations with the Chinese government to secure financing of US$50mn for the Kenyan plant, which the carmaker plans to open in 2013.

Islamic Finance

Takaful In Kenya: Watch That Space…

Takaful arrived in Kenya in February 2011. **Takaful Insurance of Africa** (TIA), the only fully shari'a-compliant insurance company in the country began operations, having received its licence from the Insurance Regulatory Authority (IRA) in January. TIA had been established in 2008. In an interview with the media in March 2011, TIA's CEO Hassan Bashir noted that the company hopes to write gross contributions of KES1,000mn (US$12mn) in its first year of operation. According to him, the opportunities come from: the overall under-insurance of Kenyans, in that only 2.8% currently have cover; the fact that 10% of Kenya's population is Muslim; the attractiveness of *takaful* to non-Muslims, and; the integrity and honesty of *Takaful*. Hassan Bashir hopes to expand operations to Tanzania and Uganda in due course. TIA's website indicates that it offers a comprehensive range of general *takaful* products.

The first office of TIA was established in the Eastleigh district of Nairobi, which has a large Muslim population. By December 2011, the company had a network of four offices. Press reports indicated that it had written contributions of US$1mn in its first four months of operations. Meanwhile, Kenya Reinsurance has indicated an interest in expanding into *re-takaful*.

As of December 2011, it is not possible to make a meaningful comment on the development of *takaful* in Kenya. At this stage, we suspect that the most likely scenario is that TIA comes reasonably close to its specified premium target – even if it takes the company 18 months rather than 12 to do so. There is also a significant possibility that *takaful* languishes. Malaysia is the only other country where a *takaful* industry has developed through the sale of products to both Muslims and non-Muslims. The *takaful* operators there had the advantages of a significantly richer population and a government (of a predominantly Muslim country) that was and is absolutely committed to the promotion of Islamic finance. Even then, it was some time before *takaful* accounted for a significant percentage of overall premiums. We also note that there is a small possibility that TIA's commencement of operations proves to be an important catalyst for the further development of insurance and Bashir's target proves to be conservative.

Insurance Risk/Reward Ratings

The Insurance Risk/Reward Ratings take into account objective measures of the current state and long-term potential of the non-life and the life segments. It also takes into account an assessment of the openness of each segment to new entrants and economic conditions. Collectively, these measures enable an objective assessment of the limits to potential returns across all countries and over a period of time. The ratings also incorporate an objective assessment of the risks to the realisation of returns. The risk assessment is based on **BMI**'s country risk rating. It embodies a subjective assessment of the impact of the regulatory regime on the development and the competitive landscape of the insurance sector.

Table: Middle East And Africa Insurance Risk/Reward Ratings

	Industry Rewards	Industry Rewards – Non-Life	Industry Rewards – Life	Country Rewards	Rewards	Regulatory Framework	Country Risks	Risks	Insurance Risk/Reward Rating	Rank
South Africa	73.75	70.00	77.50	75.59	74.48	65.00	60.90	62.54	70.90	1
Israel	56.25	52.50	60.00	73.54	63.16	80.00	68.32	72.99	66.11	2
Bahrain	32.50	35.00	30.00	74.58	49.33	85.00	70.93	76.56	57.50	3
UAE	40.00	50.00	30.00	69.60	51.84	70.00	65.46	67.27	56.47	4
Saudi Arabia	35.00	50.00	20.00	77.36	51.94	60.00	63.46	62.07	54.98	5
Oman	23.75	30.00	17.50	71.64	42.90	65.00	72.67	69.60	50.91	6
Morocco	28.75	37.50	20.00	59.01	40.85	70.00	49.23	57.54	45.86	7
Qatar	18.13	31.25	5.00	70.21	38.96	55.00	65.66	61.40	45.69	8
Kuwait	15.00	20.00	10.00	74.73	38.89	50.00	67.18	60.31	45.32	9
Egypt	27.50	27.50	27.50	58.25	39.80	60.00	54.16	56.50	44.81	10
Jordan	23.75	32.50	15.00	70.00	42.25	70.00	27.57	44.54	42.94	11
Tunisia	21.25	30.00	12.50	60.77	37.06	55.00	46.30	49.78	40.87	12
Kenya	**27.50**	**32.50**	**22.50**	**45.90**	**34.86**	**45.00**	**33.92**	**38.35**	**35.91**	**13**
Iran	22.50	35.00	10.00	51.71	34.18	20.00	43.10	33.86	34.09	14
Algeria	16.25	22.50	10.00	44.54	27.56	50.00	47.11	48.27	33.77	15
Nigeria	17.50	25.00	10.00	50.81	30.82	25.00	44.59	36.75	32.60	16
Libya	3.75	5.00	2.50	42.00	19.05	30.00	45.00	39.00	25.04	17

