UNIVERSITY OF ZIMBABWE

Graduate School of Management

Catering for the informal sector on formal medical insurance products

A dissertation proposal submitted in partial fulfilment of the requirements for the Master's Degree in Business Administration

By

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DISSERTATION TITLE					
Catering for the informal sector on formal medical insurance products					
DISSERTATION METHODOLOGY (please tick one)					
QUANTITATIVE	**X**	**QUALITATIVE**		**MIXED METHODS**	

INTAKE (YEAR AND MONTH)	
2016/07	
Registration No.:	**STUDENT NAME:**
R1610057	ChibvongodzeFarai W.
DISSERTATION SUBMISSION DEADLINE	**SUBMISSION DATE**
04 March 2019	04 Mar. 19

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ACKNOWLEDGEMENTS

I would like to thank my research supervisor Dr.O. Muvingifor her continual guidance and support throughout the entire research process. Hersupport, wisdom and knowledge in the field of finance and the operations in the informal sector has been inspiring.

Appreciation also goes to the University of Zimbabwe Graduate School of Management team, for the knowledge, skills and wisdom they have imparted to me during the course of this program. In addition, my gratitude goes to my fellow colleagues, with special mention going to Steven, Vimbiso, Desmond, Stan and Nancy.

Lastly but not least, I extend my appreciation to my wife, Chasey and my children, Unashe and Naledi for their unwavering support, encouragement and patience for the duration of this MBA program.

ABSTRACT

Zimbabwe has been experiencing a growing informal economy mainly attributable to the harsh economic conditions that have forced most formal business to operate below capacity or in some cases completely shut down operations. These challenges have negatively affected the employment rate and has drove the growth of the informal sector.

The aim of the study is to assess the readiness of medical insurance products to extend cover to this growing market. Medical insurers have often focused on servicing the formal sector and the changes may have caught them un-prepared. Government policy and strategy on financial inclusion has often neglected health insurance.

Literature has more often focused on banking and micro insurance in as far as financial inclusion is concerned and there has been little emphasis in as far as medical insurance is concerned. In addition, literature most often assumed that the informal sector has lower incomes and have no capacity to subscribe for medical insurance.

The researcher adopted quantitative research methods as the researcher sought to get insights on the subject. The study's main findings were that there is income capacity within the informal sector to subscribe to medical insurance. However, the major hinderance has been the lack of suitable medical insurance products that well-tailored to address the needs of this sector. In addition, Government has not made a deliberate effort to promote financial inclusion in as far as medical insurance is concerned with the informal sector.

Key words:

a. Informal sector
b. Financial inclusion
c. Medical insurance
d. Healthcare facilities
e. Informal traders

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1. CHAPTER 1: INTRODUCTION

Introduction

Introduce the study here? What is all about/ Quality healthcare is one of the most important factors in how individuals perceive their quality of life. The access to quality healthcare is of paramount importance to human livelihood. Healthcare funding is a fundamental issue globally and continues to be at the centre of modern-day livelihoods. The future need for healthcare services in human lives is inevitable, and there are options to financially plan for such an event. Health insurance policies are often designed to manage the risk associated with the inability to adequately cover healthcare bills.

"The obligation to pay directly for services at the moment of need – whether that payment is made on a formal or informal (under the table) basis – prevents millions of people receiving health care when they need it. For those who do seek treatment, it can result in severe financial hardship, even impoverishment."(WHO, 2010). According to the World Health organisation (2010), as the world grapples with economic slowdown, globalization of diseasesas well as economies, and growing demands for chronic care that are linked partly to ageing populations, the need for universal health coverage, and a strategy for financing it, has never been greater.

"In Zimbabwe 37% had to go without medical treatment or medicine in 2012 a 17% increase from 20% in 2011 and 21% reasons of borrowing are related to medical expenses. "(FinScope, 2014). The increasing challenges in accessing healthcare due to financial constraints has been on an alarming increase in Zimbabwe.

Financial inclusion in respect to health care financing is therefore essential. World-wide Governments have made effortsand continue to do so,in an attempt to ensure quality healthcare is delivered to all of its citizens. However, due to finite resources and other Government commitments it is not entirely possible to ensure free quality healthcare access to all.

Mostemployers within the formal sector, have made efforts to ensure their employees are financial covered for future healthcare needs, through contributing part or all of their medical aid contributions. Attention is then drawn to players within the informal sector, to whether

they have financial inclusion as far as health insurance is concerned or their ability to meet their medical bills when need arises.

Background

In Zimbabwe, there has been a growing sector of informal economic activity over the years, with more larger entities closing shop, Zimbabwe has seen a huge rise in SMEs and Informal economic activities. Zimbabwe has become one of the world's economies with the highest informal economic activities. "The three largest shadow economies*(informal economy)*are Zimbabwe with 60.6, Bolivia with 62.3 and Georgia with 64.9."(Medina & Schneider, 2018). In Zimbabwe, several legal businesses have now turned informal, with most of such activities off the tax man's radar. Among such activities are artisanal mining, retail activities, hairdressers, cross boarder traders, small scale farming and manufacturing activities.

The access to healthcare remains key to the livelihood of all citizens, irrespective of whether individuals find themselves within the formal sector or within the informal sector. With the growing informal economic sector and small to medium enterprises and declining formal sector activity, the paper seeks to analyse the impact of this economic development on the financial inclusion in respect to healthcare financing in as far as the informal sector is concerned.

WHO (2013) articulates the need to develop a health financing system in its member states. In its argument WHO sited that even the wealthier nations' have often found it difficult with the growing medical costs. In the medium to low income economies, in which most African nations lie, the problem of healthcare financing is more acute. On the backdrop of the Zimbabwean economy being dominantly informal, the Government is limited on its ability to deliver affordable quality healthcare due to budgetary constraints and hence medical insurance becomes a key proponent in ensuring access to quality healthcare.

The study was carried out when the Zimbabwe was going through some economic turbulence, including currency uncertainties, low industrial capacity, huge budget deficit, forex shortages and a liquidity crunch. Economic challenges have promoted the rise of a growing informal and SMEs. The level of activity within the informal sector is immense and cannot be ignored. In that end, significant strides have been made by a number of financial

institutions to extend financial services to this sector, examples include Steward bank who launched a POS machine product that are accessible by the informal sector and the SMEs (Kwenga POS machine), advent of Ecocash has also facilitated transactions within the informal and SMEs sectors, banks have gone into the streets opening accounts with very minimal KYC documentation to promote financial inclusion of the informal sector.

However, most financial inclusion emphasis has been mainly on banking, microfinance and micro insurance, and there has been limited attention to financial inclusion in respect to healthcare financing within the informal sector. Hence the paper seeks to explore the extent in which medical insurance has penetrated the informal sector and also evaluate its necessity thereof to the informal sector.

Statement of the problem

In Zimbabwe, health insurance productshas been to date mainly designed and marketed to the formally employed members, with the country's top two largest medical aid societies having been initial setup with the object of financing healthcare needs for those in the public service and the private formal sector employees. However, study has revealed that the majority of Zimbabwe's population are now within the informal sector, according to the IMF (2018), Zimbabwe has the third largest informal economy in the world in relation to the size of the country's GDP and size of the formal economy. "…today less than 10 percent of Zimbabwe's population is covered under medical aid and the bulk of the population has to pay for healthcare out of pocket." (Herald, 2018). Questions will therefore arise on the impact of the growing informalisation of the economy on the ability of the populates of the informal sector to finance medical bills.

"The growth of the informal economy, both in developing and developed countries has exposed the weaknesses and shortcomings inherent in the traditional approach to the provision of social security for those who fall outside of the formal economy."(Frye, 2005). According to the World Health Report by WHO (2010), the obligation to pay directly for services at the moment of need, whether that payment is made on a formal or informal (under the table) basis, prevents millions of people receiving health care when they need it. For those who do seek treatment, it can result in severe financial hardship, even impoverishment. In

Zimbabwe, according to a research carried by FinScope(2014) revealed that over 37% of the country's citizens are failing to access healthcare services due to financial constraints.

There is therefore a knowledge gap on the level of financial inclusion in as far as the health insurance in the informal sector in Zimbabwe and the impact of such to the livelihoods of those within the informal sector. The adequacy and fitness of the current health insurance products in fostering for financial inclusion is questionable and thus need to be tested and possible solutions can be suggested for further development.

Research Objectives

Objectives:

Main objective: To determine the level of impact that the growing informal sector has had on the ability of the informal sector participants to afford medical health insurance.

Other objectives

i. To determine the impact that the transition of moving from the formal economy into the informal economy has had on the informal economy participants' ability to afford health insurance
ii. To assess the appetite for and the level of take-up of health insurance cover.
iii. To identify the drivers of, and barriers to the take-up of medical insurance within the informal sector
iv. To establish the nature and level of formal healthcare institutions that informal sector players have greater access to and those that they have a lesser level of access to.
v. To offer recommendation on health insurance in Zimbabwe

1.1. Research Questions

Main question:What is the level of impact that the growing informal sector has had on the ability of the informal sector participants to afford medical health insurance

- What is the impact that the transition of moving from the formal economy into the informal economy has had on the informal economy participants' ability to afford health insurance?
- What is the appetite for and the level of take-up of health insurance cover?
- What are the drivers of, and barriers to the take-up of medical insurance within the informal sector?
- What is nature and level of formal healthcare institutions that informal sector players have greater access to and those that they have a lesser level of access to?

1.2. Hypothesis

H1: The growth of the informal sector has negatively impacted the ability to meet medical bills for those that make the transition from the formal to the informal sector.

1.3. Significance of the study

The subject of financial inclusion has been vastly researched over the years, however, emphasis on previous research has been on the marginalised, the rural population and the poor, with the main financial inclusion focusing on banking and micro finance. In Zimbabwe, the informal sector is increasingly playing a fundamental role in socio-economic development. The informal sector has made significant contribution to employment creation, innovation and the country's GDP. The Reserve Bank of Zimbabwe alluded to the fact that the informal sector is contributing over 60% of the country's GDP.

Traditionally the informal sector has been viewed as constituted by the uneducated and marginalised but there have been significant changes in the organisation of the informal sector demographics in the last decade. The informal sector, once derided as an exclusive presence for an uneducated and unskilled individual with no prospects of gaining a job in the formal sector has become a life line for a growing number of Zimbabweans, from retrenched professionals and highly skilled workers to retirees and others entering the job market for the first time.

"While the Reserve Bank of Zimbabwe (RBZ) estimates that there could be $2,5 billion circulating in the sector, a FinScopeINFORMAL TRADERS (micro, small and medium enterprises) survey that was conducted by the Ministry of Small and Medium Enterprises and Co-operative Development in conjunction with FinMark Trust and the World Bank in 2012 concluded that the turnover in the informal sector was more than $7,4 billion." (PSMAS, 2018).

With the growing significance of the informal sector'ssize and its contribution to the country's economy, there is need to analysis whether the existing medical aid models are a good fit to foster financial inclusion as far as medical insurance is concerned.

Scope of study

The study will evaluate the uptake of healthcare insurance within Zimbabwe's informal sector. The research will focus on financial inclusion within the informal sector in Zimbabwe in respect to health insurance. The study will mainly interrogate the most prominent health insurance products currently in the market, the level at which they encourage financial health insurance inclusion in Zimbabwe's informal sector. The study will also uncover the impact of having or not having health insurance within the informal sector.

The informal sector sample will mainly focus on Harare's affluent and organised informal sector, which are Mbaremusika and Glenview home industries.

2. CHAPTER TWO: LITERATURE REVIEW

INTRODUCTION

This chapter represents a literature review and contains critical analysis of the most noteworthy contributions of other researchers to the research area. The literature starts with the definitions of some of the terms closely associated with the research area.

The literature review also addresses aspects that drive the establishment of informal economic activities and theories that could possible explain the factors that promote the continued existence of the informal sector. The chapter also explores theories on healthcare financing within the informal sectors and its impact thereof. This literature review further analysis healthcare financing models in other countries that specifically aimed to address the informal sector. As a conclusion to the chapter, the gap from the pool of literature and what this study seeks to establish is identified and explained.

Definition of the terms

"There are many different views on what 'financial inclusion' means and entails in literature, but the key aspects of access to formal financial services - payments, savings, insurance, credit, and so on – by vulnerable /low income groups at an affordable cost, are fairly unanimous. Usage and accessibility issues of affordability (fair price), convenience ("no frills account"), timeliness, adequacy, and product knowledge, are among the issues emphasized by many definitions of financial inclusion."(Aro-gordon, 2016).

"Financial inclusion refers to a process that ensures the ease of access, availability and usage of formal financial system by all members of an economy."(Sunday, 2016). The United Nations defines the goals (United Nations Capital Development Fund, 2006) of financial inclusion as follows:

- access at an affordable price for all households to a wide range of financial services, which include but not limited to savings or deposit services, payment and transfer services, credit and insurance;
- well governed institutions with high performance standards
- Sound financial and institutional stability that ensure capital security.

- Promote high levels of competition to avoid participants choice and ensure correct pricing

"Financial inclusion is the provision of affordable, accessible and relevant financial products to individuals and businesses that had previously not been able to access these products."(Ernst & Young, 2017)

The Reserve Bank of India defined financial inclusion as "the process that ensures access to appropriate financial products and services by vulnerable groups such as weaker sections and low income groups at an affordable cost in a fair and transparent manner by mainstream Institutional players."(Joshi, 2011). "Financial Inclusion is the process of ensuring access to financial services and timely and adequate credit where needed by vulnerable groups such as the weaker sections and low income groups at an affordable cost."(Chinnathambi& Ramachandran, 2015)

Zimbabwe is a member of the Alliance of Financial inclusions' (AFI) since year 2012. In adherence to the objects of the AFI Zimbabwe developed a strategy to foster financial inclusion. In the Zimbabwean context, the Reserve bank of Zimbabwe (2016) defines financial inclusion as the access to a huge range of financial services in a fair and transparent environment.

Underpinning theories

Various scholars refer to the informal sector using various names including the grey market, black market, informal sector, hidden economy and shadow economy. The writer will more often refer to this sector of the economy as the informal sector. There are both legal and illegal business activities going on within the informal sector, however this paper will focus on the legal activities within the informal sector. Legal business activities will refer to the actual trade and disregard statutory requirements to exercise such business activities for instance shop licences, registration and payment of taxes.

Globally, according to Chen (2012), there is a large chunk of workforce and economic activities within the informal sector. As such this has revived the interest worldwide for the informal economy. There is a consensus that the informal sector has been growing in both depth and breadth .

Different scholars share various definitions of the informal sector with several convergent and divergent aspects to their definitions. The ILO defines the informal sector as "…activities and income that are partially or fully outside government regulation, taxation, and observation."(Baxter, Hastings, Law, & Glass, 2013). "The informal economy is the diversified set of economic activities, enterprises, and workers that are not regulated or protected by the state. Originally applied to self-employment in small unregistered enterprises, the concept of informality has been expanded to also include wage employment in unprotected jobs." (Bonfert et al., 2015)

"Many definitions of the informal sector exist, but they often include: (1) absence of formal contracts or protections for employees, (2) irregular income, (3) lack of outside government regulation or taxation, and (4) lack of health coverage through employers."(Bonfert et al., 2015)

"The shadow economy is, by nature, difficult to measure, as agents engaged in shadow economy activities try to remain undetected." (Medina & Schneider, 2018). Various scholars have put forward arguments on the main drivers for the establishment and size of the informal sector within an economy.

There are a number of school of thoughts on the informal sector, but according to Chen (2012) four dominated schools have emerged namely The Dualists, The Structuralists, The Legalists and The Voluntarists. These school of thoughts are discussed below:

- Dualists– these assume that there is no relationship between the informal economy and the formal economy. The school of thought is of the notion that the informal sector mainly constitutes the less privileged. The subscribers believe that the Government should actively is tasked with creating opportunities in the formal sector

for players in the informal sector to facilitate the transition from the informal sector to the formal sector. The Government is also encouraged to avail lines of credit to promote the growth of these players out of the informal sector.

- Structuralists – this school of thought is of the opinion that there is a direct relation between the informal and the formal sector. They argue that both sectors are driven by the interests of capitalist developments. The school of thought proffers that the development of either the informal or formal sectors is premised on the nature of capitalism, with emphasis being given to attempts to reduce labour costs and increase competitiveness, the power of the labour force and global developments being among the chief attributes of the drivers of the capitalist considerations that influence formalisation and informalisation of economies.

- Legalists – the School of thought subscribes to the idea that the regulating environment is the major attribute to the level of development of either the formal or informal environment.Thus,these believe that the legal environment can promote or discourage the growth of the informal sector. In environments were the regulatory environment is harsh the informal sector tends to thrive. They also acknowledge that there is a collusion between the Government and formal players to put up bureaucratic rules which encourage the informal traders to formalise their trade.

- Voluntarists – the school of thought pays minimal attention to the relation between the formal and informal sector. However, the subscribers note that the informal sector presents unfair competition to the formal sector. The school of thought argues that to make the business environment level, the informal sector should be subjected to the same conditions as that the formal sector is subject. The arguments site issues to do with paying taxes, regulatory compliance costsand other business operating conditions that business in the informal sector are not subjected to. The Voluntarists subscribe to the notion that one makes a choice to trade within the informal sector after carefully weighing the costs and benefits of such as sector.

According to Chen (2012) literature proposes various theories on what drives and ultimately what constitutes the informal sector. The main stream economists are of a school of thought concurs with the voluntarists, that being in the informal is deliberate well calculated move. Other economists subscribe to the notion that growth of the informal sector is premised on a failing economy. Thus, to say, when there are economic crises the informal sector thrives and where the economy is booming the formal sector thrives.

Importance of the subject which subject?

The study comes at a time when Zimbabwe is going through intense economic challenges, with a greater proportion of the population working within the informal sector. The impact of the informalisation of the economy on social security aspects needs to be analysed and need be, suggestions fostered to ensure social security of those in the informal sector.

In Zimbabwe, there has been a growing sector of informal economic activity over the years, with more larger entities closing shop, Zimbabwe has seen a huge rise in SMEs and Informal economic activities. Zimbabwe has become one of the world's economies with the highest informal economic activities. "The three largest shadow economies *(informal economy)* are Zimbabwe with 60.6, Bolivia with 62.3 and Georgia with 64.9."(Medina & Schneider, 2018).

In Zimbabwe, several legal businesses have now turned informal, with most of such activities off the tax man's radar. Among such activities are artisanal mining, retail activities, hairdressers, cross boarder traders, small scale farming and manufacturing activities.

The access to healthcare remains key to the livelihood of all citizens, irrespective of whether individuals they are within the large corporates in the formal sector or within the informal sector. With the growing informal economic sector and small to medium enterprises and a declining formal sector activity, the paper seeks to analyse the impact of this economic development on the financial inclusion in respect to healthcare financing.

The need to develop strong health financing systems is a common objective of all countries. Even the richest countries are finding it increasingly difficult to keep up with rising health care costs, and the current economic downturn is adding more pressure on health spending. In low and middle-income countries, which are where the vast majority of African countries are

ranked, scarcity of funds for healthcare financing is an even more acute problem. On the backdrop of the Zimbabwean economy being dominantly informal, the Government is limited on its ability to deliver affordable quality healthcare due to budgetary constraints and hence medical insurance becomes a key proponent in ensuring access to quality healthcare.

Discussion of existing models/frameworks and key concepts

Specific risk within the informal sector

"Informal workers face substantial risks and vulnerabilities due to insecurity surrounding their employment status and lack of control of the conditions of their employment. In addition, informal workers have limited access to affordable and appropriate health care for themselves and their families, and they may not seek care if they have insecure legal status, or due to the potential expense or loss of income. The combination of high vulnerabilities and inadequate social protections (including insufficient access to affordable health services) results in high incidences of injury, illness, susceptibility to chronic diseases and poverty."(Rockfeller, 2013)

Health insurance and health access within the informal sector:

Access to healthcare is a basic human right and the costs thereof are inevitable in one's lifetime. The cost and financing of healthcare costs usually take centre stage on the quality and ability to access healthcare services. There are various ways in which individuals can meet healthcare costs (source):

- Free of charge - This usually is when the medical costs are met by non-profit organisations, such as Doctors without borders, WHO and in some cases the Government. In these cases, the patient access healthcare at no cost dependant on

whether they meet the set criteria and also dependant on availability of such services and offers.

- Out-of-pocket – In these cases the individual finances their healthcare costs using their own finances at the point of access. Thus, the method is dependent on the financial capacity of the individual and/or their ability to pull finances together at the time of need.
- Medical cover/ Medical Insurance - In these instances an individual has a pre-existing arrangement or insurance that their subscribe to through various ways, the common one being periodic financial contributions. In these cases, individuals will rely on the insurer to meet their medical bills at the point of access.

Though free access to healthcare is an option to healthcare access, the possibility of this for the majority of people leaving in low to medium earning countries, including Zimbabwe, is far from reality due to the incapacity of their Governments to finance such. Thus, the discussion going forth, will focus on the Out of Pocket financing and medical insurance.

The United Nations through World Health Organisation (WHO) has been working to ensure that countries develop models that insure universal health coverage. The objective is to ensure that even the least privileged have access to healthcare. “However, international evidence has shown that it is problematic to achieve high coverage among the informal sector using a voluntary, contributory mechanism for several reasons. One, a significant proportion of informal workers are less well-off, compared to formal sector workers and therefore have a lower ability-to-pay for health insurance. Two, given that the informal sector is not organized in sizeable groups, it is administratively difficult to recruit, register and collect regular contributions in a cost-effective way. Membership and premium payment are therefore often voluntary leading to low uptake, poor retention and adverse selection. Three, informal sector worker incomes are often unpredictable, which makes it difficult to collect premiums regularly and increases attrition rates among this population. Voluntary insurance contributions therefore present a fairly small percentage of overall health revenues, even in countries that continue to attempt to collect them. Despite these challenges, an increasing number of Sub-Saharan African countries have either established or are in the process of

establishing a contributory public health insurance scheme. For example, Ghana, Kenya, Nigeria, Rwanda and Tanzania have contributory public health insurance schemes, while South Africa, Swaziland, Lesotho, Sierra Leone, Liberia, Zambia, Uganda, Bukina Faso and Zimbabwe are considering establishing one."(Barasa, Mwaura, Rogo, & Andrawes, 2017)

Drivers of Informal economies

In an IMF working paper, Medina and Schneider (2018), identified several drivers of the development of the informal economy. Some of these are discussed below:

i. Tax regime and social contribution costs–Where there are high tax rates and social costs, impacting significantly on the difference between the cost of doing business in the formal sector as compared to the informal sector, the informal sector tends to grow.

ii. Level of corruption and the quality of institutions– Corruption and poor institution often discourage formalisation. Corruption and poor institutions tend to make it very difficult for business to formalise and as such the majority will remain in the informal sector.

iii. Regulatory environment- Regulations often create barriers to formalise business. An over regularised environment promotes entities to operate outside the regulations and as such promote informalisation.

iv. Public sector services–Agrowing informal sector reduces the Government's tax base ultimately reducing a nation's revenue stream. This setup reduces the capacity of the Government to provide better quality services, and further forces the Government to demand more from the formal players through taxes and regulatory costs. The result would be an encouragement for business to informalise.

Chen (2012) notes that a there is an assortment of factors that drive the informal sector. Among these are individual choice, some informal players make a deliberate decision to be in the informal sector as they find the benefit of being in this space outweighing the costs.

For some being in the informal sector is not our of choice but out of necessity, tradition or other economic or social conditions. Several players within the informal sector would formalise if the conditions were right and conducive to do so.

Healthcare financing informal sector in selected countries

"The informal sector is highly diverse and its composition varies across countries and within countries. Approaches to mobilising resources from the informal sector will therefore need to take into account local factors, including the capacity to pay of specific groups and the availability of organisational structures through which its resources can be tapped."(MIntyre, Honda, & Hanson, 2014). Below is a discussion on how some countries are catering for players within the informal sector:

Kenya

"In Kenya, informal sector workers constitute about 80% of the total workforce. The sector is characterized by low and irregular incomes which make prepaying for health care difficult. As a result, existing prepayment systems including funding from government revenue and premium contributions in Kenya and many LMIC (Low to Medium income Countries) tend to exclude informal sector workers because either the funds are inadequate (in the case of funding from general government revenue) or they are too poor to pay for insurance premiums. Moreover, SHI (Social Health Insurance) schemes historically have focused on the formal sector workers because it is relatively easy by law to enforce mandatory contributions through salary deductions."(Okungu, Chuma, Mulupi, & Mcintyre, 2018)

"A number of developing countries are reforming their health systems for UHC. In Kenya, financing reforms for UHC are underway and the process of finalizing a health financing strategy (HFS) has been going on for more than two years. The draft HFS proposes a contributory health insurance model as the main health financing strategy for Kenya where both formal and informal sector workers contribute premiums to a scheme, and the government subsidizes premiums for the poor and other vulnerable groups. The contributory policy approach to financing UHC in Kenya is a technocrat-led top-down strategy with

limited public participation and partly informed by the assumption that there are sufficient financial resources in the informal sector to support the UHC agenda."(Okungu et al., 2018)

Philippines

"Philippines is one the most advanced middle-income countries with regard to its achievement in universal health coverage (UHC). Today, 82% of its population benefits from PhilHealth coverage and have access to public and private hospitals services. But still around 18 million Filipinos, mainly informal workers, are excluded from the system. While developing countries are making progress towards UHC, almost all are facing the challenge of covering the missing middle, those near poor who are covered by neither social assistance nor formal social protection mechanisms. Near poor are often referred to as the informal sector. This is also the case for Philippines, where informality is slowly decreasing but remains high, estimated at 67% of the population."(Phily, Rajikotia, & Matul, 2014)

"Many countries are looking at UHC progression with the coverage lens but the financial protection and scope of services dimensions should also be considered. In Philippines, population coverage is high but out of pocket expenditures are still higher than targeted, providing limited financial protection to the population. Though expanding progressively, PhilHealth's benefit package mainly covers hospitalization."(Phily et al., 2014)

South Africa

"The South African pre-funded health finance market is a complicated system that functions via fragmented risk pools under separate regulatory regimes for medical schemes and health insurance, respectively.

The market for pre-funded healthcare products is dominated by medical schemes. These products operate similarly to not-for-profit trust funds and service around 16% of the South African population (8.8 million people). Medical schemes are regulated by the Council for Medical Schemes (CMS) according to the Medical Schemes Act (MSA). The funds can either

function as restricted membership funds that ring-fence membership to a particular employer/industry or as open funds that make membership available to all that can afford the premiums. The market is based on the principles of solidarity and community rating and provides members with a set of prescribed minimum benefits (PMBs).”(Abraham & Fassa, 2016)

Abraham and Fassa (2016) notes that in South Africa the major draw backs prohibiting participants in the informal sector to take-up medical insurance include:

- Affordability - The cost of cover has been noted as one of the major deterrence for those in the informal sector, with low income. In RSA, the medical scheme market there have been two main policy initiatives aimed at structuring an affordable low-cost product (the Low-Income Medical Scheme initiative of 2006 (LIMS) and the Low- Cost Benefit Option (LCBO) initiative in 2015) but to date neither have come to fruition.
- Market fragmentation - The health funding market is fragmented to the extent that it impacts on the ability of the products to provide value, control costs and align incentives. This lack of integration leads to inefficiency that serves to increase costs for both health insurance and medical scheme products. This further constrains the low-income market’s ability to access cover.

Cost inflation - Healthcare Cost Inflation (HCCI) in excess of inflation has long been prevalent in the medical scheme market and has recently become a feature of the health insurance landscape. This is driven by inflation related increases in tariffs as well as utilisation increases as consumers increase the amount of health services they use. Other factors that increase costs include non-healthcare costs, regulations as well as fraud. Many of these factors require parallel risk-management and cost-containment strategies that curb health costs, which can increase non-health costs.

Key dimensions

Financial Inclusion

With the various definitions of Financial inclusion by different writers and scholars, there are three main areas of convergence – Formal Financial Services; Access of Financial Services; Usage of the Financial services and the Quality of the Financial Services. The main areas of convergence are:

i. Formal Financial services

- Various scholars agree on financial inclusion being focused around financial services, however the main points of divergency is the composition of the financial services basket and the level of importance of each. The array of financial services is very wide and can be diverse. "Financial Inclusion includes accessing of financial products and services such as: savings facility, credit and debit cards access, electronic fund transfer, all kinds of commercial loans, overdraft facility, cheque facility, payment and remittance services, low cost financial services, insurance (Medical insurance), financial advice, pension for old age and investment schemes, access to financial markets, micro credit during emergency and entrepreneurial credit."(Chinnathambi& Ramachandran, 2015). Some popular financial services are discussed below:

  Banking:

  Banking has been one aspect of financial inclusion that has taken centre stage in the quest of financial inclusion. "The 2012 FinScopeINFORMAL TRADERS Survey and the 2014 FinScope Consumer Survey revealed that 23% of Zimbabwe's adult population was financially excluded, only 30% of Zimbabwe's adult population made use of banking services as at 2014, only 14% of INFORMAL TRADERS owners were banked and only 1% of adult population made use of capital market services."(RBZ, 2016)

  Insurance:

Insurance has been another key area in as far as financial inclusion is concerned. Extending insurance to those financial excluded is deemed to protect them from financial losses. Property insurance has gained greater momentum among various insurance products in as far as research and attempt to improve inclusion.

Medical Insurance:

The subject of financial inclusion has seen most scholars putting emphasis on the banking products, thus mainly access to a bank account and other banking services and micro insurance for property. Though health insurance has been put under scrutiny time and again, its role in financial inclusion and level of importance has not been emphasised enough, thus leaving a need for further research.

"As most functional health insurance schemes in Africa are associated with formal sector employment—requiring regular contributions compatible with formal sector earning—the majority of individuals are not insured."(Arhin-Tenkorang, 2001). "Moreover, access to formal savings services enables the poor to make produc-tive investment, to be less vulnerable to health shocks and to smooth consumption expenditure." (Chinnathambi & Ramachandran, 2015). With health insurance addressing some of the basic and critical human needs, health access, the writer acknowledges the need for further study on the subject in as far as financial inclusion is concerned.

Access of Formal Financial Services

Access refers to the availability of affordable and appropriate financial products and services. The major determinants of access are:

a. Affordability
b. Product structure/ Appropriateness of product
c. Product awareness and reach

Access by the majority of the population within an economy mainly the marginalised; which include the population outside the formal economic structures, the low-income earners and those living in marginalised economies (including the informal sector). Without access, uptake of financial products and services is limited.

Usage of Formal Financial

"Usage refers to the uptake or utilisation of financial products and services. Usage can be understood as the number of interactions the client has with products and services within a given time period. For example, a client with a dormant bank account cannot be classified as financially included if they do not make use of the product and have no other financial products. Usage is often used as a proxy to determine access and uptake of financial products and thus the depth of financial inclusion."(SADC, 2016)

Quality of the Formal Financial Services

"Quality refers to product design and functionality that enhance the value of services to clients. Quality can be understood in four ways:

1) **Product fit:** products and services that are well-suited and tailored to the needs of the client.

2) **Value Add:** products and services that add value to the clients overall financial situation.

3) **Convenience:** products and services that are easily accessible and user friendly.

4) **Risk**: access to products and services should not increase the financial risk of consumers e.g. over-indebtedness due to reckless lending practices

Quality also has a direct influence over usage i.e. poor quality products will result in low usage. Furthermore, despite its importance quality remains a difficult dimension to measure financial inclusion. " (SADC, 2016)

Why Financial Inclusion:

EY (2017) identified the following as some of the key reasons why economies should advocate for financial inclusion:

- To smooth income trends
- To obtain financing to grow businesses
- To protect against natural and man-made disasters
- To save for family celebrations and other life events (births, weddings and funerals)

Discussion of contradictions in the research area

Level of income in the informal sector:

Various researchers share various positions in as far as the level income within the informal sector is concerned. Other scholars believe that the level of income is relatively lower within the informal economy as opposed to that found within the formal sector.

LITERATURE GAP

The majority of existing literature on financial inclusion has given much attention to inclusion at macro-economic, there is limited study of financial inclusion at various focus groups within an economy, especially those outside the main stream economy. With the informal sector constituting over sixty percent of low to medium income economies, such as Zimbabwe, there is need to zoom in on the informal sector to analyse various facets of this sector.

Earlier studies on financial inclusion have given focus on mainly banking products followed by insurance for property, life insurance and funeral policies little emphasis has been put on medical insurance. Accessibility of healthcare services is vital, and the two major limiting

factors to healthcare are the unavailability of quality healthcare facilities and the burden to finance healthcare costs. “Informal-sector workers often fall through the cracks of countries’ social security systems, despite being at risk and vulnerable”(Bonfert et al., 2015)

The literature is not much into financial inclusion but health insurance of the informal sector. This reflects that the study is not much linked to the topic which is the case with objectives.

3. Chapter 3

SCOPE AND METHODOLOGY CHAPTER

1.4. Introduction

A quantitative research methodology was adopted for the study. The need for a quantitative research design was necessitated by the need to draw insights from a much bigger, robust and stable sample size, hence to be able to quantify results and make statistical inferences on the participation and consumption of financial services by the informal sector in Zimbabwe. This methodology entailed the use of a structured questionnaire as a data collection tool. As the study sort to make an assessment of the healthcare landscape in the informal sector, INFORMAL TRADERS owners were sampled hence formed the target respondents for the study.

1.5. Main objective, question and hypothesis

Main objective: To determine the level of impact that the growing informal sector has had on the ability of the informal sector participants to afford medical health insurance.

Main question:What is the level of impact that the growing informal sector has had on the ability of the informal sector participants to afford medical health insurance

H1: The growth of the informal sector has negatively impacted the ability to meet medical bills for those that make the transition from the formal to the informal sector.

Research Design

The research is a conclusive research and both the casual and descriptive research design were employed for the research.

Research Philosophy

The researcher took a positivism approach to the study and believe that the research findings are factual and can be inferred to the population of study.

Population and sampling techniques

Convenience sampling was employed to select target respondents for the study. The sampled areas chosen had the most concentration of informal traders in Harare. informal traders owners were intercepted at their workplaces.

Sampling population was:

Informal Tradersin Zimbabwe;

- 18 years or older;
- Perceive themselves to be business owners/generating an income through small business activities and,
- Employ 75 people or less as well as individual entrepreneurs without any employee.

The informal traderswere asked about the number of businesses they own and if they owned more than one business, the owner was requested to identify the main business where they spent most of the time working on. The table below gives a detailed sample distribution of the study;

Listing of areas sampled for the study

Area	Total
MbareSiyaso Home Industry	62
Glenview Area 8 - Home Industry	69
TOTAL	131

Research Instrument

Questionnaire

For the purposes of establishing and measuring awareness, usage levels and assessment of the healthcare financing options in the sector, the survey instrument was formulated around key indicator variables as outlined in the table below:

Questionnaire Structure

	Specific information sort by survey instrument
1	Informal TradersDemographics
2	Financing and level of access of healthcare institutions
3	Usage of Medical Insurance

In developing the questionnaire consultations with experts in the field of finance and informal trade was done.

Pilot Study

The questionnaire was piloted in Harare downtown and 10 pilot interviews were done. Insights and feedback from pilot interviews were then used to further refine the instrument.

Data Collection Administration

Data collection

Two people assisted with data collection. The data collectors were briefed and trained on the objectives and guidelines of the study. Recruitment of data collectors was based on educational qualifications and prior experience in data collection especially in the financial servies sector. They also had to go through a rigorous mock interviewing session and a question by question review of the survey instrument. After the training session, each Data

collector was required to do a pilot interview. A de-briefing session was also done to check on issues arising from the pilots.

Quality Control Standards

In order to uphold the integrity and authenticity of the data, rigorous quality control checks at different levels of the research cycle were put in place. The quality control measures were intended to enforce the general standard of interviewing and the adherence to the specific training objectives as provided for during the briefing and training sessions.

Accompaniments

On commencement of fieldwork the data collectors were accompanied on their first interviews to check on efficiency and administration of the survey instrument. The accompaniments also enabled the supervisor to observe the interview as well as understand any problems arising during the implementation of the questionnaire.

Editing of completed interviews

Completed questionnaires were reviewed on a daily basis as they were submitted from field. The editing process was intended to check on the proper recording of responses on the questionnaires, completeness of questionnaires and to check on unexpected issues arising on the general flow and administration of the questionnaire i.e. refusals by respondent to answer certain questions. On the basis of editing findings, interviewers were requested to re-group every morning to discuss and share problems encountered on their previous day's experience and to come up with possible solutions. Through editing, problems were identified and subsequently communicated to the responsible interviewer to take corrective action usually on a daily bases.

Data Processing logic control checks

In addition to field control checks by supervisors, data control checks were also enforced through advanced data entry programming. The data entry template was programmed to check on the flow of logic and contradicting responses on the questionnaire. Questionnaires

that were not consistent with logic controls were sent back to the respective interviewer for back-checking.

Data Gathering, Processing and Analysis

The data was handled in SPSS format. Data capturing was done using SPSSPCDEII and the captured data was then exported to IBM SPSS for Windows Version 20 for statistical analysis. SPSS was used for analysis because of it's high computational power in data cleaning and analysis

Editing and Coding

Before the data was captured, questionnaires were 100% checked for completeness and consistency. All questionnaires were scrutinised for logic field errors before they were captured.

Data Capture

A Data Entry template was developed to mimic the questionnaire used for data collection. This was done to guide data entry and to minimize data capturing errors. The main advantages of using SPSSPCDII for data capturing was that it provided an exceptional platform for data verification, data validation and programming. It provided two interfaces thus: Data Entry and Data Verification Modes. The Data Verification mode was used by a second person to verify what was captured by the first person in Data Entry Mode, and if there were any discrepancies, the program would report back. 10% of each data entry clerk's work was verified.

Data Analysis

General statistical tables were produced, and these formed the basis of survey results interpretation. The results of each variable were cross analysed by demographic variables i.e. gender, age category, INFORMAL TRADERS sector and duration in business.

External validity

For purposes of external validity the researcher the size of the sample was considered. A larger sample will improve the quality of the results and its ability to be generalised to the whole population. A pilot study was carried out to pre-test the instrument and adjustments were made to improve the instrument.

Internal validity

The researcher consultant the research Supervisor for advise on the design of the questionnaire. Apart from the Supervisor, the researcher engaged colleagues in the informal sector to also develop the instrument, with the main on being on the understandability and phrasing of the questions. A computation ofCronbach's alpha coefficient was81% confirming reliability.

Research ethics

The researcher took ethical issues seriously and part of the ethical issues adhered to were:

1. Confidentiality and Privacy – individuals in the informal sector take confidentiality of their identity seriously and as such the researcher assured the respondents that confidentiality will be adhered to
2. Safety -The research was conducted at time when there were some social disturbances. Safety of both the researcher and the respondents were ensured by avoiding interviews in times of disturbances

Limitations

The study was confirmed to Harare only and hence results would be biased towards informal traders'operating in Glenview and Mbare.

Some respondents turned down appointments for various reasons. Some of the respondents were too busy, some were away on holiday, while others just turned down the interviews for no apparent reasons. Some respondents complained that they have been interviewed on several occasions and were not seeing the benefit of their participation in the survey.

Only available respondents were interviewed.

CHAPTER 4: RESEARCH FINDINGS AND ANALYSIS

1.6. Introduction

The proceeding chapter discusses the research findings. A cross sectional analysis was done on each indicator variable against key demographic variables. It was this cross tabulation of key outcome variables which thus formed the bases of the survey results interpretation. The chapter starts with a brief outline and description of the respondent demographic profile followed by a detailed discussion of key characteristics of the healthcare delivery system in the informal sector in Zimbabwe. The end of the chapter gives a brief synopsis of the major findings of the research survey.

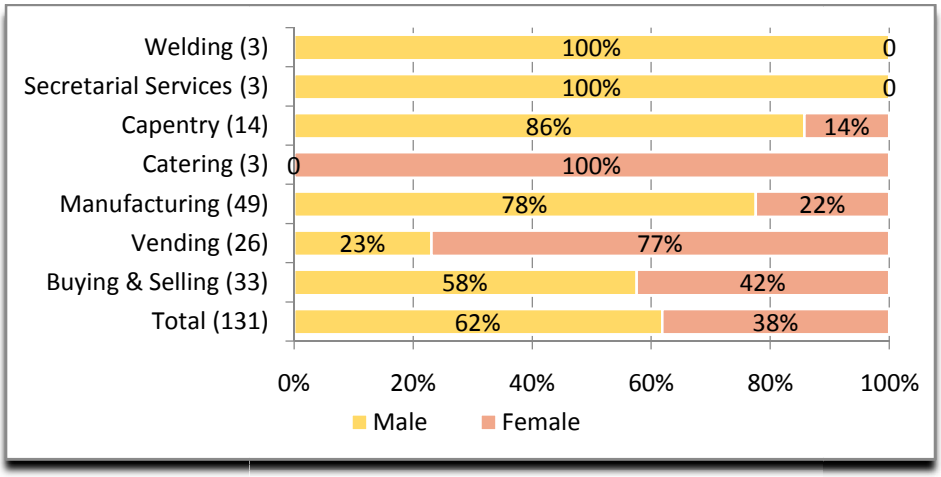
1.7. Response rate

The researcher utilized research assistance who conducted interviews and thus the response rate was 100%.

1.8. Sample Demographics

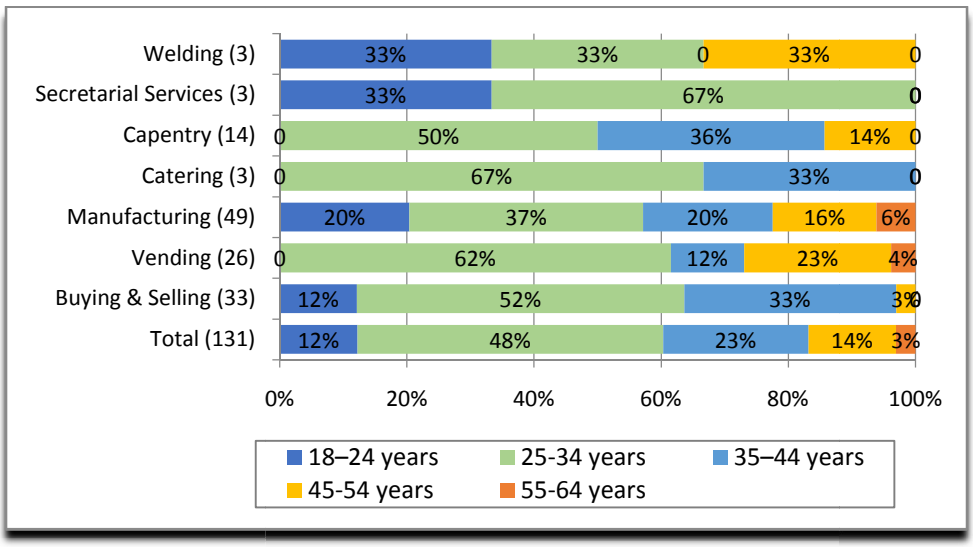
The study was confined to Harare only and was carried out in Mbare and Glenview home industries. These areas were thought to give a fair representation of the micro enterprising activities in Zimbabwe as they are characterized by a high volume of numerous informal activities given their proximity to the major high density settlements in Harare. From a total sample of 131 respondents, most interviews were carried out in Glenview home industry compared MbareSiyaso home industry. However, the samples were skewed towards males with a sample split of 62% males against 38% females.

Figure1: Micro enterprise Activities by Gender



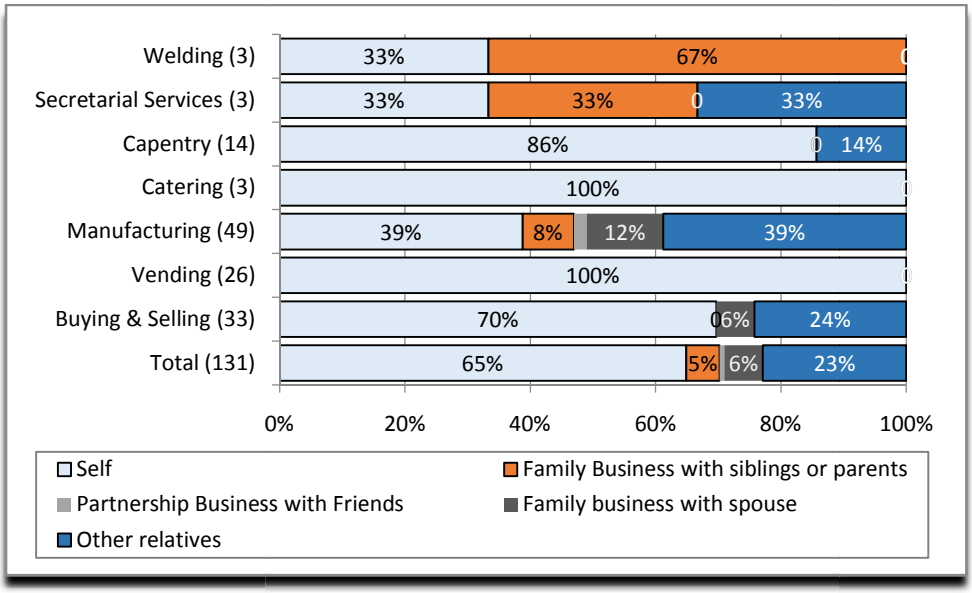
The chart above highlights the major informal activities by gender.A closer look at gender participation in the informal sector showed that males were more actively involved compared to their counterparts, male participation was 62% to that of females 38%, in the areas that were sampled. However, there was polarization in micro enterprising activities as males were more dominant in heavy jobs such as carpentry and manufacturing constituting 86% and 78% respectively, while females were more prevalent in vending and catering. However, both genders were also involved in buying& selling.

Figure 2: Micro enterprise Activities by Age



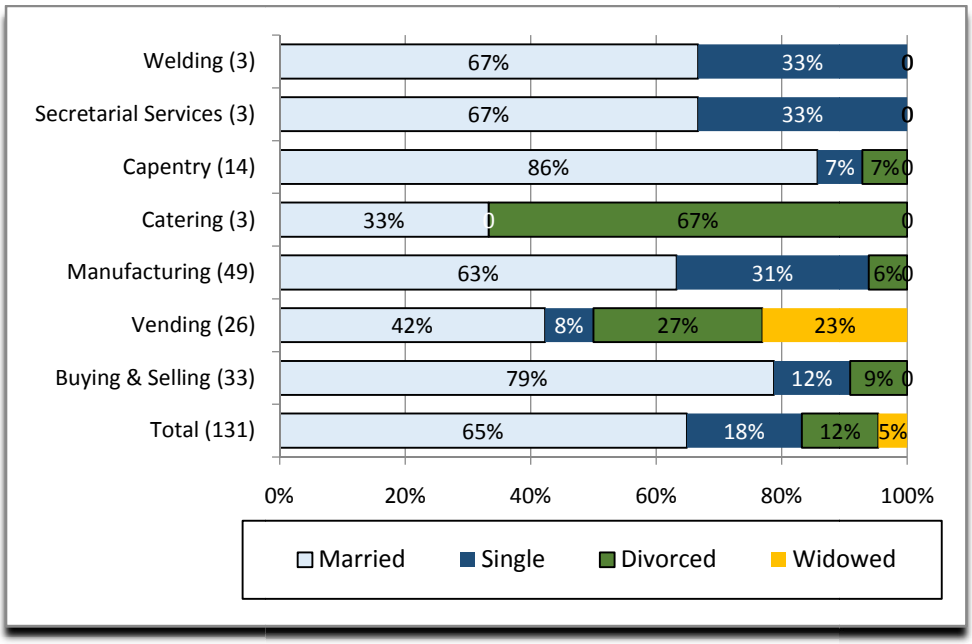
The chart above highlights the major informal sector involvement by age. The study established that the majority of the informal sector participants were aged between 25 to 34 years of age. The study also established that the majority of the 55 to 64 year age group featured more in manufacturing activities.

Figure 3: Business Ownership by micro enterprise Activity



The majorityof the micro enterprises activities were individually owned, as those owners were hands on in the enterprise, while there were few instances were people would pull their resources to form a business. Prominent individual businesses were vending, carpentry and buying & selling. Manufacturing was performed by various people such as extended family members, spouse and parents. The chart above shows the major forms of business ownership in the informal sector of the sampled areas.

Figure4: Marital Status by micro enterprise activity



The majority of informal businesses were carried out by married couples, more prevalently were businesses in buying & selling carpentry, buying & selling and manufacturing. However the divorced were also common in vending and catering. The chart above shows the major micro enterprise activities by marital status. The stats may suggest the pressure to generate income based on marital status.

4.3: Level of Education

Table 1: Education status by Type of business

		TYPE OF BUSINESS						
	Total (131)	Buying & Selling (33)	Vending (26)	Manufacturing (49)	Catering (3)	Carpentry (14)	Secretarial Services (3)	Welding (3)
Primary Education	10%	3%	38%	4%				
O Level	**64%**	**55%**	**58%**	**69%**	**100%**	**57%**	**100%**	**100%**
A Level	12%	21%	4%	10%		21%		
Under Graduate	2%	3%		2%				
Post Graduate	5%	15%		2%				
Tertiary Education	8%	3%		12%		21%		

The majority of respondents had completed secondary education followed by 'A' Level. On overall, the majority of respondents across all the business types that were surveyed had completed 'O' Level. However, respondents with some primary education were notable in the vending business, while the under and post graduate respondents were in the buying & selling business. Tertiary education respondents were prevalent in the carpentry and manufacturing business. The chart **above** shows the distribution of respondent's education against the type of business.

1.9. Consumption of Financial Services by the informal Sector

Table 2: Uptake of financial services products in the informal sector

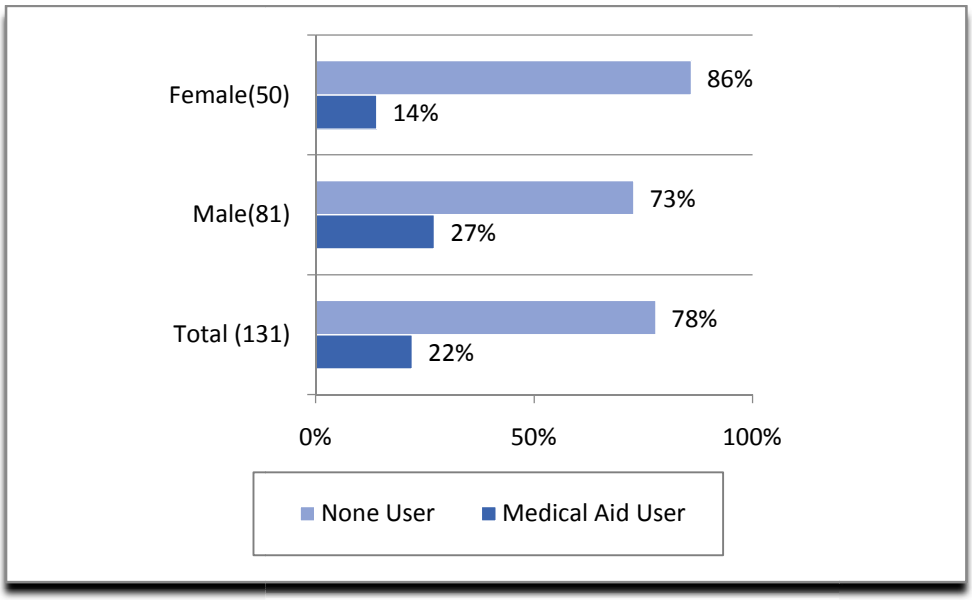
		TYPE OF BUSINESS						
Financial Products	Total (131)	Buying & Selling (33)	Vending (26)	Manufacturing (49)	Catering (3)	Carpentry (14)	Secretarial Services (3)	Welding (3)
Funeral insurance	66%	76%	62%	57%	67%	93%	33%	67%
Bank account	65%	88%	31%	59%	100%	93%	33%	67%
Motor vehicle insurance	27%	36%	4%	31%		50%		33%
Medical Aid	22%	48%		18%		29%		
Property insurance	1%	3%						

The study also sort to establish the consumption of various financial products and services by the informal sector. It emerged that, funeral insurance and bank account were more popular in the sector, while the uptake of medical insurance and property insurance were the least used. Funeral insurance was popular across all the businesses types surveyed. Research results also established that vendors reported the minimum use of banking services across.

1.10. Usage of Medical aid services by Gender

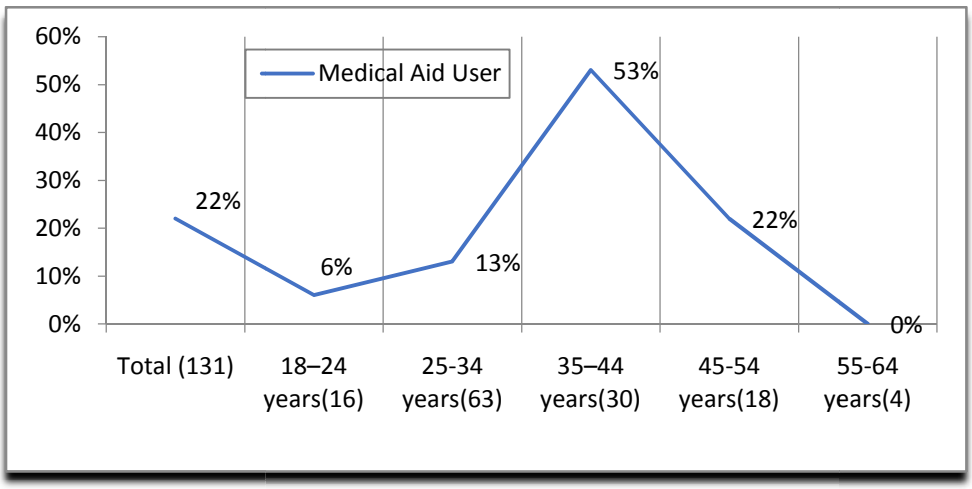
A cross analysis of medical aid services by gender revealed that its usage was skewed towards males while females had a low uptake.

Figure 5: Usage of Medical Insurance by Gender



1.11. Usage of Medical aid services by Age

Figure 6: Usage of Medical Insurance by Age category

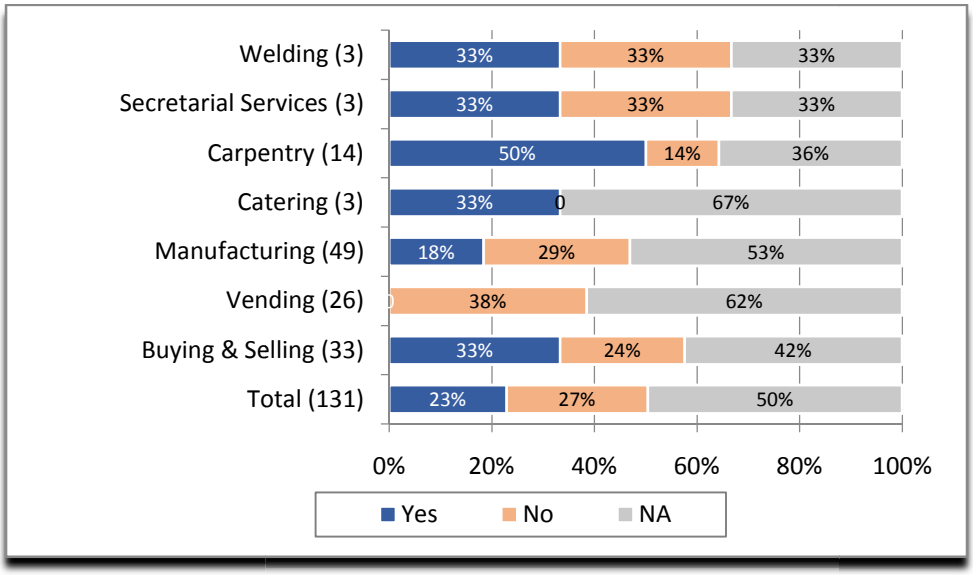


A further analysis of medical insurance consumption by age showed that active uptake started from 34 years and ended at 54 years, while the peak age group was 35-44. Low uptake was

reported in 18-24 years age group as well as the 55-64 years age group. What are the implications of these results?

Linkage of micro enterprise activity to previous job experience

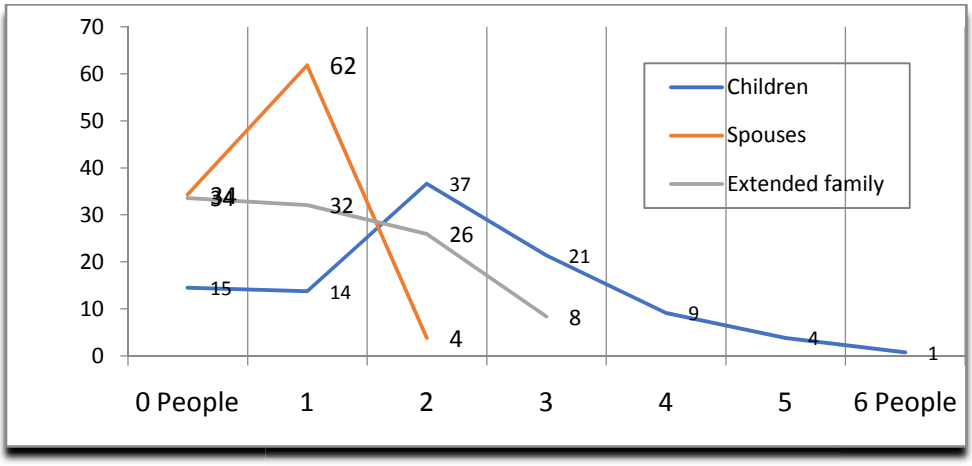
Figure 7 :Business links with previous employer



The research also wanted to establish the transfer of skills from the formal into the informal sector. Very few businesses had skills transfer links from the formal sector as it emerged that about 50% of the respondent had either been formally employed. It was in the carpentry business were the business operators had significant traceable links to their previous employers.

Household size

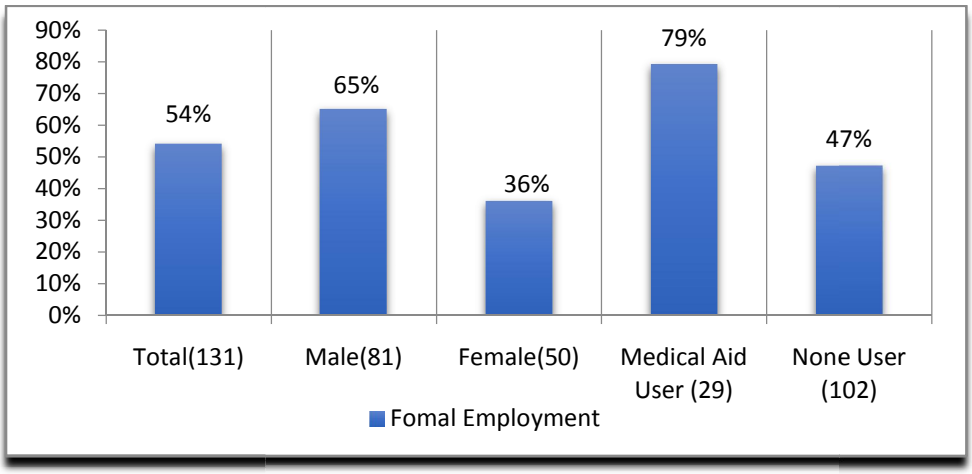
Figure 8 :Distribution of household family members



The average number of spouses per household was 1, while the average numbers of children were 2 children. Average number of extended family members was also 1. Implications of the results.

Formal employment history

Figure 9 Uptake of medical insurance in the formal employment

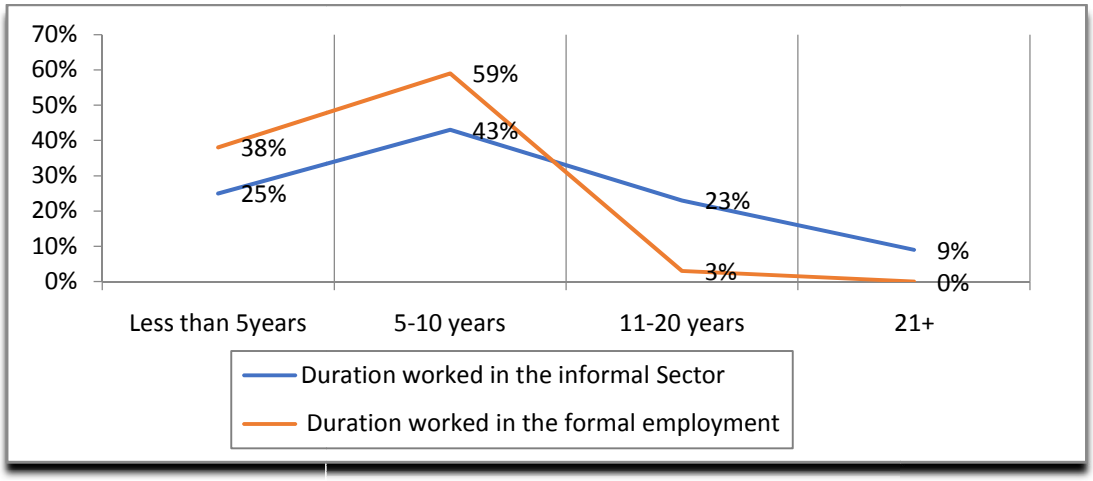


More than half of the sample respondents were formally employed before they ventured into the informal sector. It also emerged that more males were once employed in the formal sector compared to their female counterparts. Study results also confirmed a relationship between having medical insurance and being formally employed. This is shown by 47% of respondents who stopped subscribing to medical insurance when they moved into the informal sector. This is also confirmed by the low uptake of medical insurance by the

informal sector. The graph above shows the relationship between formal employment and the uptake of medical insurance

Duration of employment in the formal sector

Figure 10: Duration in employment



An assessment of employment history showed that the majority of respondents had worked for a period of 5- 10 years in formal employment compared to the informal sector. However, respondents tend to have more working life in the informal sector as shown by 23% who reported having between 11-20 years and above. Implications

Duration of employment and the uptake of Medical Insurance

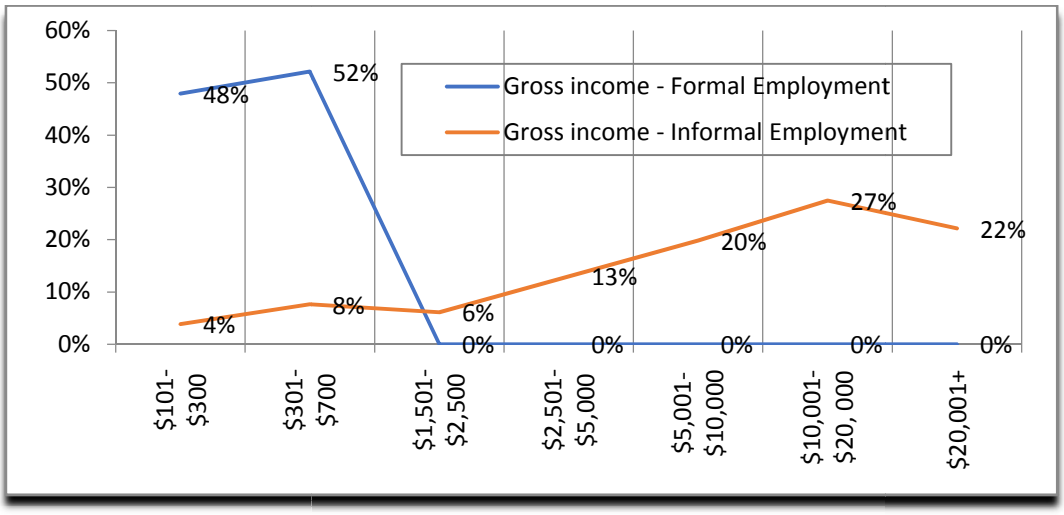
Table 3: Duration working in the informal sector and the uptake of Medical Insurance

		Gender		Usage of medical insurance	
Duration in the informal Sector	Total (131)	Male (81)	Female (50)	Medical Aid User (29)	None User (102)
Less than 5years	25%	26%	24%	7%	32%
5-10 years	43%	41%	46%	52%	43%
11-20 years	23%	26%	18%	41%	15%
21+	9%	7%	12%		10%

On overall,females tend to have worked in the informal sector for more years than males. The uptake of medical aid in the informal sector started to pick from 5 years of working in the sector.

Gross monthlyincome in the formal employment

Figure 11: Distribution of Gross Income earned



A comparative analysis of the gross incomes for the two sectors showed that the majority of people earned above $700 in the formal employment compared to their counterparts in the informal sector who were pocketing $2,500 and above as gross income per month.

Gross monthly income earned by type of business

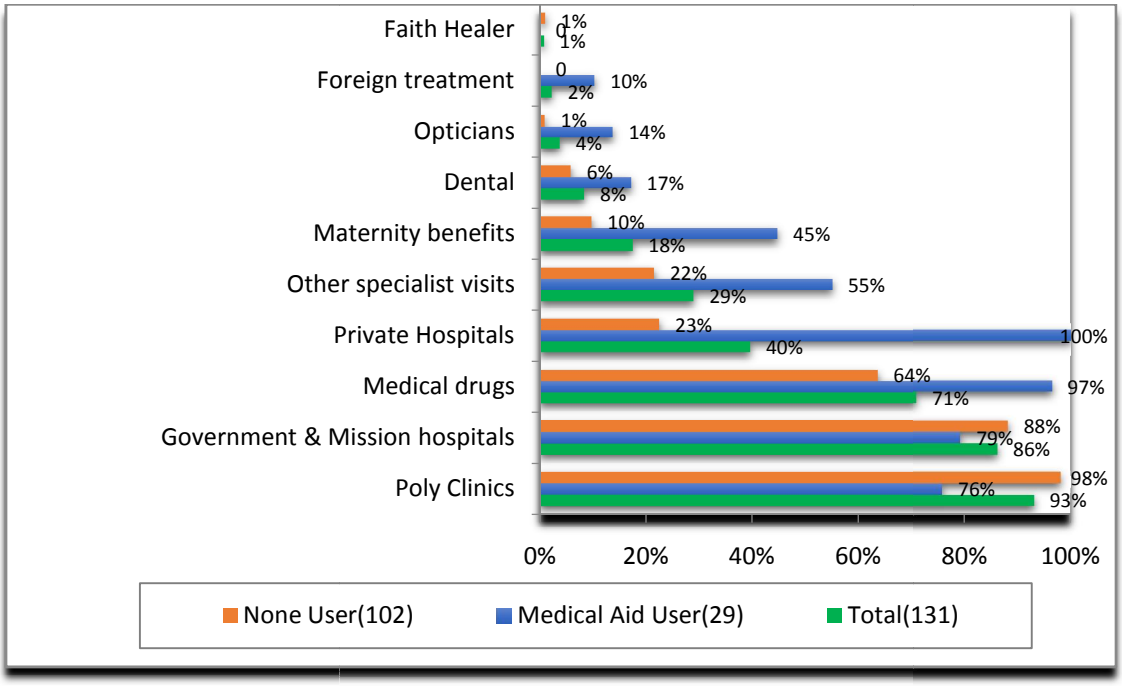
Table 4: Distribution of gross monthly income in the informal sector

		TYPE OF BUSINESS						
	Total (131)	Buying & Selling (33)	Vending (26)	Manufacturing (49)	Catering (3)	Carpentry (14)	Secretarial Services (3)	Welding (3)
$101-$300	4%	6%		6%				
$301-$700	8%	9%	4%	10%			33%	
$1,501-$2,500	6%		27%			7%		
$2,501-$5,000	13%	9%	42%	4%		7%		
$5,001-$10,000	20%	24%	23%	14%	67%	7%	33%	33%
$10,001-$20, 000	27%	21%	4%	39%	33%	50%		33%
$20,001+	22%	30%		27%		29%	33%	33%

The majority of informal businesses were earning above $2,501 as gross income per month depending on the type of business involved. However, majority of the Buying & Selling enterprises earned between $5,001-$10,000, Vendors earned between $2,501-$5,000, Manufacturers earned between $10,001-$20,000 and Carpentry businesses earned $10,001-$20,000. The table above highlights gross monthly income earned by informal businesses surveyed.

Figure12: Awareness and usage of healthcare institutions in the informal sector

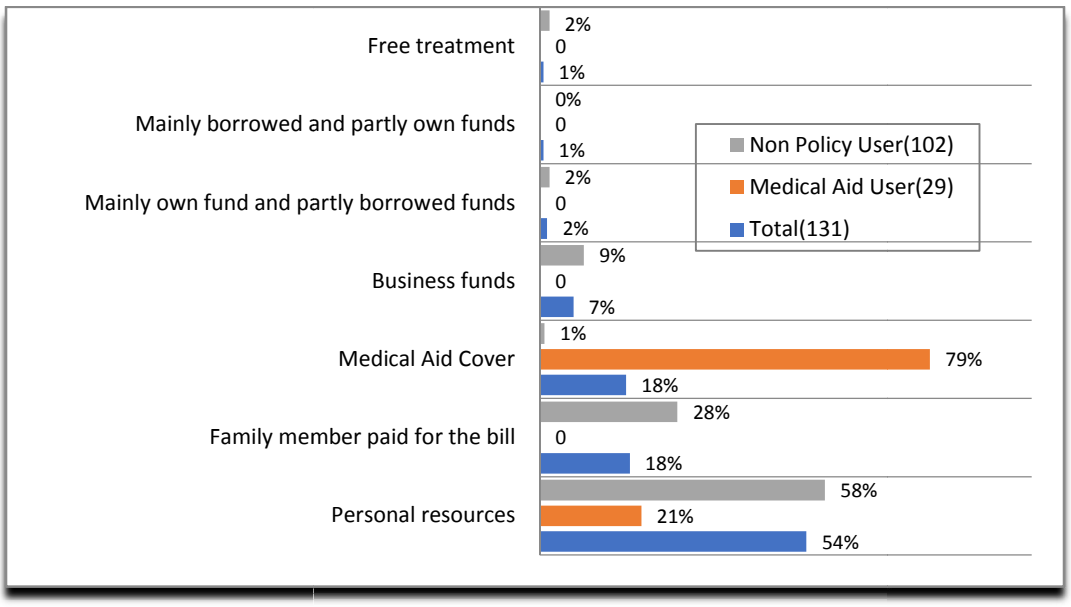
Healthcare institutions ever used



As assessment of the awareness and usage of healthcare institutions by the informal sector revealed that Poly Clinics, Government/Mission hospitals and Medical drugs were the most used institutions for healthcare services. However, non-medical aid policy holders accessed healthcare services through Poly Clinics and Government hospitals, while policy holders used Private hospitals and medical drugs.

Sources of fundsfor medical bills in the informal sector

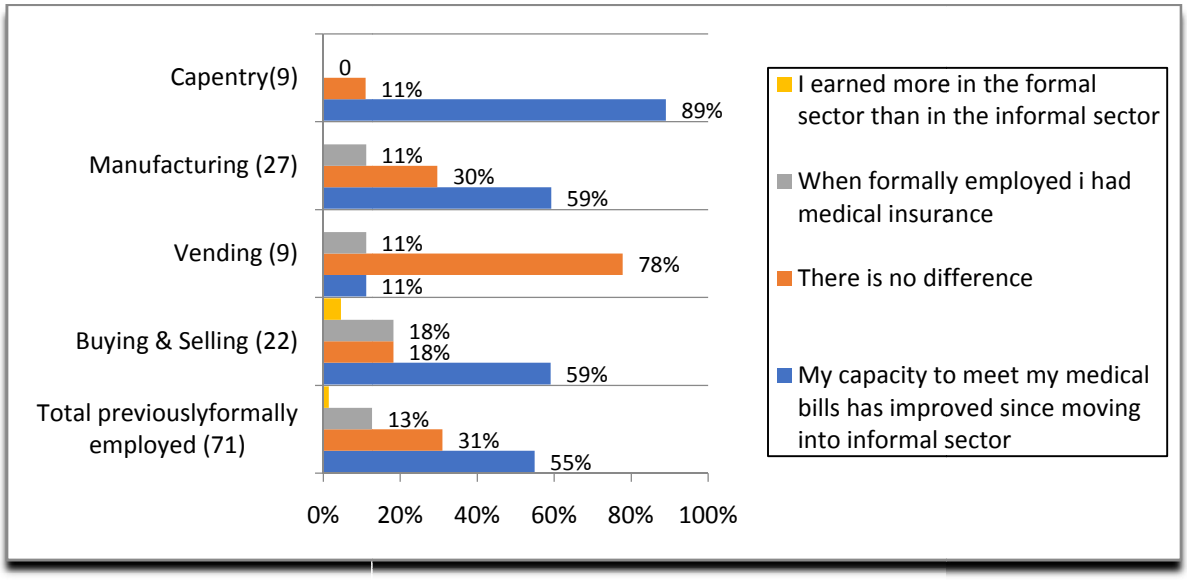
Figure 13: *Sources funds for medical bills*



Generally, respondents used personal resources to fund medical bills. However, a significant number sourced funds from family members, while a few used their medical aid cover. It is also important to note that those who used personal resources to fund medical bills, did not have medical aid cover, as well as those who used family members.

Difference in health finances in the informal sector

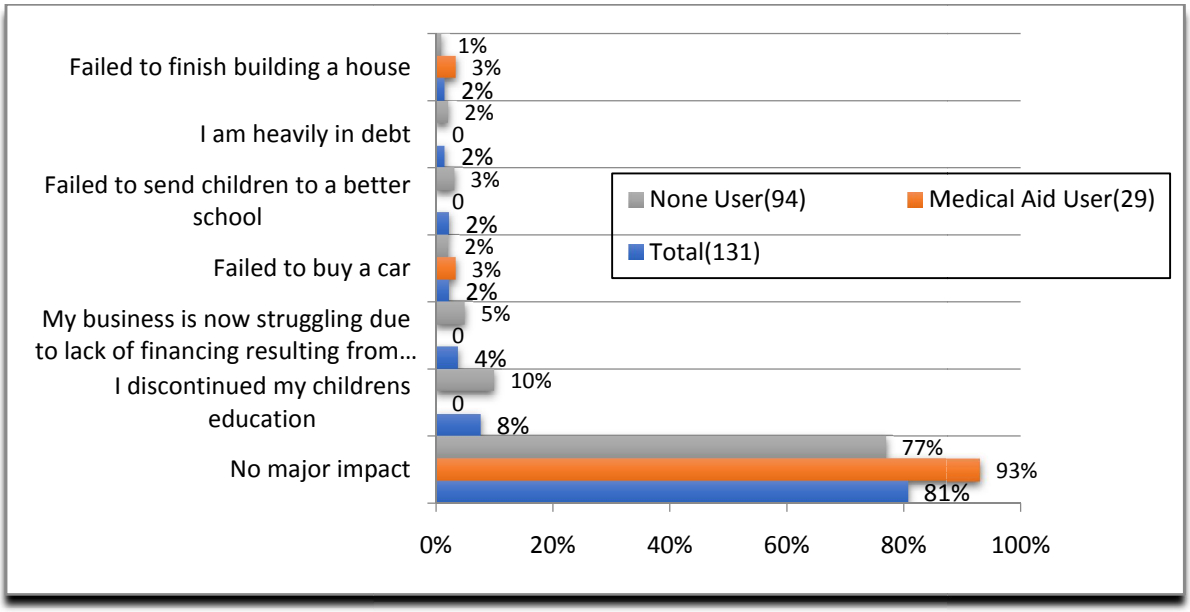
Figure 14: Differences in health financing in the informal employment



There were incredible significant differences in the manner in which respondents who were in the formal employment were now financing health bills. It emerged that they were now empowered to meet their own medical bill. However, 31% felt that there was no difference since they had moved into the informal sector. An insignificant proportion felt that there was a difference because they used to have medical insurance cover when they were formally employed. A sector analysis revealed that all business types surveyed concurred that they were now able to meet their own medical bills apart from vendor.

The impact meeting medical bills on the informal sector

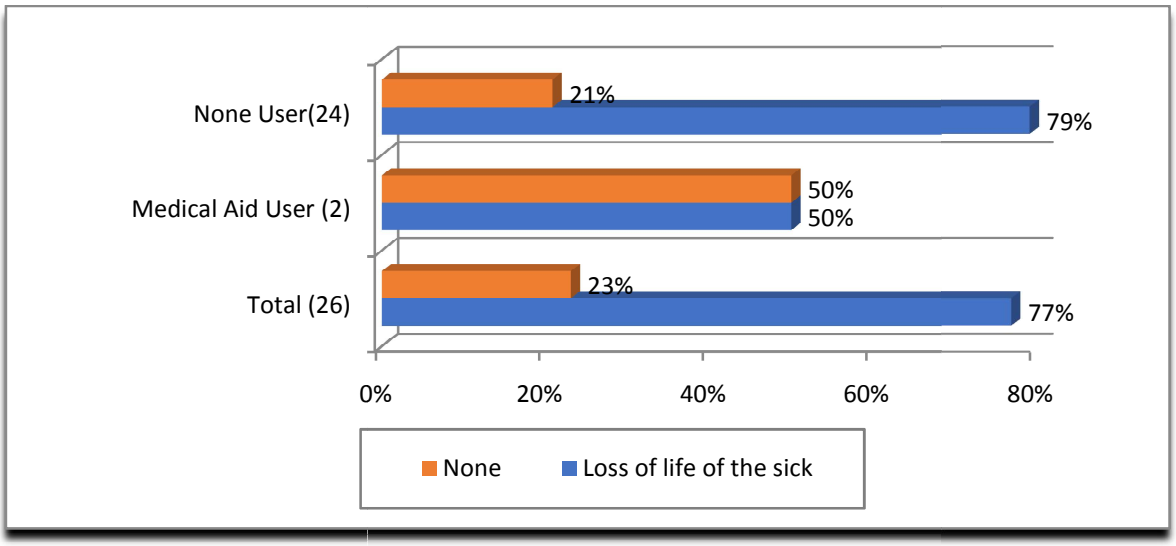
Figure 15: Impact of meeting medical bills



On overall, the informal sector seems contented as the effect of meeting medical bills did not have a negative effect on the sector as shown by 81% on no major impact. This was also concurred by respondents who did not have medical aid cover. An insignificant proportion of respondents discontinued their children's education due to the effect of meeting medical bills, but again this is coming from a small base.

5 The effect of failure to pay medical bills

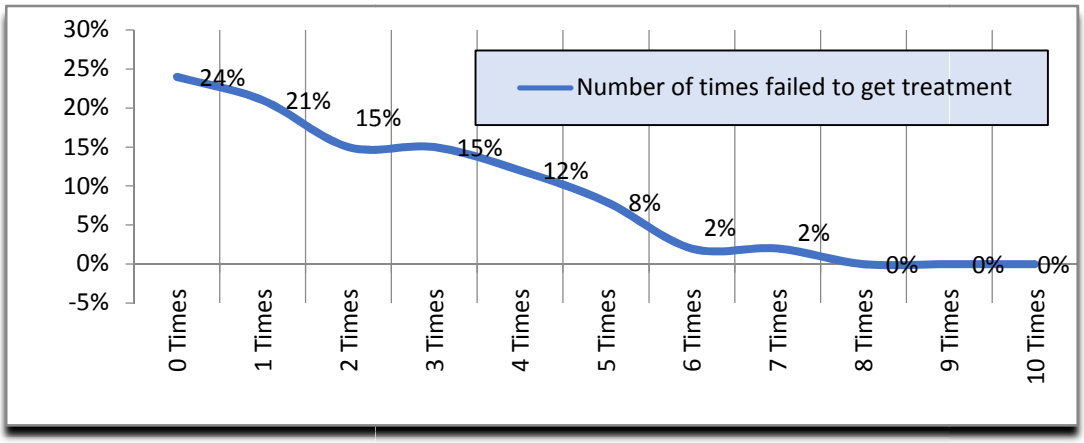
Fig 17: Worst case scenario of failing to pay medical bills



Loss of life was the worst scenario that happened after failure to pay medical bills. 23%. However, this was faced by respondents who did not have medical aid insurance cover.

Prevalence of failed healthcare services

Fig 18: Number of times failing to access healthcare out 10



Respondents were also asked to rate the number of times out of 10 that they failed to get adequate or the level of recommended healthcare service due to financing challenges. Overall, the majority of respondents accessed healthcare services on the first attempt. However, there were exceptional cases were a respondent had to visit a healthcare service centre more than 2 times. The average number was 2 times out of 10 visits. The chart above highlights the number of times respondent failed to get healthcare service due to financing challenges.

Frequency of failure to access healthcare

Tables 5: Average number of times respondent failed to access service from a healthcare institution

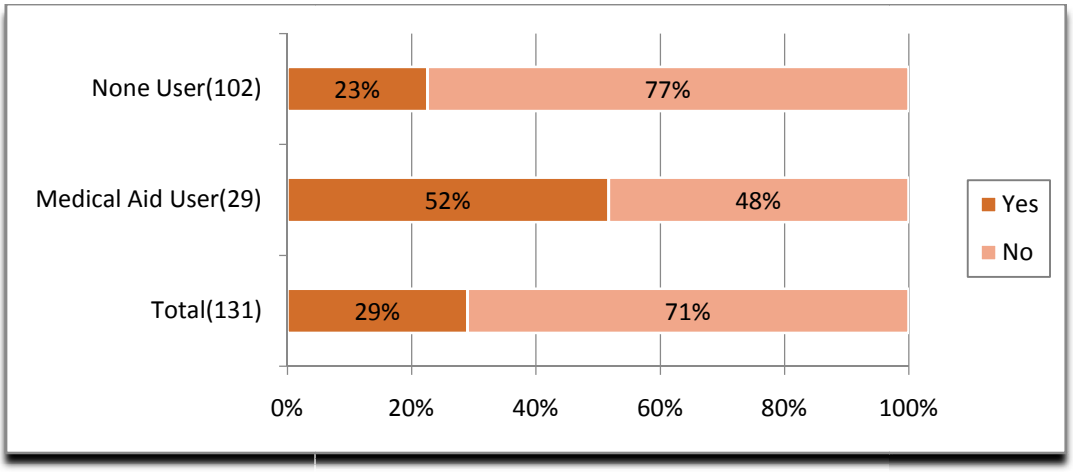
		MEDICAL AID INSURANCE	
Healthcare Institution	Total(131)	Medical Aid User(29)	None User(102)
Poly Clinics	0	0	0
Government & Mission hospitals	1	0	1
Private Hospitals	2	0	2
Maternity benefits	0	0	0
GP visits	0	0	0
Dental	0	0	1
Opticians	0	0	1
Other specialist visits	1	0	1

Medical drugs	2	1	2
Foreign treatment	0	1	0

Respondents were also tasked to rate the number of times out of 10 that they failed to access healthcare services due to lack of funding. The table above shows the average number attempts out of 10. On overall, respondents made an average of 2 attempts at Private hospitals and Medical drugs, while 1 attempt was made at Government hospital and Other specialist visits. Number represents health service that was accessed on the first attempt. A further analysis by medical aid usage, showed that it was the non-medical aid policy holders who made an average of 2 attempts while failing to access healthcare due to lack of funding.

Prevalence of chronic diseases in the informal sector

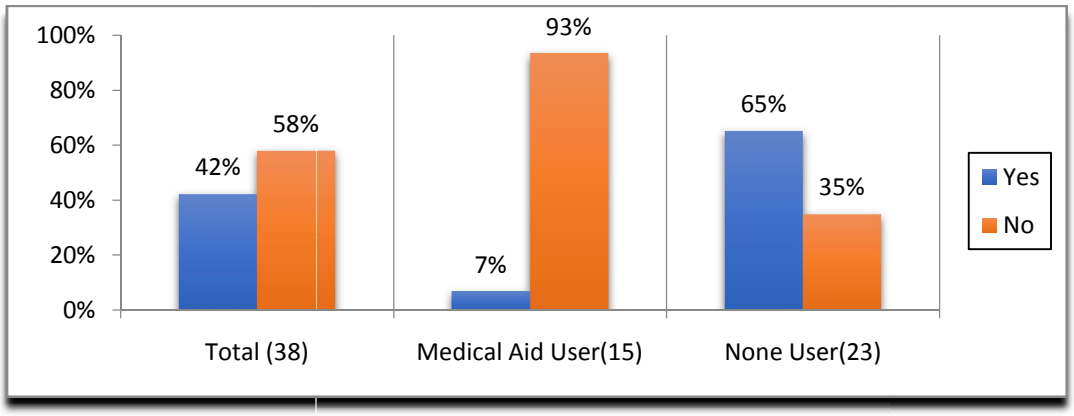
Fig 19: Incidence of a chronic disease in the household



The majority of respondents did not have a chronically ill person that they were financially responsible for. A cross analysis by medical aid usage revealed that 52% of respondents living with such a person had a medical aid insurance, but again coming from a small proportion representing 22% of the total sample size.

Assessment of the impact of taking care of a chronically ill person on the informal sector

Fig 20: Assessment of the impact of taking care of a chronically ill person on the informal sector



The survey also sort to establish the impact of taking care of a chronically ill person on members operating in the informal sector. 58% of respondents living with a chronically ill person indicated that they were not negatively affected in their ability to take care of such a person. However, it was the medical aid policy holders who were not negatively affected. The majority of non-medical aid policy holders reported being negatively affected.

The impact of taking care of the chronically ill on the informal sector

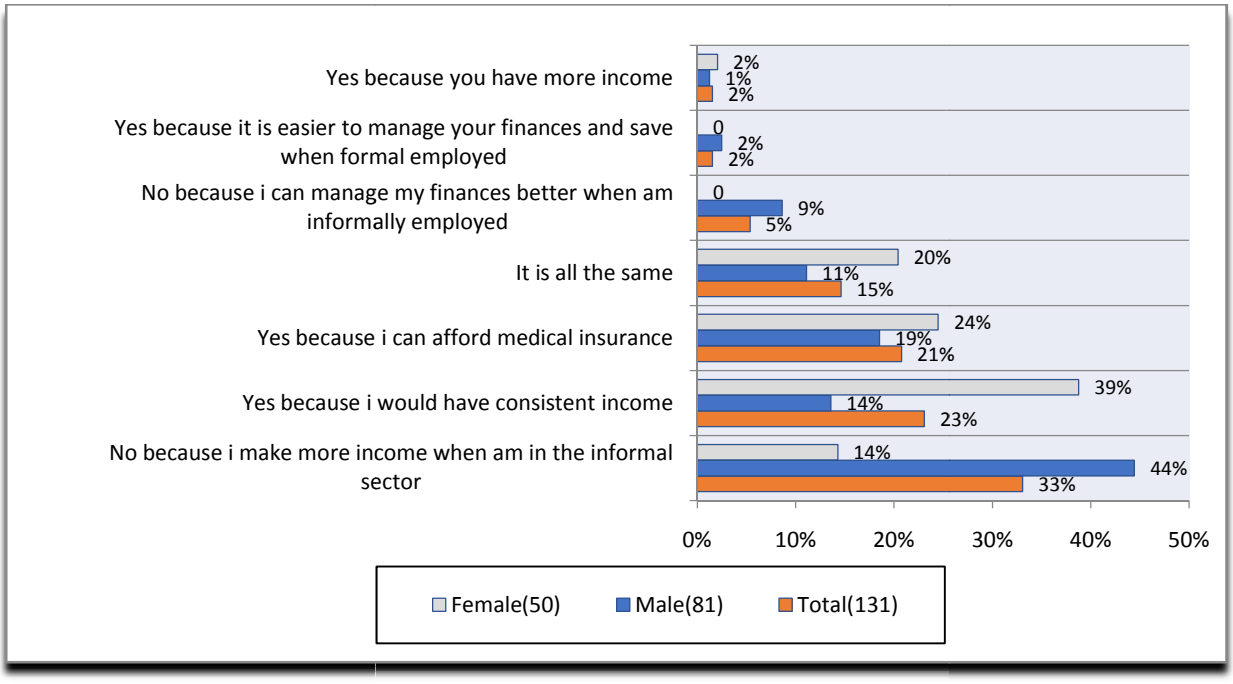
Table 6: Measuring the impact of taking care of the chronically ill person on the informal sector

		TYPE OF BUSINESS				MEDICAL AID USAGE	
	Total (16)	Buying & Selling (7)	Vending (5)	Manufacturing (3)	Catering (1)	Medical Aid User(1)	None User (15)
Inconsistent revenues	75%	71%	80%	100%		100%	73%
Inadequate revenues	25%	29%	20%		100%		27%

Respondents who were negatively affected by taking care of the chronically ill person/s were further probed to ascertain the effect of the impact on the sector. However, the majority of respondents pointed out inconsistent revenues as the major effect while 25% were faced with inadequate revenues. Inconsistent revenues were reported across the major business types that were sampled. Again, the major effect was felt by non-medical aid policy holders.

A comparison in meeting medical bills

Fig 21: A comparison of being in the formal employment or in the informal sector on meeting medical bills



The majority of respondents concurred that they were actually making more money in the informal sector than they were when formally employed. However, other respondents felt that they were going to be better placed to meet medical bills if they were formally employed. These respondents pointed out that formal employment was going to guarantee them with a consistent income and also to accord them an opportunity to take up a medical insurance policy. The majority of males were happy with the money they were making in the in formal sector as they were able to meet their medical bills. It was their female counterparts who were driven by the sense of being in a comfort zone, i.e. being able to have a consistent income and being able to take up a medical insurance policy.

Table 7: A comparing of business types on their ability to sustain the shareholders

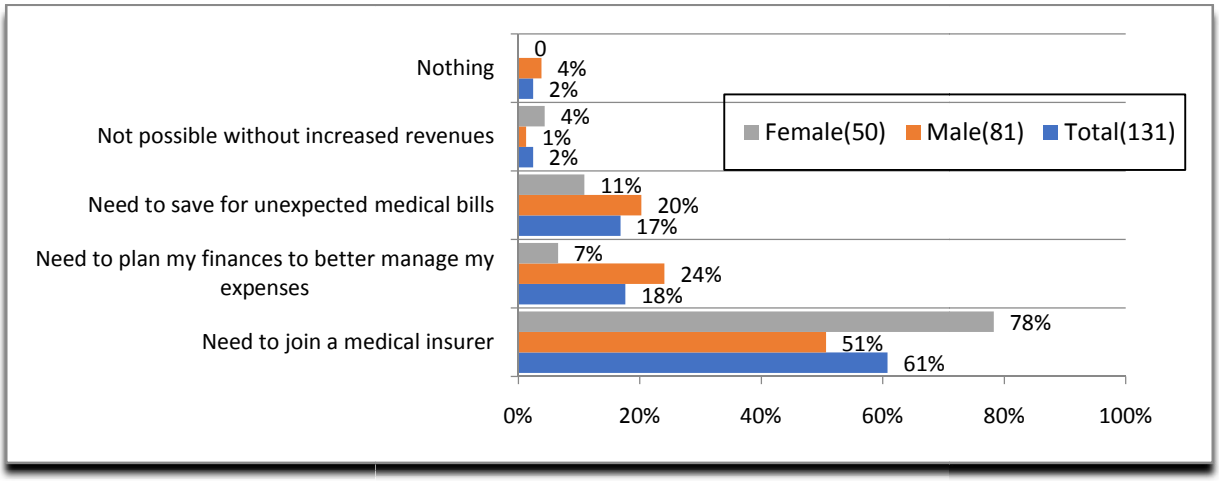
		TYPE OF BUSINESS						
	Total (131)	Buying & Selling (33)	Vending (26)	Manufacturing (49)	Catering (3)	Carpentry (14)	Secretarial Services (3)	Welding (3)
No because i make more income when am in the informal sector	33%	44%	4%	35%	33%	64%		33%
Yes because i would have consistent income	23%	22%	46%	12%	67%	7%	33%	33%
Yes because i can afford medical insurance	21%	13%	31%	24%		7%	33%	33%
It is all the same	15%	22%	15%	12%		7%	33%	
No because i can manage my finances better when am informally employed	5%			12%		7%		
Yes because it is easier to manage your finances and save when formal employed	2%			2%		7%		
Yes because you have more	2%		4%	2%				

income								

A further sector analysis revealed that respondents in the Buying & Selling businesses, Manufacturing and Carpentry, were making lots of money hence were better placed to meet their medical bills. It was those respondents in micro enterprises such as Vending and Catering who were not excelling well in their businesses such that they were not able to meet their medical bills. The table above shows a sector analysis on the types of businesses and their ability to sustain the business owners.

Suggestions on ways to improve the ability to meet medical bills

Fig 22: Suggestions on how to improve the ability to meet medical bills



A free question was thrown on respondents to get their insights on what aught to be done to improve their ability to meet their medical bills at the current income revenue levels. The majority of respondents suggested the idea of joining medical insurance. Females expressed the enthusiasm to take up medical insurance in contrast to males who took a tough stance

against the uptake of medical insurance services by suggesting the need to plan their finances better and the need to save money for emergencies.

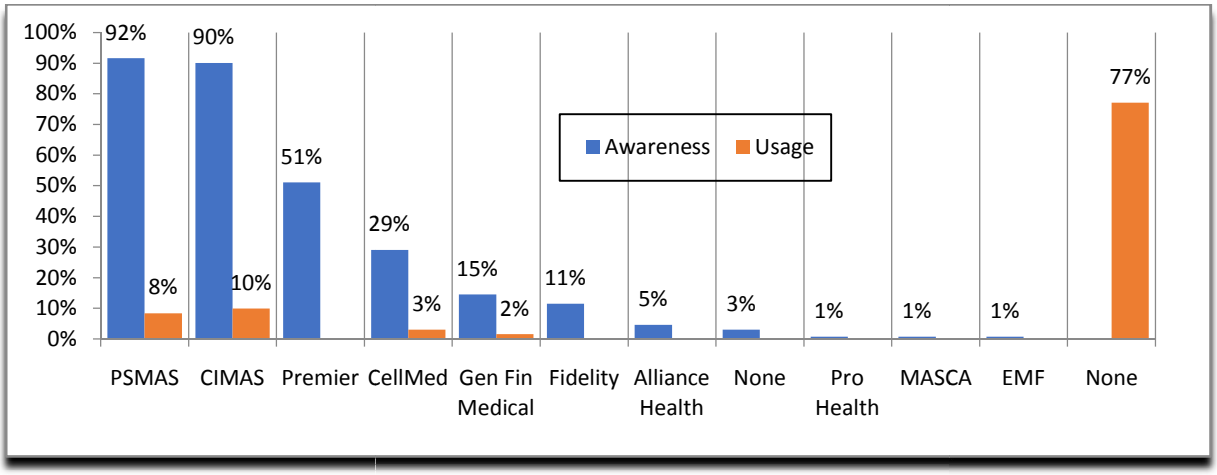
Table 8: Suggestions on how to improve the ability to meet medical bills by Type of Business

		TYPE OF BUSINESS						
	Total (131)	Buying & Selling (33)	Vending (26)	Manufacturing (49)	Catering (3)	Carpentry (14)	Secretarial Services (3)	Welding (3)
Need to join a medical insurer	61%	43%	85%	56%	67%	57%	100%	67%
Need to plan my finances to better manage my expenses	18%	32%		25%		7%		
Need to save for unexpected medical bills	17%	21%	12%	13%	33%	29%		33%
Not possible without increased revenues	2%	4%	4%	2%				
Nothing	2%			4%		7%		

A cross analysis by sector established that all business types surveyed were keen to join medical aid insurer as a way and means to improve their ability to meet medical bills at their current revenue levels. The table above highlights some of the suggestions that were given by type of business.

Awareness and usage of Medical Aid Institutions by the informal sector in Zimbabwe

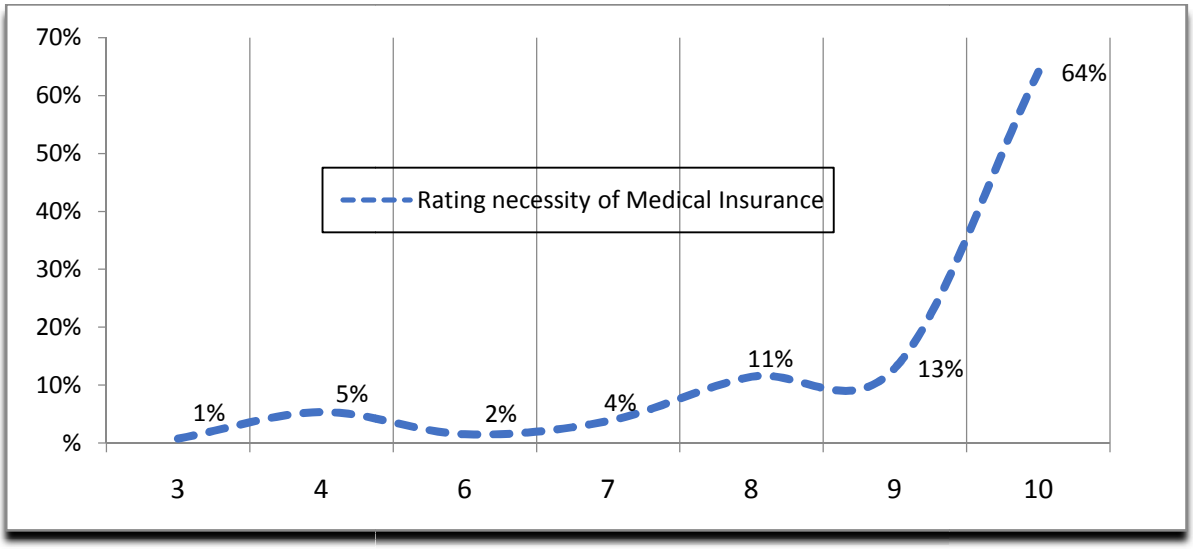
Fig 23: Awareness and usage of Medical Aid institutions in Zimbabwe



PSMASand CIMAS had the highest awareness levels followed by Premier. Other numerous medical aid institutions emerged but with very low awareness levels. It was disturbing to note that the uptake of medical aid services was very low in the informal sector in Zimbabwe. Most respondents sampled in the sector were not using medical aid. A very small proportion of the sample was using CIMAS and PSMAS.

Necessity of medical insurance in the informal sector

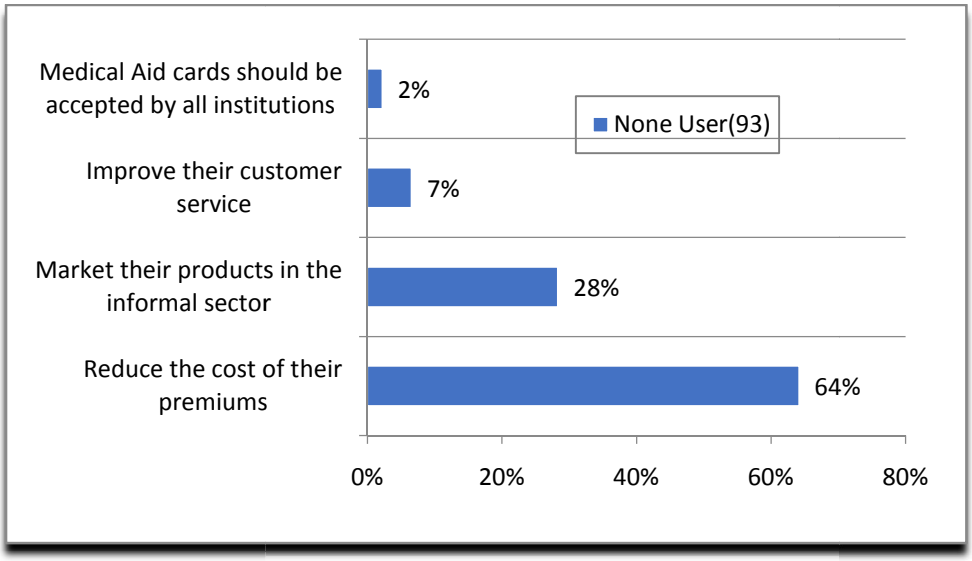
Fig 24: *Rating necessity of medical insurance*



Respondents were asked to rate whether medical aid insurance was a necessity on a 10 point scale raging from 1 to 10, where 1 was strongly disagree and 10 strongly agree. It emerged that 64% of the sample rated medical aid as a necessity though the uptake level was very low in the informal sector.

Ways to increase the uptake of medical insurance in the informal sector

Fig 25: Reasons contributing to the low uptake of medical insurance in the informal sector

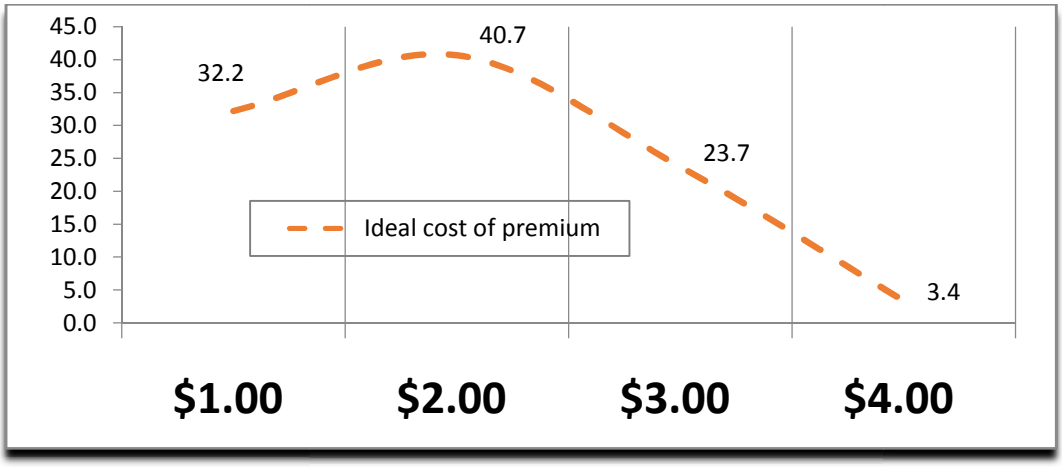


None users of medical aid insurance were asked why they were not eager to uptake the medical aid insurance services. It emerged that cost of premiums was the major deterrent

factor. Awareness creation and promotion were also cited by the sector as the major factors contributing to the low uptake of medical aid services in Zimbabwe.

Average cost of medical aid premium in the informal sector

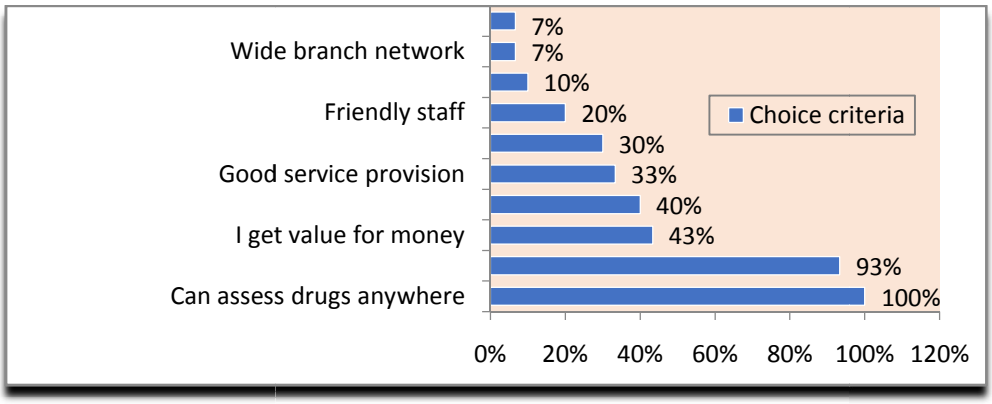
Fig 26: Suggested cost of medical aid premium



Respondents who felt that the cost of premiums was restrictive were asked to suggest an ideal cost. Majority of respondents suggested $2.00 as the ideal cost for a premium. while 32% of the respondents suggested $1.00. The graph above shows the suggested cost of a premium.

Critical choice factors in medical insurance market

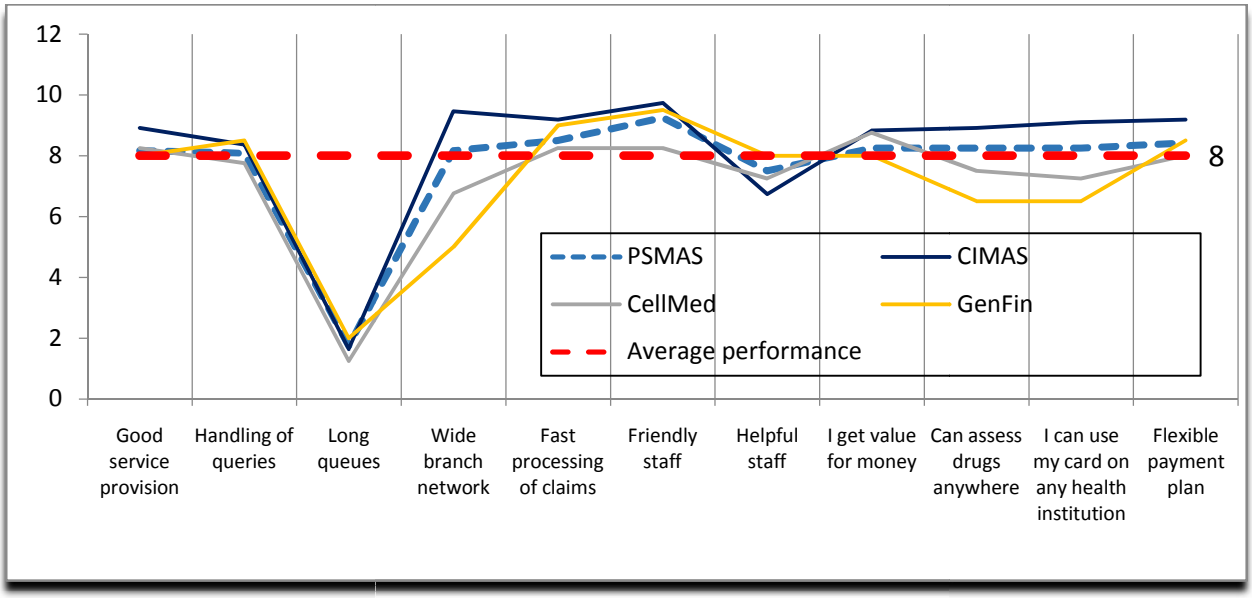
Fig 27: Choice criteria to select medical aid institutions



Medical aid insurance policy holders were asked to give the choice criteria that they used to select the medical aid institutions that they used. The ability to access drugs anywhere was cited as the major key market driver followed by the use of the medical aid card on any healthcare institution. Other numerous choice criteria were suggested as highlighted on the above graph.

Rating performance of Medical Aid service providers

Fig 28: Rating performance of medical aid insurers on critical choice factors



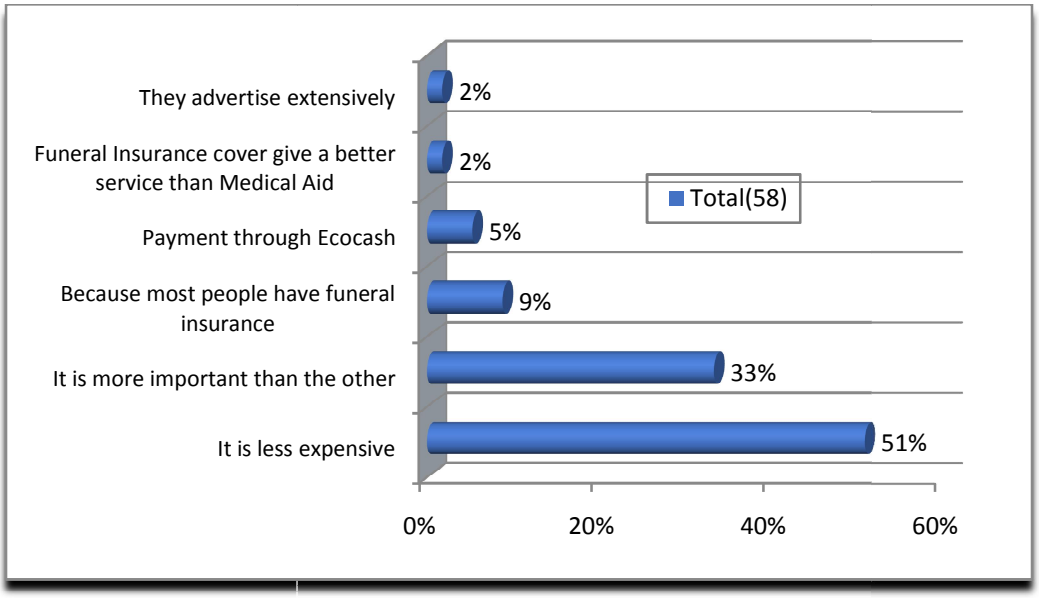
Medical aid policy holder were again asked to rate the performance of their medical aid insurers on critical choice factors using a scale of 1 to 10, where 1 was strongly disagree and 10 strongly agree. An average score was computed to represent an average performance on critical choice factors. This would mean that, if a medical aid institution was rated above average that would imply negative performance on the particular attribute being rated. However this is not always true as it depends on the way the attribute way phrased, for example see the attribute LONG QUEUES above.

CIMAS performed exceptionally well on most critical choice factors except on helpful staff. PSMAS also did well but it was again pulled down by poor performance on helpful staff attribute. CellMed was driven by value for money attribute, friendly staff and fast processing

of claims. GenFin was driven by the attribute flexible payment plan, friendly staff and fast processing of claims.

Reasons for subscribing to medical insurance

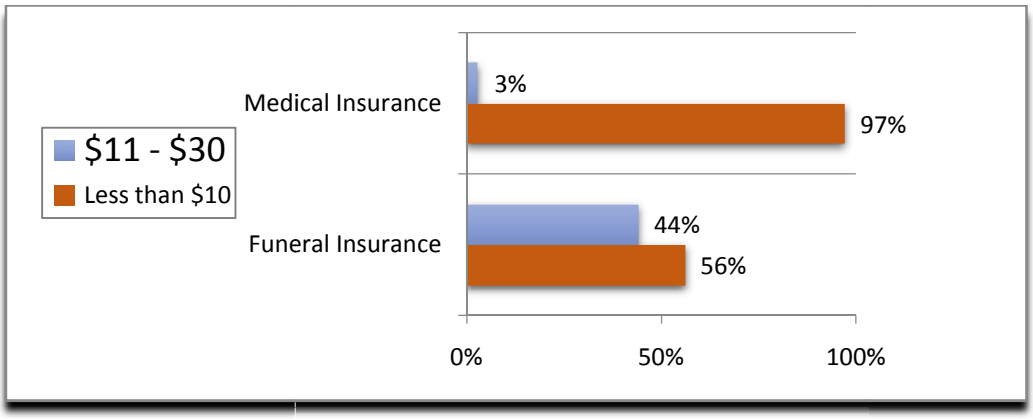
Fig 29: Reasons for having funeral insurance without a medical insurance



The use of different financial service products was also evaluated. Respondents who had funeral insurance were asked reasons for not having medical aid insurance.It emerged that most respondents felt that funeral insurance was less expensive compared to medical aid insurance. Again, 33% felt that funeral insurance was more important than medical aid. The graph above highlights some of the reasons that were passed though.

Perceived ideal cost of insurances

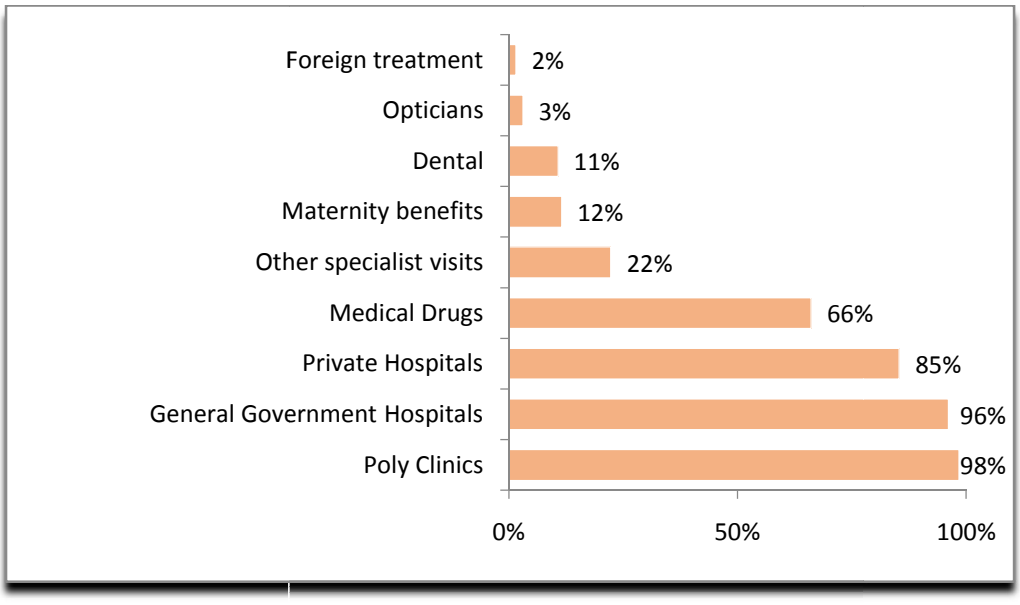
Fig 30: Cost of Funeral insurance and Medical insurance per month



On overall, funeral insurance users were paid less than $10 per month, while 44% reported paying between $11 and $30. However the cost was $1.44. Majority of medical aid insurance users paid 97%.

Benefits expected from ideal market price

Fig 31: Expected benefits from less than $10 monthly contribution

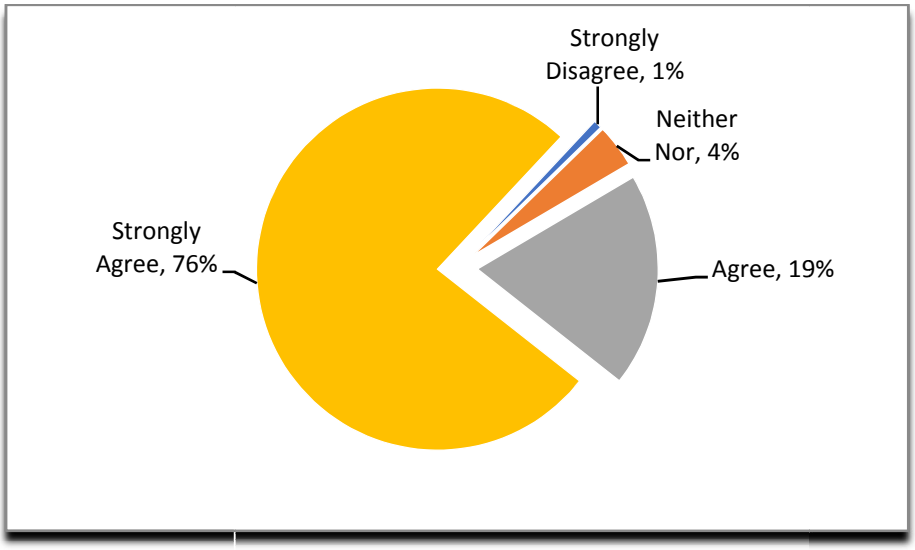


97% of medical aid users who suggested paying less than $10 per month were asked on the type of benefits they would expect to get. The majority of them expected to get Poly Clinic,

General Government hospital, Private Hospitals and Medical drugs from less $10 monthly contribution.

Perception of the of national health insurance by the informal sector

Fig 32: Rating the Government's responsiveness to solving healthcare challenges

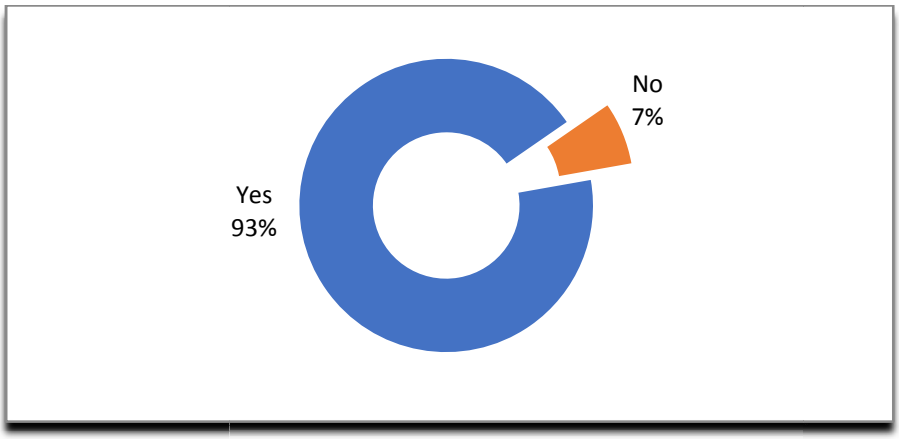


Respondents were asked to rate the idea of Government to setting up a national health insurance that gives insurers access to facilities like Government hospitals, Poly clinics and Mission hospitals. They were required to rate the idea as a responsive approach to solving their challenges in accessing healthcare services on a 5 point scale, where 1 was strongly agree and 5 being strongly agree.

76% of the respondent strongly agreed to the idea, while 19% just agree on the idea as a responsive approach to solving their challenges in accessing healthcare.

Market readiness to the national health insurance

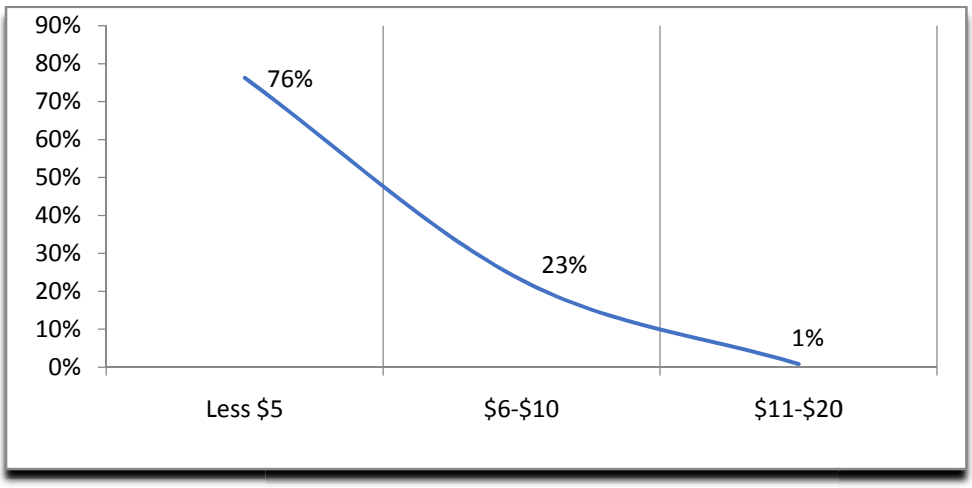
Fig 33: *Whether people would be will to contribute to the Government's initiative*



The majority of respondents expressed their willingness to contribute to the Government's initiative of setting up a national health insurance

Fig 34: Ideal cost for the national health insurance policy

Fig 35: Suggested monthly contribution per adult



Respondents who agreed to subscribe to the Government's initiate of setting up a national health insurance policy were asked to suggest the approximate contribution they were willing to pay for an adult person per month. 76% suggested contributing less than $5 to the national health insurance policy per month for an adult person.

Other ways of funding the national health insurance

An insignificant number of people who disagreed to the idea of a national health insurance policy suggested that it was the Government's responsibility to fund the health policythrough taxes.

1.12. Statistical Analysis

Medical insurance cover and ability to adequately meet medical bills

Chi-Square ($\chi 2$) test was used to determine at 5% significance level any association between the current usage of medical aid and failure to get adequate or the recommended healthcare due to lack of finance.

However, a Chi-Square ($\chi 2$) test showed that there is a significant difference between the current usage of medical aid and failure to get adequate or the recommended healthcare due to lack of finance.

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
D5 Usage of medical Aid * Q6 Have you failed to get adequate or the recommended healthcare due to lack of finance?	131	100.0%	0	0.0%	131	100.0%

Notes: NS=not significant, *= p<0.05, **: p<0.01, ***=p<0.001

D5 Usage of medical Aid * Q6 Have you failed to get adequate or the recommended healthcare due to lack of finance? Crosstabulation

Count

		Q6 Have you failed to get adequate or the recommended healthcare due to lack of finance?		Total
		Yes	No	
D5 Usage of medical Aid	Medical Aid User	17	12	29
	None User	82	20	102
Total		99	32	131

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.798[a]	1	.016		
Continuity Correction[b]	4.678	1	.031		
Likelihood Ratio	5.362	1	.021		
Fisher's Exact Test				.026	.018
Linear-by-Linear Association	5.753	1	.016		
N of Valid Cases	131				

Medical insurance cover and its relation to cover chronically ill patience within the informal sector

Chi-Square ($\chi 2$) test was used to determine at 5% significance level any association between the use of medical aid and the negative impact to take care of a chronically ill person.

However, a Chi-Square ($\chi 2$) test showed that there is a no significant difference between the use of medical aid and the negative impact to take care of a chronically ill person.

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
D5 Usage of medical Aid * Has the fact that you are in the informal sector negatively impacted on your ability to take care of this person?	38	100.0%	0	0.0%	38	100.0%

Notes: NS=not significant, *= p<0.05, **: p<0.01, ***=p<0.001

D5 Usage of medical Aid * Has the fact that you are in the informal sector negatively impacted on your ability to take care of this person? Crosstabulation

		Has the fact that you are in the informal sector negatively impacted on your ability to take care of this person?		Total
		Yes	No	
D5 Usage of medical Aid	Medical Aid User	1	14	15
	None User	15	8	23
Total		16	22	38

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	12.768[a]	1	.000		
Continuity Correction	10.479	1	.001		
Likelihood Ratio	14.660	1	.000		
Fisher's Exact Test				.001	.000
Linear-by-Linear Association	12.432	1	.000		
N of Valid Cases	38				

Necessity and take up of medical insurance in the informal sector

Chi-Square ($\chi 2$) test was used to determine at 5% significance level any association between the use of medical aid and whether medical aid was viewed as a necessity. However, a Chi-Square ($\chi 2$) test showed that there is a significant difference between the use of medical aid and whether medical aid was viewed as a necessity.

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
D5 Usage of medical Aid * Q15 Do you agree that medical insurance is a necessity?	131	100.0%	0	0.0%	131	100.0%

Notes: NS=not significant, *= p<0.05, **: p<0.01, ***=p<0.001

D5 Usage of medical Aid * Q15 Do you agree that medical insurance is a necessity? Crosstabulation

Count

		Q15 Do you agree that medical insurance is a necessity?		Total
		Yes	No	
D5 Usage of medical Aid	Medical Aid User	29	0	29
	None User	94	8	102
Total		123	8	131

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	2.422[a]	1	.120		
Continuity Correction[b]	1.248	1	.264		
Likelihood Ratio	4.149	1	.042		
Fisher's Exact Test				.198	.127
Linear-by-Linear Association	2.404	1	.121		
N of Valid Cases	131				

1.13. HYPOTHESIS

H1: The growth of the informal sector has negatively impacted the ability to meet medical bills for those that make the transition from the formal to the informal sector as mediated by the reduced medical insurance cover.

Results have shown that the transition from the informal sector has reduced the take-up of medical insurance. There is a 22% take-up of medical insurance against a 66% take up of funeral insurance and 65% for bank accounts (table 2). However, the study has unveiled that the low take-up of medical cover did not in fact negatively influence the ability of players in the informal sector to meet their medical bills as the income levels improved as one made a transition from the formal to the informal economy.

4. CHAPTER 5 – CONCLUSION

1.14. Introduction

The chapter shares insights that the researcher obtained in conducting the study. An analysis on whether the research aims and objectives were attained will be made by analysing the research objectives against the research outcomes. Ultimately the key aim of the study is to make a contribution to the pool of knowledge in respect to the informal sector and their healthcare financing needs. In addition, suggested solutions to address the problem statement will bethat have the capacity to foster an improvement in the livelihood and wellbeing of those in the informal sector.

1.15. Research Aim and Objectives

The main objective of the study was to determine the level of impact that the growing informal sector has had on the ability of the informal sector participants to adequately meet their medical bills and the level of health insurance cover within the sector. The study established that the take-up of the health insurance was low within the informal sector. However, the study established that the lack of health insurance for the majority of the individuals did not have a significant impact on the ability to meet medical bills.

i. To determine the impact that the transition of moving from the formal economy into the informal economy has had on the informal economy participantsability to afford medical insurance.

- The objective was met, the researcher uncovered that participants in the informal sector are earning relatively more than what they were within the formal sector.

ii. To assess the appetite for and the level of take-up of health insurance cover.

- Literature review uncovered that the level of healthcare insurance was low within the informal sector, a position which was cemented by the research

iii. To identify the drivers of, and barriers to the take-up of medical insurance within the informal sector

- The objective was met, the study uncovered that the level of medical insurance cover is relatively low within the informal sector.

iv. To establish the nature and level of formal healthcare institutions that informal sector players have greater access to and those that they have a lesser level of access to.

- A trend was uncovered that suggest a particular level of access of healthcare institutions within the informal sector.

Hypothesis:

H1: The growth of the informal sector has negatively impacted the ability to meet medical bills for those that make the transition from the formal to the informal sector as mediated by the reduced medical insurance cover.

The above hypothesis was not confirmed as true. The study uncovered that indeed medical insurance cover reduces when one makes a transition into the informal sector, however this has not negatively mediated the ability of the informal sector participants. This has been the case mainly due to the ability of players within the informal sector to make relatively more income than the point when they were formally employed. The researcher also discovered that players within the informal sector usually seek medical services from municipal and Government medical facilities which are relatively cheaper than private facilities.

5.3 Conclusion and key findings

The researcher concludes the following in as far as the matter under study is concerned:

- The informal sector comprises of both men and women who undertake commercial enterprises
- The majority of individuals who make a transition from the formal to informal sector have the ability to influence the level of their earnings
- Players in the informal sector that venture into manufacturing make relatively more earnings
- Individuals in the informal sector are prone to use the Government hospitals and municipal healthcare facilities as opposed to private healthcare facilities
- