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Accessibility of Health Insurance among Informal Sector Workers in Dar es Salaam Tanzania: What Are the Barriers?

Bertha Mwinuka[1,2,3]*, Elizabeth Echoka[2], Jackline Nyaberi[3]

[1]Department of Health Systems Management, School of Public Administration and Management, Mzumbe University, Morogoro, Tanzania
[2]Centre for Public Health Research, Kenya Medical Research Institute, Nairobi, Kenya
[3]School of Public Health Jomo Kenyatta University of Agriculture and Technology (JKUAT), Juja, Kenya
Email: *bertham5@mzumbe.ac.tz

Abstract

Background: World Health Organization's agenda on Universal Health Coverage (UHC) calls for a protected accessibility to health services. Globally, 1.3 billion people lack access to health services and around 61% are on informal employment. The informal employment exposes individuals to more risks that increase the demand for access to health care services. Health insurance enables households to access health services while being protected against catastrophic health care expenditures. Challenges in accessing health insurance hampered the uptake to health insurance and this has led to an increased morbidity, mortality and catastrophic health care expenditures. **Objective:** This study examines the barriers to accessibility of health insurance among the informal sector workers. **Methods:** A cross-sectional study was performed from September to December 2020 to 889 informal sector workers. Data was collected by using questionnaire, multi-stage sampling technique was used and the respondents were randomly selected from 12 streets. Chi-square test and multivariate logistic regression were used for analysis through the use of Statistical Package for Social Sciences (SPSS) version 23. **Results:** Most of the respondents were uninsured (91.1%), more than half (63.6%) were male and the mean age of most respondents was 34.8 years (SD ± 10.4). The barriers to accessibility of health insurance are mistrust of insurance schemes, inadequate information about health insurance, and inaccessibility of health insurance offices and unaffordability of insurance premiums. **Conclusion:** Barriers to accessibility of health insurance are practical and they require policy intervention. Subsidized insurance programmes and improvement of mobile based insurance and improved strategies on information dissemination on insurance information will facilitate access and hence improve uptake.

1. Introduction

Access to quality healthcare has continued to be a global dilemma which attests to elusive health for all principles. Increased costs for health care have made many needy people including the informal sector workers fail to access health services (Bhoi, Joshi, & Joshi, 2022). Global health expenditure report reveals increased expenditures on health. In developing countries annual health spending has reached to 6% while for developed countries is 4%. This spending is growing faster than the rest of the global thus governments should look for alternative financing structures (World Health Organization (WHO), 2022).

Health spending consists government expenditure, out-of-pocket payments (OOP) and insurances. Out-of-pocket payments for health care refer to payment for health care utilized at the health facility (World Health Organisation, 2021). OOP services have not only decreased utilization of health services due to unaffordability but also increased catastrophic health expenditures especially to poor people who are exposed to ill health (Galárraga, Sosa-Rubí, Salinas-Rodríguez, & Sesma-Vázquez, 2010). On average, OOP payments for people in LMICs are about 40% of health spending and this amount contributes to inaccessibility and low utilization of health services (World Health Organization and World Bank, 2017). To improve accessibility of health care services without suffering any financial constrains among the poor, health systems should have different financing systems like tax and pre payments (Khandker, 2005). Health insurance is the most viable funding strategy in ensuring sustainable revenue to the health systems and improving access to health care services to disadvantaged population like the informal sector workers. The prepayment scheme allows risk pooling and cross-subsidization between the healthy and sick as well as to the poor and rich individuals (Umeh & Feeley, 2017).

Risk sharing mechanisms such as health insurance enables individuals to access health services without suffering any financial constrains at the point of sickness. The presence of health insurance not only facilitate access to quality health care (Fadlallah et al., 2018; Mathauer, Saksena, & Kutzin, 2019) but also its a strategy to protect poor people against health care costs and thus a move towards UHC (Osei Afriyie, Hooley, Mhalu, Tediosi, & Mtenga, 2021). LMICs have implemented varied insurance plans like voluntary and mandatory health insurance schemes together with a mix of these schemes for improved accessibility to medical care (Ranson, Jayaswal, & Mills, 2012). For example, Ghana in early 1990s started Community-Based Health Insurance Schemes (CBHIS) and in 2003 the National Health Insurance Scheme (NHIS) was formed by the Government of Ghana in order to facilitate a wide coverage of health services to

Ghanaians by using the district and private health insurance schemes and up to 2021, 68.6% of the Ghanans had health insurance (National Insurance Commission, 2019).