Scores out of 100, with 100 the best. Source: BMI

Competitive Landscape

Major Players In Kenya's Insurance Sector

Kenya's insurance sector is regulated by the Insurance Regulatory Authority, which was established under the Insurance (Amendment) Act of December 2006. The act became effective on May 1 2007. The IRA formulates and enforces insurance standards, particularly in relation to compulsory lines such as compulsory third-party motor liability insurance. It also approves tariffs and rates of insurance, deals with complaints from the public, and monitors the viability of insurers. It monitors and enforces claims settlement which includes limiting ownership of a single individual shareholder to 25% and increasing the minimum capital requirement from the KES50mn to KES150mn for life insurers. Prior to 2007, the insurance sector was regulated by the Office of the Commissioner of Insurance, part of the Ministry of Finance that was established early 1987. The authority's website is www.ira.go.ke.

As of late 2011, the IRA listed 44 insurance companies, 141 brokers and 105 licensed insurance investigators. There are also 23 insurance surveyors, 21 loss adjusters, 14 medical insurance brokers and 75 motor assessors.

In March 2011, the IRA cancelled the licences of 102 brokers for failing to adhere to regulations in a clean-up of the sector, leaving only 158 firms in business. The regulator also did not renew the operating licenses of three companies – **Blue Shield**, **Concord** and **Madison** – for compliance failures. The latter has since been issued a licence. Blue Shield was placed in statutory management by the Commissioner of Insurance in September 2011.

The trade association is the Association of Kenya Insurers. The AKI was set up in 1987 and is the umbrella group for the country's insurers. Its website is www.akinsure.or.ke. Its aims, in broad terms, include representation of the insurance sector to government and the general promotion of insurance in Kenya.

In the 1980s legal restrictions required that the insurers be locally owned. These restrictions are not absolute. **Pan Africa**, the largest player in the life segment, has a strategic partnership with South Africa's **African Insurance**, which has been a subsidiary of financial services giant **Sanlam** since 2005. The Kenyan operations of South Africa's **Old Mutual** are among the 10 largest life groups. Also present is the local subsidiary of South Africa's **Metropolitan Life.**

In the non-life segment, **Chartis** – the rebranded global non-life business of **AIG** – remains one of the largest operators. **Kenindia** is the result of the 1979 merger of the Kenyan subsidiaries of four of India's largest insurers – **New India Assurance**, **Oriental Insurance**, **United India Insurance** and **Life Insurance Corporation of India**. Kenindia is structured as a joint venture between these companies, each of which has a 9-10% stake, and prominent members of Kenya's Indian business community.

Kenindia's local partners include **Chandaria Foundation/Comcraft Group**, the **Sansora Group** and the **Mahendra Group**.

The countries in SSA whose insurance sectors are profiled by **BMI** are Kenya, Nigeria and South Africa. Kenya's insurance sector is similar in structure to Nigeria's in that is consists of a surprisingly large number of companies that are, by most standards, very small. As is discussed in the company profiles, some of the larger companies have operations in neighbouring countries such as Uganda and Tanzania. In this respect they are similar to their Nigerian peers. There are two main differences, however. First, there is no Kenyan equivalent of **NICON**, the former state-owned insurer in Nigeria. Although NICON has lost ground compared to other insurers over recent years, it is still one of the larger players in Nigeria by most measures. Second, there is much more significant foreign (particularly South African) presence in Kenya, especially in the life segment, which is far more developed than Nigeria's. We also note that the general level of transparency in the insurance sector Kenya, thanks mostly to the reports published by the AKI, is much better than the level of transparency in the Nigerian insurance industry.

Table: Non-Life Companies' Premiums And Market Share, 2008-2009

	Premiums, 2008, KESmn	Premiums, 2009, KESmn	Market share, %
Jubilee	3,109.3	3,690.0	8.6
APA	3,002.9	3,603.6	8.4
UAP	2,465.2	3,062.9	7.1
Kenindia	2,831.7	2,834.0	6.6
Chartis (formerly AIG)	2,084.9	2,066.6	4.8
BlueShield	2,203.2	1,965.2	4.6
Heritage	1,712.2	1,919.0	4.5
Lion	1,597.7	1,740.2	4.0
ICEA	1,416.8	1,653.0	3.8
Cooperative	1,280.7	1,653.0	3.8
First Assurance	1,350.1	1,647.1	3.8
British American	993.0	1,454.0	3.4
Africa Merchant	976.6	1,387.4	3.2
Directline	696.2	1,188.2	2.8
Real	872.3	1,167.6	2.7
General Accident	887.9	1,119.9	2.6
Occidental	874.5	1,028.0	2.4
CFC Life	631.3	848.7	2.0
Fidelity	737.9	796.9	1.8

Table: Non-Life Companies' Premiums And Market Share, 2008-2009

	Premiums, 2008, KESmn	Premiums, 2009, KESmn	Market share, %
Cannon	602.1	795.7	1.8
Concord	668.9	675.2	1.6
Madison	549.8	664.1	1.5
Gateway	527.4	623.0	1.4
Germinia	513.0	619.3	1.4
Kenya Orient	439.2	586.8	1.4
Mayfair	454.8	561.2	1.3
Trident	440.0	517.9	1.2
Tausi	487.3	511.4	1.2
Intra	462.8	502.1	1.2
Phoenix	628.6	492.5	1.1
Mercantile	377.4	425.1	1.0
Corporate	365.8	368.2	0.9
Pacis	251.9	313.6	0.7
Kenyan Alliance	156.9	294.8	0.7
Pioneer	130.5	169.5	0.4
The Monarch	114.7	162.7	0.4

Source: AKI

Table: Life Companies' Market Shares, 2009 (KESmn)

	Ordinary premiums	Group premiums	Total premiums	Market share, %
Pan Africa	1,512.2	1,513.0	3,025.2	22.9
British American	1,912.9	589.0	2,501.9	19.0
ICEA	584.0	687.7	1,271.7	9.6
Cooperative	102.6	1,119.1	1,221.6	9.3
Jubilee	482.8	605.0	1,087.8	8.2
CFC Life	926.4	121.1	1,047.5	7.9
Madison	434.6	80.6	515.2	3.9
Old Mutual	378.5	78.1	456.6	3.5
UAP Life	207.9	168.6	376.5	2.9
Kenindia	292.7	56.2	348.9	2.6
Pioneer	290.0	40.6	330.5	2.5
Apollo	35.7	148.1	183.8	1.4
Shield Assurance	131.1	17.1	148.2	1.1
Heritage	na	143.1	143.1	1.1
Metropolitan Life	60.0	52.3	112.3	0.9
Corporate	99.1	1.6	100.6	0.8
First Assurance	na	98.8	98.8	0.7
Cannon	73.9	4.8	78.7	0.6
Mercantile	34.6	8.1	42.7	0.3
Monarch	na	38.3	38.3	0.3
Kenyan Alliance	na	34.7	34.7	0.3
Trinity	17.3	na	17.3	0.1
Geminia	13.0	1.4	14.4	0.1

na = not available/applicable. Source: AKI

Company Profiles

APA Insurance

Website	www.apainsurance.org
Overview	APA Insurance is the largest insurer in East and Central Africa. It was formed in 2003 by the merger of Apollo and Pan-Africa General. APA was the first insurance company in Kenya to undertake HIV/AIDS cover. Premiums in 2010 amounted to around KES4.3bn.
Operations	APA has nine regional offices in Kenya. It also has a wholly owned subsidiary company, APA Insurance (Uganda), which is licensed to operate in that country. The Ugandan business is crucial to the company in opening up other markets in the region and maintaining a regional presence. APA is active in exploring other markets and seeking regional expansion. APA also owns a 46% share of Reliance Insurance Company in Tanzania, which helps to boost its regional presence. In April 2011, the company announced LeapFrog Investments injected KES1.15bn (about US$14mn) into Apollo Investment, which includes APA Insurance, Apollo Life Assurance, Apollo Asset Management and Gordon Court. LeapFrog is the world's largest investment fund focused on insurance to underserved people and markets. Apollo said it would increase its stake in APA through the acquisition of a 39.97% holding previously owned by Pan Africa Insurance Holdings. At the end of April 2011, APA announced the launch of a new comprehensive motor product called BimaBamba. The product includes: KES100,000 of cover for hospitalisation in the wake of an accident; income supplement of up to KES1,000 per day for up to six days in the event of hospitalisation; cover for political violence; excess protection, and; a subsidised vehicle tracking devices. Unusually, premiums may be paid monthly rather than annually and in advance. Payments may be made by cash, M-PESA, Airtel Money and PesaPoint. In mid-2011, APA made payment of claims to farmers who had been adversely affected by weather conditions in the February- May 2011 planting season. It said: 'Wheat farmers in Narok were hit by a severe drought occasioning a total crop failure. The month of April was particularly the worst drought episode in the region for the past 32 years with the exception of the year 1993. This prompted a compensation payout … of KES10,000 for ever acre covered by APA Insurance, for the seven (Agricultural Finance Corporation-backed) farmers who collectively covered 336 acres of wheat. 'The cover provides lump sum payment that will assist the farmers to be ready for the next season. The availability of such insurance covers will encourage banks, MFIs and specialist corporations like the AFC to provide loans to farmers, as they will have the insurance which repay the loan to the financier.' The new IBWI product has been developed in conjunction with the World Bank, the Rockefeller Foundation, the Kenya Meteorological Department and the UK Department for International Development.

Apollo

Website	www.apollo.co.ke

Overview

Apollo was first incorporated in 1977. Originally based in Mombasa, its headquarters have been in Nairobi since 1981. Apollo is focused on delivering life insurance products and related services throughout Kenya.

As well as its insurance products, Apollo offers a range of saving and investment vehicles.

In February 2010, the company launched a credit life product designed to help poor people live a life in dignity. The credit life cover insures micro-finance institutions in case of death, permanent total disability and critical illness of their borrowers, which in turn provides a safeguard to ensure continuity of business of the borrower by his family.

In April 2011, the company announced that LeapFrog Investments invested KES1.15bn (US$14mn) in Apollo Investment, which includes APA Insurance, Apollo Life Assurance, Apollo Asset Management and Gordon Court. LeapFrog is the world's largest investment fund focused on insurance to underserved people and markets. Its capital and global insurance expertise should help Apollo become a pre-eminent regional player in insurance in East Africa, including in micro-insurance. At about the same time, Apollo announced that it had exercised its pre-emptive rights to buy the 39.97% stake in APA that had previously owned by Pan Africa Insurance Holdings.

Operations

Apollo operates throughout Kenya, but mainly from its base in Nairobi. It has two offices in the capital and offices in Mombasa and Nakuru.

It operates through two main divisions: individual solutions and solutions for businesses and organisations. Apollo also works with agency offices in Eldoret and Kakamega.

Blue Shield Insurance

Website	www.blueshield.co.ke
Overview	Blue Shield Insurance was established in 1982 and has a presence across Kenya. The company is one of the oldest domestically owned insurance companies in Kenya. It offers a wide range of products tailored to customers' specific needs. These are split into three main categories: general insurance products, life insurance products and agriculture insurance products.
Operations	Blue Shield Insurance operates as a composite insurer. It is composed of three shareholding directors and three non-shareholding directors. It is the only Kenyan insurance company with a woman as chairperson. The company's head offices are in Nairobi and it has a countrywide branch network and a strong team of intermediaries including brokers and agents. There are 32 branches across Kenya. The company split its life and general insurance into separate operations in 2010. It was established as a composite insurance company in 1982 and has broad asset base of more than KES3.1bn. Its share capital of KES250mn. The company has an elaborate and well managed countrywide branches network. The companyy has authorised share capital of KES250mn and an asset base of over KES3.1bn.
News	Blue Shield split its life and general insurance in 2010. This move was designed to make a clear split between the two divisions – after cash flow deficits in the general business had, apparently, been covered by funds from the life business. On September 16 2011, the Commissioner for Insurance placed Blue Shield under statutory management. The statutory manager imposed a moratorium on payments by the (general) insurance company to its policy holders for 12 months. The commissioner stressed that the life business previously written by Blue Shield, and which had been transferred to a vehicle known as Shield Insurance, has no problems. Blue Shield was unable to meet its obligations to policyholders and other creditors.

Jubilee Holdings

Websites www.jubileeholdings.com, www.jubileeinsurance.com

At A Glance

Jubilee Insurance is the largest composite insurer in Kenya and East Africa. It focuses on medical insurance products. The company operates from a strong financial base throughout East Africa. The group reported gross premiums for 2010 of KES11.5bn, up by 25% from 2009. It also announced an 84% increase in pre-tax profit for 2010 to KES2,053bn.

Operations

Jubilee's Insurance business is operated through a network of head offices in the East African capitals of Nairobi, Kampala and Dar es Salaam, along with eight branches across the region. It has been in operation since 1937 when it was incorporated as The Jubilee Insurance Company, based in Mombasa.

Jubilee has been listed on the Nairobi Stock Exchange since 1984. In 2005, the company expanded to cross-list on the Ugandan Securities Exchange and in 2006 on the Dar es Salaam Stock Exchange. The company has about 400 employees across East Africa.

The company took advantage of strong economic growth in 2010 in East Africa and initiated an aggressive regional expansion campaign. It launched subsidiaries in Burundi and Mauritius and plans to enter new markets every year. By 2014, Jubilee expects to be in 14 markets in Africa.

At the end of Q111 the company released its results for 2010, which showed strong growth. Gross premiums rose by 25% to KES11,484mn. Profit before income tax increased by 84% to KES2,053mn. Total assets stood at KES31,600mn at the end of last year.

Kenindia

Website www.kenindia.co.ke

At A Glance

Kenindia Assurance Company is Kenya's largest non-life insurer. It was the first insurance company in Kenya. It has 13 branches in Kenya, and brokers and subsidiary divisions abroad.

Operations

Kenindia was formed in 1979 by the merger of four insurers: New India Assurance, Oriental Insurance, United India Insurance and the Life Insurance Corporation of India.

Kenindia has a presence in the East Africa region through its Tanzanian subsidiary. The company's market share for non-life premium in Kenya is above 9%.

Kenindia's business profile is composed of four main segments:

- Fire insurance: 22%
- Marine insurance: 12%
- Motor insurance: 32%
- Other: 35%

Pan Africa

Website	www.pan-africa.com
At A Glance	Pan Africa Life Assurance is one of the largest companies in the Kenyan insurance market. It has been in business since 1947 and is one of only two life insurance companies quoted on the Nairobi Stock Exchange. It has more than 338,000 policyholders in Kenya, equating to a market share of 17% of the Kenyan life insurance market.
Operations	Pan Africa conducts business through a network of 15 branches throughout Kenya. It is headquartered in Nairobi and has offices in Eldoret, Mombasa, Embu, Kisii, Nakuru, Kisumu, Nyeri, Machakos, Thika, Meru, Naivasha and Westlands. The company merged parts of its non life insurance business with Apollo insurance in 2003 in order to form APA insurance. It maintains a strategic partnership with African Life of South Africa, the. Since 2005 African Life has been a fully owned subsidiary of Sanlam, one of the largest life companies in South Africa. Pan Africa can justly claim to be something of a pioneer in Kenya. It was the first company to introduce individual and group life products without the HIV/AIDS exclusion and the first player to offer life insurance without a medical test. It 'remains the only life insurer in Kenya with an entire portfolio of individual life business that pays claims irrespective of the cause of death, where death falls outside the prescribed waiting period.' It was also the first life company to offer unit-linked products in Kenya.
News	At the end of Q111, Pan Africa Insurance Holdings (PAIHL) announced that its subsidiary PA Securities would sell to Apollo Insurance the 39.97% stake held in APA Insurance. This deal was consistent with the original agreement reached between PAIHL and Apollo when they merged their general businesses in 2003 to form APA. It said: 'The board of Pan Africa has considered that this investment has served its purpose, having seen it grow and mature. Pan Africa will continue with its focus on the long-term insurance business. Apollo, being the majority shareholder in APA will exercise its rights of pre-emption to purchase the Pan Africa shareholding to allow it flexibility in pursuing the group's strategy in the region.'

BMI Methodology

BMI's insurance reports provide insights into the operating conditions in and prospects for insurance in over 60 mostly developing countries. The reports incorporate the latest information available from official sources such as regulators, international associations of regulators and trade associations; comparable information from other countries; and **BMI**'s economic and risk data. The reports focus on gross written premiums in two segments: non-life and life. Unless stated, 'premiums' refers to gross written premiums.

In **BMI**'s reports, non-life insurance includes health insurance premiums if these are normally considered by industry observers to lie within the mainstream insurance sector. Non-life insurance includes inwards reinsurance premiums if these would normally and reasonably be considered a significant part of the non-life segment. In practice, this means that we generally include inwards reinsurance in developed countries and offshore financial centres that specialise in insurance. We consider outwards reinsurance to be an expense. Life insurance includes all long-term savings products that are legally structured as insurance products. Life insurance premiums do not, therefore, include contributions to pension plans and other long-term savings schemes unless they are legally constituted as being within the insurance sector.

Life Segment

In projecting life premiums, we consider two aspects: the likely development of population and of life density (life premiums per capita). Typically, we forecast life density for 2016 and assume density changes evenly from 2012 to 2016. In some cases there will be clear reasons why life density is not likely to change evenly over time. In such cases, we forecast life density from year to year. Forecasts of life density for 2016 typically take into account the following factors: life density in 2012; density in nearby countries at a similar level of development; relative importance of life insurance in terms of overall retirement savings; and other factors promoting or retarding evolution of the life segment.

Non-Life Segment

In making projections of premiums in the non-life segment, we consider two aspects: the likely development of nominal GDP and of non-life penetration (non-life premiums as a percentage of GDP). Typically, we forecast non-life penetration for 2016 (the end of the forecast period) and assume that non-life penetration changes evenly from 2012 to 2016. However, in some cases, an examination of the various lines (motor, accident/health, liability etc) that constitute the non-life segment indicates that the non-life penetration is not likely to change evenly over time. In such cases we forecast the non-life penetration from year to year. Forecasts of non-life penetration for 2016 typically take into account the following factors: non-life penetration in 2012; penetration in nearby countries at a similar level of development; whether or not health insurance is generally considered to be within the insurance sector; and other factors promoting or retarding evolution of the non-life segment.

Autos

At a general level, we approach our forecasting from both a micro angle and a macro perspective,

assessing the expansion plans of relevant multinationals/ indigenous firms, while also taking account of the prevailing economic outlook. In this latter respect, BMI projections for macro variables such as industrial output, private consumption, government investment, monetary policy and GDP growth play a key role.

Tourism

There are a number of principal criteria that drive our forecasts for each tourism sector variable. Figures for the tourism sector data are based, where possible, on industry associations/operators, government/ministry sources and official data. Where these are unavailable, tourism forecasts are based on a range of variables:

- Government policy, industry trends and expenditure levels stated in international and national press.
- Industry trends and expenditure levels stated in tourism company official financial reports or releases.
- Likely expenditure and growth patterns owing to international developments/demographic patterns.
- Likely alterations in expenditure patterns owing to economic/political activity.

Burden Of Disease

The burden of disease in a country. This is forecasted in DALYs (disability-adjusted life years) using **BMI**'s Burden of Disease Database, which is based on the WHO's burden of disease projections and incorporates World Bank and IMF data.

Security Risk Ratings

BMI's Security Ratings service, which integrates closely with our Country Risk service, offer a comprehensive comparative analysis of security risk across three key areas – interstate conflict, terrorism and physical safety for expatriate workers – across major states in each region. The ratings are combined to form a composite security rating to provide an overall guide to long-term trends and risks. Finally, we integrate our short-term political and economic ratings with the terrorism rating, to indicate a state's vulnerability to a sustained terrorist campaign or major terrorist attack. In all instances, the rated period is two years, with each country assigned a score out of 100, with a low score indicating a high level of risk.

Insurance Risk/Reward Ratings

BMI's Insurance Risk/Reward Rating has a threefold approach. First, we assess market attractiveness and risks to the predictable realisation of profits in each state, capturing operational dangers facing companies. Second, we identify objective indicators that serve as proxies for issues/trends in the industry to ensure consistent evaluation across states. Finally, we use **BMI**'s Country Risk ratings to ensure the ratings capture broader issues relevant to the industry and that may limit market attractiveness or imperil returns. The ratings system – which integrates with all industries covered by **BMI** – offers an industry-leading insight into prospects/risks for companies. The ratings divide into two distinct areas:

Rewards

Evaluation of the industry's size and growth potential in each state, and also broader industry/state characteristics that may inhibit its development.

Risks

Evaluation of industry-specific dangers and those emanating from the state's political/economic profile that call into question the likelihood of anticipated returns being realised over the assessed time period.

Indicators

The following indicators have been used. Almost all indicators are objectively based.

Table: Insurance Risk/Reward Indicators And Rationale

Rewards	
Insurance market	**Rationale**
Non-life premiums, 2012 (US$mn)	Indicates overall sector attractiveness. Large markets more attractive than small ones.
Growth in non-life premiums, five years to 2016 (US$mn)	Indicates growth potential. The greater the likely absolute growth in premiums the better.
Non-life penetration, %	Premiums expressed as % of GDP. An indicator of actual and (to an extent) potential development of non-life insurance. The greater the penetration the better.
Non-life segment measure of openness	Measure of market's accessibility to new entrants. The higher the score the better.
Life premiums, 2012 (US$mn)	Indicates overall sector attractiveness. Large markets more attractive than small ones.
Growth in life premiums, five years to end-2016 (US$mn)	Indicates growth potential. The greater the likely absolute growth in premiums the better.
Life penetration, %	Premiums as % of GDP. An indicator of actual and (to a certain extent) potential development of life insurance. The greater the penetration the better.
Life segment measure of openness	Measure of market's accessibility to new entrants. The higher the score the better.
Country structure	
GDP per capita (US$)	A proxy for wealth. High-income states receive better scores than low-income states.
Active population	Those aged 16-64 in each state, as a % of total population. A high proportion suggests that market is comparatively more attractive.
Corporate tax	A measure of the general fiscal drag on profits.
GDP volatility	Standard deviation of growth over 7-year economic cycle. A proxy for economic stability.
Financial infrastructure	Measure of financial sector's development, a crucial structural characteristic given the insurance industry's reliance on risk calculation.
Risks	
Market risks	
Barriers to entry	Subjectively evaluates de facto/de jure regulations on development of insurance sector.
Regulatory environment	Subjectively evaluates impact of regulatory environment on the competitive landscape.
Country risk (from BMI's Country Risk Ratings)	
Short-term financial risk	Evaluates currency volatility.
Short-term external risk	State's vulnerability to externally induced economic shock, which tend to be principal triggers of economic crises.
Policy continuity	Evaluates the risk of sharp change in broad direction of government policy.
Legal framework	Strength of legal institutions. Security of investment key risk in some emerging markets.
Bureaucracy	Denotes ease of conducting business in a state.

Source: BMI

Weighting

Given the number of indicators/datasets used, it would be inappropriate to give all sub-components equal weight. Consequently, the following weight has been adopted.

Table: Weighting Of Indicators

Component	Weighting, %
Rewards, of which	70, of which
– Insurance market, of which	65, of which
– Life	– 50
– Non-life	– 50
– Country structure	– 35
Risks, of which	30, of which
– Market risks: regulations and impact on development and competitive landscape	– 40
– Country risks	– 60

Source: BMI