(**Journal of Educational Management & Social Sciences (JEMSS)**

Volume 3, Number 2, 2022, Pages 16 – 26

Journal Home Page

https://journals.irapa.org/index.php/jemss/

National Health Insurance Fund in the Informal Sector: Challenges and Constraints Experience from Dar es Salaam, Tanzania

Mathias Mkude

Department of Gender Studies, Tengeru Institute of Community Development, Arusha, Tanzania
Email: matimkude@gmail.com

ARTICLE INFO

Article History:

Received:	August	20, 2022
Revised:	September	13, 2022
Accepted:	October	25, 2022
Available Online:	November	20, 2022

Keywords:

Social inclusion, NHIF, NHIF packages, Informal sector, Insurance Funds in Tanzania

JEL Classification Codes:
O15, O47, R13

ABSTRACT

This qualitative research and interpretative paradigm study investigated the challenges and constraints of the National Health Insurance Fund (NHIF) inclusion of the informal sector in Dar es Salaam, Tanzania. Sixteen respondents were involved in this study through an in-depth interview as a primary method of data collection. Content and thematic analysis were used to draw themes from data. Findings revealed that the operation of the NHIF in the informal sector is facing challenges such as a lack of information about health insurance; the packages attract sicker than healthy individuals and informal social protection attracts individuals more than NHIF. Furthermore, the study revealed that the implementation of the NHIF in the informal sector is constrained by the limitation of other family members, waiting time after joining the NHIF, limited services to the first-year members, and the exclusion of people above 59 years in special insurance packages. The study concludes that the inclusion of the informal sector in the NHIF packages is experiencing challenges and constraints, areas that need to be addressed for the successful widening of the coverage. The study recommends that NHIF should expand its coverage to promote universal health coverage and enhance sustainable development goal number three.

Corresponding Author's Email: matimkude@gmail.com

INTRODUCTION

Health Insurance Schemes are the foundation for achieving universal health coverage (UHC) (van Hees et al., 2019). While the UHC has been established in many developed countries, developing countries like Tanzania are still lagging in extending the coverage to their different social groups (Barimah&Mensah 2013; Mills et al., 2012 Isaya, et al.2018). UHC is an essential tool that presents the availability of health services to all members of society, irrespective of their ability to pay. It generally protects individuals from suffering financial

hardship caused by ill-health (Jehu-Appiah et al., 2011). UHC is also a means to promote social inclusion in the health sector (van Hees et al., 2019). Social inclusion is necessary because it reduces inequalities brought by the different social-economic statuses of individuals in access to health (Dugarova, 2015). In Tanzania, the total population of 24% is covered by CHF and 9% under NHIF (Tungu, et al., 2020)

In Organization for Economic Cooperation and Development (OECD) countries, better and affordable health service is given to all through UHC (Overbye, 2005). In other parts of the world, such as countries in Asia and Latin America, the NHIF is used as an essential tool to extend health insurance coverage to majorities and, thus, achieve universal health coverage (Bachmann, 1994). For stance in Southern Korea, Universal Health Insurance was achieved just 12 years after the establishment of the National Health Insurance Scheme in 1977 (Wang et al., 2018).

The government of Tanzania established the NHIF in 1999. Initially, the schemes aimed to cover all public servants, their spouses, and children or dependents not exceeding four in number (URT, 2018). The NHIF also included retirees who were previously members of the Fund and councilors when they were in office. However, the NHIF coverage gradually increases to cover the informal sector (Borghi et al., 2015; Quaye, 2019). The scheme is contributory with comprehensive packages such as outpatient, inpatient, specialized surgery, pharmaceuticals, optical services, and orthopedics. While the NHIF is compulsory for civil servants, individuals and groups from the informal sector join the scheme voluntarily. Through the NHIF, the core group of workers from the public sector enjoys the same benefits, while 6% of the premium is collected from employers and employees (Ulandssekretariatet, 2018). The NHIF covers only 9% of Tanzania's total population (Tungu, et al., 2020)

The coverage of the NHIF is only 9% of the total population, and the majority is civil servants (formal sector) because civil servants must be members of the NHIF (Tungu, et al., 2020). This implies that the majority of the people, especially individuals and communities from the informal sector, suffer from a lack of adequate health insurance provided by NHIF. It is with this view that this study investigated the challenges and constraints faced by NHIF in the inclusion of the Informal Sector in Tanzania.