In 1990s, the government of Tanzania introduced health insurance as a strategy to redress the escalating health care expenditures as well as to protect the households from catastrophic health care expenditures (Borghi et al., 2013). The introduction of insurance schemes aimed at providing financial risk protection to poor people who can not afford medical costs. Two types of pre payment schemes were formed namely Community Health Fund (CHF) (1996) and the National Health Insurance (NHI) (2001). The uptake on prepayment schemes among the individuals who are not in formal organization (CHF members) is about 24% while those in formal organizations (NHI members) are 6%. CHF membership is voluntary and its target is the population on informal sectors and it applies principles of solidarity (Lambrecht, 2017; Ndomba & Maluka, 2019) while NHI was initially formed for the government employees but in 2013 it was extended and allowed membership for people from the informal sectors and their membership is voluntary (Macha et al., 2014).

The available insurance policies to large extent favours the small population of the formal sectors and exclude individuals out of formal systems of employment (Alfers, Lund, & Moussié, 2017). The report by International Labour Organisation (ILO) states that the social protection in many LMICs is geared towards formal sector workers and leaving behind those in informal sectors (ILO, 2021). In Tanzania employees in governments, in private institutions and other parastatals pay a set of premium based on monthly salary. The employee's contract stipulates the deductions of the premium in percentage and the type of insurance scheme that he/she belongs. For example, all the government employees have enrolled into NHI and they can access services to the different accredited health facilities in the country (Pastory, 2013; Wang, Temsah, & Mallick, 2017). In rural areas, CHF was introduced so as to ensure availability and accessibility of health care services that would be affordable to the rural population and informal sector workers (Macha et al., 2014; Mtei & Mulligan, 2007). The informal sectors pay the premium in lump sum of the premium and don't pay it on monthly basis because the informal sector workers are not stationed at one place as the result premium collection becomes difficult (Ndung'u, 2015). Due to this, individuals with no stable income they fail to pay the premium. The CHF members access the health services at the respective health facilities in the region without paying the out of pocket (Mtei, Mulligan, & Ngnie-Teta, 2012).

Despite the efforts of the government and other stakeholders like private insurers to increase the benefit packages, provision of different premium rates, presence of different insurance schemes and to expand of insurance scheme to accommodate the informal sectors still the uptake of insurance among the informal sector workers is low while individuals in formal sector/wealthier are the advantaged groups. This implies that, health insurance is not in favor of the poor

people in the society as the result they fail to access in terms of information, finance and geographically. Taking into account that informal sector employs almost 75% of the Tanzanian and contributes over 80% of total GDP (CAG, 2019; TDHS, 2016) easy accessibility of health insurance to this group is very important for the health of the community. Dror et al. (2016) and Tran et al. (2017) showed that inaccessibility of health insurance services have led to low enrollment to health insurance and therefore failure on accessing the health insurance services. To ensure huge enrollment to health insurance, its easiness on accessibility is vital. The accessibility should be both on physical, economic (affordability) and in terms of information (Lutinah, 2020).

Several studies have been conducted within Tanzania (Nageso, Tefera, & Gutema, 2020; Kapologwe et al., 2017; Mushi & Millanzi, 2019) and outside of Tanzania (Adewole, Akanbi, Osungbade, & Bello, 2017; Alfers, 2013; Muttaqien et al., 2021) with a focus on protection of informal sector workers. Some of these studies showed that inaccessibility to health insurance is among the factors for low uptake among the informal sector workers (Bendig & Arun, 2011; FAO, 2019). Other contributing factors to low health insurance subscription rates include negative attitudes of service providers both at the health care facilities and insurance offices (Kumi-Kyereme, Amu, & Darteh, 2017). Difficulties in accessing insurance services or using insurance cards discouraged renewal of health insurance cards (Tran et al., 2017).

Few studies have focused on the barriers to accessibility of health insurance (Fadlallah et al., 2018; FAO, 2019). Most of these studies have been conducted out of Dar es Salaam and were not exhaustive enough and were limited to general population and not the informal sector workers. Taking into account that in Tanzania informal employment makes 75% of total employment and contribute over 80% of total GDP (Ndung'u, 2015; TDHS, 2016), examining the berries to accessibility of health insurance is significant so as to come up with innovative strategies to overcome the barriers and improve uptake of health insurance and achieve the UHC on a near future.

2. Methods

2.1. Study Setting

This study was conducted in Dar es Salaam region which is located along the Indian ocean. The region is divided into three administrative municipals and 90 wards with 4.36 million people which is equal to 10% of the total population in the country (TDHS, 2016). Major economic activities include manufacturing, real estate, accommodation facilities and food services centres which contribute to 17.02% of GDP (Shewamene et al., 2021).

2.2. Sample Size

Yamane formula for sample size determination was used whereby 95% confidence level, marginal error of 5%, design effect of 2.0 and an increase of 10% to

account for non response was considered. Based on this consideration, the obtained sample size was 889. The inclusion criteria for this study were 18 years and above, willingness to participate in the study regardless the insurance status, residing in Dar es Salaam for more than one year and involvement in informal sector activities which include but not limited to riding motorcycle, driver, food vender, small business owners for more than one year and above. Exclusion criteria were if the individual's age is below 18 years of age, unwillingness to participate in the study, and not doing either of the informal sector activities and not meeting the stated inclusion criteria.

2.3. Data Collection and Management

We collected data by using a pre-tested semi-structured questionnaire containing three sections (general information about the respondents, information about uptake of health insurance and barriers to accessibility of health insurance). This questionnaire was developed from reliable and validated questionnaires used to develop the research questionnaires in previous studies (Binnendijk, Koren, & Dror, 2012; Hitimana, Lindholm, Krantz, & Nzayirambaho, 2018; NBS & OCGS, 2013; Hussien & Azage, 2021) Six research assistants who were conversant with respondents' language and environment were trained to collect the data. Data were cleaned to remove incomplete responses and irrelevant information (Nshakira-Rukundo, Mussa, & Cho, 2021). Clean data were analyzed by using Statistical Package for Social Sciences (SPSS Version 23).

2.4. Sampling Methods

Multistage sampling technique was used in this study. Stage one and two lottery method was used to select wards and streets (two wards from each municipality and 12 streets (2 from each ward)) respectively. Stage three, a total of 889 respondents who were proportionally to the population in each ward was randomly selected.

2.5. Technical Considerations and Data Analysis

Multiple linear regressions were sought in this study to examine the effect of independent variables on the dependent variable. The examinations look at the combined effect as well as individual effects. In all families of regression models, it is inappropriate to use the highly correlated predators in the same model. It also makes modest sense to include independent variables in the model that are highly correlated as this won't make exceptional significant contribution to the regression model for it will mask each other's effects. If the variables are highly correlated among themselves, the predictive power of the predictors will definitely obscure the predictive power of the response variable. Thus, it was important to ensure such diagnostic is done to have a multiple linear regression model that fits the data. This study used uptake of health insurance as a dependent va-

riable which is a binary choice. The independent variables were long queues and waiting time at the insurance offices, dissatisfaction with services, unaffordability of health insurance premium, difficulties to access insurance selling points, poor quality of services and inadequate information about insurance services. The model to be examined is as indicated underneath.

$$y = \alpha + \beta_1 x_1 + \beta_2 x_2 + \beta_3 x_3 + \beta_4 x_4 + \beta_5 x_5 + \beta_6 x_6 + \varepsilon$$

where $\alpha = \text{constant}$, $\beta'_s = \text{coefficients}$ while the $x_{i's}; i = 1, 2, \cdots, 6$ are independent variables.

Assessment of association was done to the summarized data by using descriptive statistics and logistic regression. A statistically significant result was determined by a p-value of <0.05.

2.6. Ethical Considerations

The research was approved on 7th March 2020 by the Tanzania's National Heath Research Ethics Review Committee (NHRERC) reference number (NIMR/HQ/ R.8a/Vol.IX/3375) under the National Institute of Medical Research (NIMRI). Also the participants were informed on the purpose of the study, written and verbal consents for participation and publication of the study results was obtained from the study respondents prior to commencement of the study. The study followed the Helsinki declaration and the confidentiality of participants was maintained.

3. Results

3.1. Characteristics of Study Participants

A total of 889 people aged 18 years and above participated in the study. The age of the respondents was between 18 to 60+ years with the mean age of 34.8 years (SD ± 10.4). More than half majority (91.1%) have no health insurance. Compared to women, 63.6% of the participants were male. Regarding education, almost half of the participants (49.4%) had primary level of education and 48% of the respondents had income between $43.3 to $129.9 as shown in Table 1.

3.2. Uptake of Health Insurance

The result indicated that only few (8.9%) informal sector workers had health insurance (Table 2). The NHI was the main insurer (75.9%) followed by private health insurance (16.5%) and 7.6% belonged to CHF. This suggests a low enrollment in health insurance among the study participants. Almost three quarter (74.7%) of the non members of health insurance are willing to enroll into health insurance.

Barriers to accessibility of health insurance

The results revealed that informal sector workers do not know where to get enrolment forms (82.3%) and more than three quarter of the respondents (83.8%) are not aware of the enrolment procedures. In addition to that, the results showed

that long queues and waiting time at the insurance offices, dissatisfaction with services, unaffordability of health insurance premium, difficulties to access insurance selling points, poor quality of services and inadequate information about insurance services were the hindering factors to accessibility of health insurance as shown in Table 3.

Table 1. Characteristics of the respondents (n = 889).

Characteristics	Attributes	Frequency	Percentage
Sex	Female	324	36.4
	Male	565	63.6
Age	≤20	33	3.7
	21 - 30	348	39.1
	31 - 40	258	29.0
	41 - 50	178	20.0
	51 - 60	55	6.2
	61+	17	1.9
Marital status	Married	574	64.6
	Unmarried	315	35.4
Education	No any formal education	40	4.5
	Primary level	439	49.4
	Secondary level	313	35.2
	Tertiary level	97	10.9
Income ($) (1 USD - 2310 Tsh)	<43.3	287	32.3
	43.3 - 129.9	426	47.9
	129.9 - 216.5	115	12.9
	216.5 - 303.0	26	2.9
	303.0+	35	3.9
Economic activity	Small businesses (petty traders)	540	60.7
	Driver (car and tricycle and motorcycle	115	12.9
	Mechanical workers	106	11.9
	Food vendors	97	10.9
	Farmer and herdsman	31	3.5
Facility of preference	Government health facilities	489	55.0
	Private health facilities	350	39.4
	Over the counter medication	31	3.5
	Tradition healer	19	2.1

Table 2. Uptake of health insurance among informal sector workers.

Characteristics	Attribute	Health insurance uptake status	
		Member of HI	Non-member of HI
		N (%)	N (%)
Health insurance uptake	Uptake status	79 (8.1)	810 (91.9)
Sex	Male	52 (9.2)	513 (90.8)
	Female	27 (8.3)	297 (91.7)
Age (years)	≤20	3 (9.1)	30 (90.9)
	21 - 30	12 (3.4)	336 (96.6)
	31 - 40	14 (5.4)	245 (94.6)
	41 - 50	27 (15.2)	151 (84.8)
	51 - 60	17 (30.9)	38 (69.1)
	61+	6 (35.3)	11 (64.7)
Marital status	Married	65 (11.3)	509 (88.7)
	Unmarried	14 (4.4)	301 (95.6)
Education	No any formal education	1 (2.5)	393 (97.5)
	Primary level	31 (7.1)	408 (92.9)
	Secondary level	21 (6.7)	292 (93.3)
	Tertiary level	26 (26.8)	71 (73.2)
Income ($) (1 USD - 2310 Tsh)	<43.3	10 (3.5)	277 (96.5)
	43.3 - 129.9	29 (6.8)	397 (93.2)
	129.9 - 216.5	19 (16.5)	96 (83.5)
	216.5 - 303.0	5 (19.2)	21 (80.8)
	303.0+	16 (45.7)	19 (54.3)
Economic activities	Food vendors	6 (6.2)	91 (94.1)
	Driver (car and tricycle and motorcycle)	12 (10).4	103 (89.6)
	Mechanical workers	11 (0.4)	95 (89.6)
	Farmer and herdsman	3 (9.7)	28 (90.3)
	Small business	47 (8.3)	568 (91.7)
Family size (number of people)	1 - 3	22 (7.4)	275 (92.6)
	4 - 6	41 (8.5)	443 (91.5)
	7 - 9	14 (14.3)	84 (85.7)
	10+	2 (20.0)	8 (80.0)
Membership to an economic group	Food vendors group	2 (66.7)	1 (33.3)
	Drivers group	10 (38.5)	16 (61.5)
	Entrepreneurship groups	11 (37.9)	18 (62.1)

Continued

	Trade union at the marketplace	6 (35.3)	11 (64.7)
	Not a member of any economic group	50 (6.1)	764 (93.9)
Type of health insurance	National health insurance	60 (6.7)	
	Private health insurance	13 (1.5)	810 (91.1)
	Community health insurance	6 (0.7)	
Insurance premium payments	Individual	41 (51.9)	
	Wife	11 (13.9)	
	Individual through association	8 (10.1)	
	Husband	8 (10.1)	
	Children	7 (8.9)	
	Relative and friends	4 (5.1)	

Table 3. Barriers to accessibility of health insurance.

Barriers to accessibility of health insurance	Responses		
	Agree	Undecided	Disagree
Long queues and waiting time at the insurance offices	616 (69.3%)	114 (12.8%)	59 (17.9%)
Dissatisfaction with services at insurance offices	600 (67.5%)	111 (12.5%)	178 (20.0%)
Unaffordability of insurance premiums	597 (67.2%)	92 (10.3%)	200 (22.5%)
Difficulties in accessing health insurance selling points	479 (53.6%))	169 (19.0%)	241 (27.1%)
Inadequate of information about health insurance	453 (51.0%)	142 (16.0%)	294 (33.1%)
Mistrust to insurance providers	445 (50.1%)	18 (2.0%)	426 (47.9%)
Poor quality of services at the insurance selling points	382 (43.0%)	171 (19.2%)	336 (37.8%)

3.3. Regression Analysis

The logistic regression (Table 4) revealed that the informal sector workers who had no trust to insurance providers were 0.69 times less likely to access insurance services ($p = 0.004^*$; Exp (B), 0.693; CI, 95%; 0.538 - 0.892) while those who were unable to pay for insurance premiums were 0.47 times less likely to access the insurance services ($p < 0.001^*$; Exp (B); 0.466; 95% CI; 0.329 - 0.662). Informal sector workers who had difficulties in accessing health insurance selling points were 1.4 times less likely to access health insurance ($p = 0.046^*$; Exp (B); 1.446; 95% CI; 1.006 - 2.078) and the respondents with inadequate of information about health insurance were 0.56 times less likely to access health insurance ($p = 0.004^*$; Exp (B); 0.564; 95% CI; 0.382 - 0.882).

Table 4. Logistic regression for barriers to accessibility of health insurance and uptake.

Barriers to accessibility of health insurance	B	S.E.	Wald	Df	Sig.	Exp (B)	95% C.I. for EXP (B)	
							Lower	Upper
Mistrust to insurance providers	−0.367	0.129	8.071	1	0.004*	0.693	0.538	0.892
Unaffordability of insurance premiums	−0.763	0.179	18.221	1	0.000*	0.466	0.329	0.662
Difficulties in accessing health insurance selling points	−0.369	0.185	3.971	1	0.046*	1.446	1.006	2.078
Inadequate of information about health insurance	−0.573	0.198	8.344	1	0.004*	0.564	0.382	0.832
Poor quality of services at the insurance selling points	0.030	0.198	0.022	1	0.881	1.030	0.699	1.518
Constant	0.329	0.455	0.523	1	0.470	1.390		

Note: * = Significant $p < 0.05$ B = Beta Coefficient SE = Standard Error. Exp (B) = Exponential Value of B (Beta).

4. Discussion

This study examines the barriers to accessibility of health insurance among informal sector workers in Dar es Salaam, Tanzania. The study found that the uptake to health insurance is 8.9%, this rate is lower compared to the country's target of 45% that was set to be achieved by the country by 2015 (Hitimana, Lindholm, Krantz, & Nzayirambaho, 2018). Low enrolment rate to insurance schemes make some people especially uninsured to either opt for OOP that lead to catastrophic health care expenditures and cause impoverishment or not to access services at all. Inaccessibility of health care services affect many people and it raises morbidity which result to further injuries or death (Binnendijk et al., 2012). With regard to barriers to accessibility of health insurance, the study showed that there are significant barriers to accessing health insurance among the informal sector workers. These barriers include inadequate information about health insurance, unaffordability of insurance, mistrust to insurance providers and inaccessibility of insurance selling points (see Table 4).

Inadequate information appears to negatively influence the choice and uptake of health insurance by the informal sector workers in the study region. This finding is similar to other studies from within and outside Tanzania. For example, a study by Kapologwe and others (Kapologwe et al., 2017) that focused at identifying barriers and facilitators used to enroll and re-enroll people in insurance schemes in Tanzania showed that lack of detailed information about insurance schemes negatively influences uptake. From Sub-Saharan Africa, Tran et al. (2017) on their study in Northern Vietnam reported that lack of awareness and misconception of the public regarding health insurance scheme as one among other reasons that influence uptake. Uninformed individuals are less likely to enroll in health insurance. Similar study findings were made by (Green, Hayek, Tarabeia, Yehia, & HaGani, 2017) who pointed out that there is a large gap on understanding of health insurance policy and what the beneficiary get during service utilization. Individuals have no right information about how health insurance operates, where to go and get the insurance services as well as how to enroll. A possible explanation for this could be due to inaccurate information

conveyed to the public from the insurance providers in collaboration with politicians during sensitization with the aim of getting majority to enroll into health insurance and hence misleading. Therefore, ensuring availability of accurate information about operation of health insurance will encourage many informal sector workers to participate in the different available insurance schemes.

Unaffordability of health insurance premium is a major problem to households with unstable income. Our study revealed that informal sector workers fail to access health insurance due to lack of funds to pay the insurance premiums. This finding is similar to that of Kapologwe and others (Kapologwe et al., 2017) who found that there is higher possibility of richer people in Tanzania to invest in healthcare and thus are able to afford the premiums. Another study in Rwanda among rural Nyanza residents pointed out that unaffordability of insurance premium is the reason for poor people not to access health insurance (Ridzuan & Wan Zainon, 2019). A possible explanation is that the premium rates set by the insurance schemes are not in favor with the ability to pay by the informal sector workers as the result the informal sector workers fail to afford required premium. Perhaps this is due to the nature of their work which gives them low income and hence they become unable to save and pay the insurance premium at once while they also have some other expenditure for their life. Non involvement of the informal sector workers during premium set up (Haazen Dominic, 2012) contribute to low acceptance rate as the result majority fails to pay the premium.

Concerning trust to the schemes our findings showed that the informal sector workers do not trust the insurance schemes. Lack of trust in insurance providers can be linked to the fact that community members possess no appropriate information about the operationalization of the insurance scheme especially on the insurance benefits/packages. The mismatch on service provided to the insurance beneficiary and those which were advertised during awareness campaigns make individuals assume that the schemes do not provide promised services.

Unavailability of some services lead to mistrust to the scheme and hence low renewal and uptake to insurance schemes. This finding is in line with the results from other researches in Nepal and Southern Ethiopia. These studies reported that limited transparency about the benefit packages and lack of trust of the community on the commitment of community based health insurance administrators created mistrust and hence low enrolment to health insurance (Garfield & Orgera, 2019; Green et al., 2017). Therefore increased transparency and improved information dissemination about insurance by involving the available insurance schemes, health providers and the communities will reduce the barriers and hence majority uptake to health insurance.

Furthermore, this study found that inaccessibility of health insurance selling points and services like the insurance company offices, were reported as a barrier to accessibility of health insurance. Most of insurance offices are located in urban areas and the offices are fewer in relation to demand and this makes service accessibility difficult. Also, the fact that not all individuals live in towns

where the offices are located, therefore for those who live in rural areas its accessibility becomes a problematic and hence low uptake. Also the shortage of staff like in other sectors (Sirili, Kiwara, Gasto, Goicolea, & Hurtig, 2017) contributes to services inaccessibility. Individuals who have travelled from rural areas once they don't get services timely they end up postponing to get services. Similar findings has been reported by (Basaza, Criel, & Van Der Stuyft, 2007; Kumi-Kyereme, Amu, & Darteh, 2017) that longer waiting time at the scheme office and chaotic administration of the district schemes is the major barrier to informal sector workers to access health insurance.

5. Conclusion

The barriers experienced by the informal workers in accessing the insurance scheme are very basic and practical ones. The government has significant effort to include the informal sector workers into insurance scheme but the existing barriers require collaborative and innovative strategies to overcome them. Involvement of the private sectors and the beneficiaries on planning the premium amount and considering subsidizing premium will facilitate accessibility of health insurance services.

In order to ensure accessibility of information there should be a regulation that will ensure the insurance schemes provide comprehensive and accurate information during awareness campaign. Making mobile based insurance accessibility reliable for accessing insurance services remotely will reduce the barriers and more informal sector workers will enroll into health insurance. Improving the accessibility of health insurance selling points such as insurance offices, brokers and agents by setting up more locations id rural areas and where people live and work will increase uptake to insurance schemes. Strengthening the available community based insurance schemes in rural areas by providing more technical support on awareness campaigns on operations of insurance schemes will facilitate majority uptake to insurance schemes and hence achievement of UHC.

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Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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