LITERATURE REVIEW

Ayanore, et al., (2019) investigated the inclusion of the general population by NHIF in Ghana. It was revealed that, since its establishment in 2003, the NHIF has greatly covered the population of more than 40% by 2014. The rationale for the establishment of NHIF in Ghana targeted not only quality health accessibility to all but also poverty reduction by eliminating out-of-pocket payments (Barimah & Mensah, 2013). Therefore the NHIF in Ghana has exempted vulnerable groups such as pregnant women, persons with mental disorders, social security recipients and pensioners, elderly (above 70 years) from paying NHIF premium but accessing health care under NHIF (Ayanore, et al., 2019). The government established different sources of funds to widen and strengthen the NHIF services both in form of benefits and population coverage. Similarly, the premium for the informal sector varies from district to district, but the minimum premium is 8 USD per annum (Barimah & Mensah, 2013). Even though the premium is affordable to the wider population, The NHIF has considered that enrolled members have access to comprehensive health care with their dependants who are below 18 years

Barasa et al. (2018) Investigated the role of NHIF in promoting social inclusion of the marginalized groups in Kenya. Initially, the NHIF was established mainly to provide health insurance cover to the formal sector in 1966. However, in 1972 the NHIF was expanded to cover individuals and informal sectors to promote social inclusion and Universal Health Coverage (UHC). The purpose of UHC was to improve financial protection during Ill-health and promote equitable access to quality health services. In this regard, Mbau, R. et al., (2020), revealed that the introduction of NHIF as a health reform strategy in Kenya aimed to achieve UHC by covering both formal and informal sectors in Kenya. However, the enrolment of the informal sector in the NHIf faces challenges because the majority of the informal workers are not capable of paying the proposed premium by NHIF.

Other studies have investigated the role of NHIF in enhancing social inclusion. According to Cheng (2015), The NHIF in Taiwan has achieved social inclusion and Universal Health Coverage (UHC) by 99.9% of the total population (23.4 million) in 2013. The achievement of social inclusion and universal health coverage started in 1995. The NHIF in Taiwan is based on the egalitarian ethical principle in which members have equal access to health services. Social inclusion in health insurance leaves no one behind, including both citizens of Taiwan and foreigners living in the country (Wu, Majee, & Kuo, 2010). The country uses the NHIF System as a single insurer, but all beneficiaries have greater freedom of choice when need to access health care. Health care in Taiwan is provided by both private and public. The NHIF in Taiwan provides comprehensive benefits packages ranging from inpatient, outpatient, dental care, traditional Chinese medicine, renal dialysis, prescription drugs, prenatal care, physical rehabilitation, home nursing, chronic mental illness care, and preventive services (Cheng, 2015).

Mills et al., (2012) found that a lack of information about the availability of voluntary health insurance to the informal sector, lack of user-friendly registration processes, and poor customer care set limit the health insurance coverage in the informal sector. Other challenges are poverty, low quality of services, limited packages, and lack of trust in scheme and health care providers (Renggli et al. 2018). Additionally, the management team's insufficient capacity at the district level, lack of commitment from the council, high administration costs, weak medical supply chain, lack of transparency and accountability, and poor data quality.

Mushi and Millanzi (2019) investigated that the low uptake of health insurance in the Informal sector is caused by the low level of income and limited knowledge about health insurance. The informal sector's earnings are inadequate not only to pay for the health insurance premiums but also to cover healthcare-related costs such as transportation, user fees, drugs, and others. The low income exposes people in the informal sector to the vulnerability of poverty when a family member falls sick. Similarly, the majority of individuals in the informal sector depend on getting health care from pharmacies, traditional attendants, and conventional medical facilities.

Verbrugge et al., (2018) investigated that the absence of formal social protection in the informal sector does not imply that people have no social security. Instead, it represents the fact that people rely on informal social welfare. But the low uptake of formal social protection such as health insurance is contributed by several factors such as dynamics of the informal sectors, unregistered nature of the informal sectors, and lack of representation in trade unions. Other factors are lack of regular income, unwillingness or inability of the people in the informal sector

to contribute to social protection, and the fact that some people in the informal sector are reluctant to formality and prefer to remain informal.

The Challenges Facing Health Insurance Funds in Including the Informal Sector in NHIF

Existing literature has predominantly investigated the challenges to the social inclusion of the national health insurance fund in the formal sector. Fewer works of literature have examined these challenges in the informal sector. These studies have found that lack of information about the availability of voluntary health insurance to the informal sector, lack of user-friendly registration processes, and poor customer care limit health insurance coverage in the informal sector (Mills et al. 2012& Sychareun, V., et al. 2016). Other challenges include poverty, low quality of services, limited services in packages, and lack of trust in schemes and health care providers (Renggli et al. 2018). Mushi and Millanzi (2019) found that the low uptake of health insurance in the informal sector is associated with a low level of income and limited knowledge about health insurance. While most of these studies explored upcountry regions such as Morogoro and rural areas, less has been documented on the challenges facing the enrollment of the informal sector in health insurance schemes in Dar es Salaam.

This study aims at advancing the prior research by examining the challenges faced by the informal sectors in Dar es Salaam in their enrollment into the National Health Insurance Fund. Specifically, this research aimed to investigate the challenges and constraints of the National Health Insurance Fund (NHIF) inclusion of the informal sector in Dar es Salaam, Tanzania. The study deployed social inclusion theory; the content and thematic methods were used to analyze my qualitative data. The study addressed the following questions:

1. How is social inclusion constrained by NHIF health package benefits in Dar es Salaam?
2. What are the challenges facing NHIF in its role of social inclusion in the informal sector?

MATERIALS AND METHODS

This study was conducted in Dar es Salaam, the largest city and business center in Tanzania, located between latitude 6.36 degrees to the south of the Equator and longitude 3.9 and 33.3 to the east of Greenwich. The active labor force working in both formal and informal sectors in Dar es Salaam is 1.9 million, compared to 5.1 million in the rest of the urban areas in Tanzania (NBS, 2014). On the other hand, Dar es Salaam is comprising of 28% of informal sector employment as well as one-third of the non-farming activities taking place in urban areas of the country (Adams et al., 2013 & Lokina, et al., 2017). This was the reason behind the selection of the mentioned study areas. The study deployed qualitative research and used the interpretative paradigm. This study is qualitative because it aims to understand the social inclusion experience of NHIF members from the informal sector. An in-depth interview was the main data collection method. During the interview, both the researcher and the interviewer had an opportunity to explain, understand and better explore opinions, behavior, experiences, and phenomenon under investigation. This study involved 16 respondents, of which six were from NHIF. Others were six petty traders operating in different informal sectors, two taxi drivers, and two artists. After 16 interviews, a researcher stopped collecting more interviewees as no new issues were emerging and hence considered the situation as saturation of data. Data collected were subjected to content and thematic analysis (Braun, V. & Clarke, V. 2014), whereby all the stages of analysis were strictly followed.

RESULTS

The challenges to the social inclusion of NHIF in the informal sector.

The challenges in this study consider the barriers for individuals to join the NHIF packages for the informal sector. The operations of the NHIF in the informal sector are facing challenges such as a lack of information about health insurance, sickness insurance over health insurance, and the existence of informal social protection.

Lack of Information about Health Insurance in the Informal Sector

Lack of information about health insurance in the informal sector means the limited understanding of health insurance by informal sector individuals to the point of being easy to lie. The findings of this study revealed that the limited understanding of health insurance among informal sector communities is a hindrance to including the majority in the NHIF's health insurance. The majority of the informal sector population believes that they only need health insurance when they fall sick and when they experience severe sickness. Thus, the majority of the informal sector population dropped from health insurance after the first year of membership when they did not fall sick or use their health insurance cover.

"Bad people approach them and tell them not to join the health insurance; they tell them, what if you pay one hundred thousand annually and you do not fall sick? That means you have lost; you better ask for God's favor" – Petty trader (P1)

High Premium and Consequential Attitude Change

A high premium means the expensive payment for the NHIF packages to the informal sector. This study revealed that the design of the NHIF packages and premium for the informal sector exposes the scheme to high expenditure as unhealthy people are more likely to join than healthy people. The designed premium for the informal sector by NHIF is costly for an individual who has an alternative in access to health care to join. The individuals from the informal sector, who are likely to join the scheme, do so because they have noticed health indicators that they will shortly need expensive health care services. Individuals in the informal sector who have no history of severe sickness, and indicators of severe sickness, exclude themselves from joining the NHIF as they find it costly and avoidable.

"The premium is not friendly, so when I think about those packages with their cost, I see there is a problem. It has been caused by NHIF; instead of having health insurance, they manufactured sickness or treatment card." -Petty trader (P2)

Interviews also revealed similar views from the National Audit Office on evaluating the NHIF performance in Tanzania. The findings of the reports stated that;

"Most of the poor citizens are not accessing quality health care due to wash medical care costs, and therefore they are risking their health and lives as well"- NHIF PAR, 2019

The study shows that the facilitation of social inclusion by NHIF packages in the informal sector is experiencing challenges such as higher premiums, lack of health insurance information, and using informal social protection. Similar to previous studies, the findings of this study found that Poverty (higher premium), lack of health insurance information, limitation in

health care access, and using informal social protection are the challenges to including the informal sector in the NHIF packages

Informal Social Protection attracts individuals than NHIF

The existence of informal social protection means the existence of self-support for the informal sector, which is not regulated by laws. The findings of this study revealed that operating informal social protection in the informal sector hinders the inclusion of the NHIF packages. Informal social protection operates through the existing organized groups in the informal sector. The constitutions of organized groups provide members with the provision of accessing financial and moral support when the need arises. Thus, people from informal communities rely on informal social protection because it protects them beyond health care.

"In the informal sector they have their groups with social protection mechanism, even on their constitutions they have provisions which state that their members can benefit something when they experience difficulties."- Petty trader (P2)

Therefore, the findings of this study are not in line with the findings of the previous studies that investigated the inclusion of the informal sector by NHIF packages and found that the challenges to the social inclusion by NHIF packages in the informal sector were a lack of information about the availability of voluntary health insurance to the informal sector, lack of user-friendly registration processes, limitation in the health care access, poverty and presence of the informal social protection.

CONSTRAINTS OF SOCIAL INCLUSION BY NHIF HEALTH PACKAGES

Despite the NHIF's efforts to cover the informal sector with health insurance, the majority of the population remains uncaptured by the health insurance packages. The implementation and the increase of the coverage by NHIF health insurance to the informal sectors are constrained by NHIF operations through the limitation of dependents, the waiting time after joining the NHIF, Limited services to the first-year members, and the exclusion of people above 59 years in special insurance packages. These constraints are further discussed in the following subsections:

Limitation of the other members of the family(Dependants)

A Dependent's limitation means the exclusion of dependents from individual annual payment premiums. Respondents revealed that the NHIF packages in the informal sector allow only the individual as a member for each package. That it prohibits more than one person from benefiting from an individual's premium unless a member tops up a payment to cover that Dependent. The tendency to make payments once a year is not favorable to the majority, especially when they want to pay for their Dependent's premium.

"When you look, the majority of the informal sector's income is irregular and they tell you it covers only you. So, when you tell a couple to pay six hundred thousand for each or there is another one for 1,200,000 Tshs when you see the packages. It removes people (from health insurance) because they cannot afford, even on services, they have demarcation." – Petty trader (P1)

Interviews also revealed similar views from the NHIF magazine examining Tanzania NHIF in the four years of the fifth regime. The NHIF director-general from the magazine says;

"Through news packages, citizens will have access to evaluating the package suitable for an individual to join to access services all the time"- NHIF Magazine, 2019

The waiting time after joining the NHIF

The waiting time after joining the NHIF means the denial of health care services for NHIF members for one month and below. The findings showed that the NHIF packages for the informal sector had got a waiting time between joining the scheme (NHIF) and access to service. While children must wait for 90 days, adult is supposed to wait for 30 days before they may access health care under health insurance. It is the primary concern for the community from the informal sector to have access to health care right after paying a premium because sometimes sickness comes with no alert.

"For the voluntary members, we have gatekeeping of one month. It's a grace period of waiting for their card. Therefore, if he/she joined while sick, within a month, she/he would not be able to get services within one month."- NHIF Staff (P3)

Limited services to the first-year members

The limited services to the first-year members mean the limited services to first-year members compared to the continuing members. Respondents revealed that the package of NHIF members varies from first-year members and those continuing with their membership. While continuing members have access to a variety of health care services, the new members have limited access to health care. During the first year of membership, ultrasound, maternity health care, kidney service, and cardiovascular services are not part of the cover.

"*They tell, you cannot have an ultrasound, also for women, they cannot receive medical benefits when they deliver in the first year of their membership, they have to spend from out of their pocket because that service is excluded." Petty trader (P4)*

Interviews also revealed similar views from the National Audit Office on evaluating the NHIF performance in Tanzania. The findings of the reports stated that;

"*NHIF beneficiaries were complaining about spending much time to receive the required services and failure to get all required diagnostic tests based on the level of health facilities- NHIF PAR, 2019."*

Excluding the people above 59 years in special insurance packages

Excluding people above 59 years in special insurance packages means denying access to the reduced premium (100,000 Tsh.) for older adults from 60 years and above. Respondents revealed that the NHIF packages for the informal sector consider age as a primary criterion in their packages. When the organized groups in the informal sector enjoy the minimization of premium, the benefits suit people only below 60 years. The situation exposes groups to severe challenges because the groups comprise different age categories, including people above 60 years old.

DISCUSSION

This study is extending the previous kinds of literature in Tanzania that examined the challenges to the social inclusion by NHIF packages in the informal sector to examine. Existing research on these challenges has not extensively examined the Dar es salaam region and income-generating informal sectors. This study found that there are challenges to the social inclusion of NHIF in the informal sector in Dar es Salaam. Also, there exist constraints on social inclusion by NHIF health packages in the informal sector.

Consistent with previous studies, this research has documented that lack of information about health insurance in the informal sector, high premiums and its consequential attitude change as well as existing of informal social protection, which attract individual more than NHIF are serious challenges to the inclusion of the informal sector to the NHIF packages (Verbrugge et al.,2018; Domapielle, M. 2014 &Mushi and Millanzi 2019; Renggli et al. 2018 & Mills et al. 2012). This study notes that most community members, especially in Tanzania, were used to free government services. According to Kigume and Maluka (2021), introducing formalized health service schemes pays low attention to neglect. This calls for further promotion of NHIF services national wide, publicizing its services. Similar to the findings of this study, Verbrugge et al.,(2018) and Harriss-White (2010) argue that informal social protection plays a vital role in the developing world, especially in supporting access to health care services for individuals belonging to the informal sector. Consistent with the findings of this study, the authors emphasize that the failure of formal social protection in the health sector is superseded by informal structures such as family networks, mutual support schemes, religious institutions, and informal business networks

This study shows that including the NHIF packages to the informal sector is constrained by limitations on dependents in the NHIF package to the informal sector, the long waiting time to access service after being an eligible member of the NHIF, limited access to services for the first-year members, higher premium, a complicated 51 mechanism for the premium collection and exclusion of the older people of 59 years and above. Similar to previous studies, the findings of this study found the higher premium, a complicated mechanism for the premium collection, and limited access to services where the constraints to including the informal sector by the NHIF packages (Agustina, R., et al. 2019&Barasa et al., 2018). However, contrary to the previous studies, the findings of this study revealed the limitation on dependents in the NHIF package to the informal sector, the long waiting time to access service after being an eligible member of the NHIF, and the exclusion of the older people of 60 years and above to be constraints to including the informal sector or the promotion of the UHC by NHIF.

There is a need for further research on problems that insurance schemes encounter in low-income countries. A more viable solution includes designing affordable premiums for voluntary members so that risk pooling can be guaranteed. Even the formation of the scheme should adopt a down-up approach so that the concrete need and ability of the wider community can be reflected in the design and provision of the NHIF packages. The community members have to be involved in the creation of schemes that fit their economic and social-cultural contexts.

CONCLUSION AND RECOMMENDATION

Conclusion:

Based on the findings of this study, it can be concluded that the inclusion of the informal sector in the NHIF packages is experiencing challenges and constraints factors. Despite the need for health insurance in the informal sector, the participation of the informal sector community in the design and implementation of health package packages by NHIF is necessary. The NHIF packages need not only focus on collecting the contribution/premium and increased coverage but also the provision of unlimited services to all members, especially for severe and costly sicknesses. The NHIF packages to the informal sector need to include dependents because for a covered individual to be protected from financial burden caused by sickness, their dependents must be protected as well.

Recommendation:

The study recommends that NHIF widen its coverage to achieve universal health coverage and advance sustainable development goal number three (good health and well-being). The study revealed that NHIF could extend its coverage by designing an affordable premium suitable for all social classes and crow in on the existing informal social protection available in the informal sector. Other mechanisms for extending health insurance coverage to the informal sector by NHIF are including dependents in the packages, working with microfinance operating supporting health insurance in the informal sector, and eliminating discrimination based on age when the group packages are designed.

REFERENCES:

Adams, A., De Silva, S. J., & Razmara, S. (2013). *Improving Skills Development in the Informal Sector: Strategies for Sub-Saharan Africa.* Washington, DC: The World Bank.

Agustina, R., Dartanto, T., Sitompul, R., Susiloretni, K., Suparmi, & Achadi, E. (2019). Universal health coverage in Indonesia: concept, progress, and challenges. *The Lancet*, 75-102.

Ayanore, M., Pavlova, M., Kugbey, N., Fusheini, A., Tetteh, J., Ayanore, A., . . . Groot, W. (2019). Health insurance coverage, type of payment for health insurance, and reasons for not being insured under the National Health Insurance Scheme in Ghana. *Health Economics Review*, 1-15

Bachmann, M. (1994). Would national health insurance improve equity and efficiency of health care in South Africa?Lessons from Asia and Latin America. *SAMAJ, 84,*, 153-157.

Barasa, E., Rogo, K., Mwaura,, N., & Chuma, J. (2018). Kenya National Hospital Insurance Fund Reforms: Implications and Lessons for Universal Health Coverage. *Health Systems & Reform*, 346–361.

Barimah, K., & Mensah, J. (2013). Ghana's National Health Insurance Scheme: Insights from Members, Administrators, and Health Care Providers. *Journal of Health Care for the Poor and Underserved*, 1378-1390.

Borghi, J., Makawia, S., & Kuwawenaruwa, A. (2015). The administrative costs of community-based health insurance: a case study of the community health fund in Tanzania. . *Health Policy and Planning*, 19-27.

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers? *Int J Qual Stud Health Well-being*, 1-2.

Cheng, T. M. (2015). Reflections On The 20th Anniversary Of Taiwan's Single-Payer National Health Insurance System. *Health Affairs*, 502–510.

Domapielle, M. (2014).Health insurance and access to health care services in developing countries. *Journal of Government and Politics.*, 80-91.

Dugarova, E. (2015). *Social Inclusion, Poverty Eradication and the 2030 Agenda for Sustainable Development.* Geneva: UNRISD.

Harriss-White, B. (2010). Work and Wellbeing in Informal Economies: The Regulative Roles of Institutions of Identity and the State. *World Development*, 170–183.

Isaya, D. (2018). *Assessment of Factors Influencing the Informal Sector to Enroll in Health Insurance Schemes in Tanzania: A Case of Motorcycle Drivers in Dar Es Salaam.* Morogoro: Mzumbe University.

Jehu-Appiah, C., Aryeetey, G., Spaan, E., Hoop, T., Agyepong, I., & Baltussen, R. (2011). Equity Aspects of the National Health Insurance Scheme in Ghana: Who is Enrolling, Who is Not and Why. *Social Science and Medicine*, 157-165.

Kigume, R., & Maluka, S. (2012). The failure of community-based health insurance schemes in Tanzania: opening the black box of the implementation process. *BMC Health Serv Res 21*,, https://doi.org/10.1186/s12913-021-06643-6.

Lokina, R., Nyoni, J., & Kahyarara, G. (2017). *Social Policy, Gender, and Labour in Tanzania.* Dar es Salaam: ESRF.

Mbau, R. et al. (2020). Examining purchasing reforms towards universal health coverage by the National Hospital Insurance Fund in Kenya. *International Journal for Equity in Health*, 1 - 18.

Mills, A., Ally, M., Goudge, J., Gyapong, J., & Mtei, G. (2012). Progress Towards Universal Coverage: The Health system of Ghana, South Africa, and Tanzania. *Health Policy and Planning*, pp. 14 -22.

Mushi, L., & Millanzi, P. (2019). *Health insurance for informal workers: What is hindering uptake? Perspectives from female food hindering uptake? Perspectives from female food.* Morogoro: Mzumbe University.

Overbye, E. (2005). Extending social security in developing countries: a review of three main strategies. *International Journal of Social Welfare*, 305–314.

Quaye, R. (2019). Is it Cash or Card? National Health Insurance Scheme of Tanzania: A Decade and Half of the Progress. . *Tanzania Journal of Sociology*, 21 -31.

Rebmann, N. (2020, January 1). *What is descriptive research design?* Retrieved November 05, 2020, from https://askinglot.com/what-is-descriptive-research-design-pdf

Renggli, S. e. (2018). Looking at the bigger picture: how the wider health financing context affects the implementation of the Tanzanian CommunityHealth Funds. *Health Policy and Planning*, 1 -12.

Sychareun, V., Vongxay, V., Thammavongsa, V., Phummavongsa, P., & Durham, J. (2016). Informal workers and access to healthcare: A qualitative study of facilitators and barriers to accessing healthcare for beer promoters in the Lao People's. *International Journal for Equity in Health*, 1-10.

Tungu, M., Amani, P., Hurt, A., Dennis,, Mwangu, M., & Lindholm, L. (2020). Does health insurance contribute to improved utilization of health care services for the elderly in rural Tanzania? A cross-sectional study. *Taylor & Francis Group*, 1-10.

Ulandssekretariatet. (2018). *Tanzania and Zanzibar Labour Market Profile.* Copenhagen: Danish Trade Union Council for International Development Cooperation.

URT. (2018). *Social Security Laws and Regulations.* Dodoma: URT.

VanHees, S., O'Fallon, T., Hofker, M., Dekker, M., Polack, S., Banks, L., & Spaan, E. (2019). Leaving no one behind? Social inclusion of health insurance in low- and middle-income countries: a systematic review. *International Journal for Equity in Health*, 2-16.

Verbrugge , B., Ajuaye, A., & Van Ongevall, J. (2018). *Contributory Social Protection for the Informal Economy? Insights from Community-Based Health Insurance (CBHI) in Senegal and Tanzania.* Leuven: KU Leuven.

Wang, H., Juma, M., Rosemberg, N., & Ulisubisya, M. (2018). Progressive Pathway to Universal Health Coverage in Tanzania: A Call for Preferential Resource Allocation Targeting the Poor. *Health System and Reform*, 79-283.

Wu, T. Y., Majee, A., & Kuo, K. (2010). An overview of the healthcare system in Taiwan. *London Journal of Primary Care*, 115–119.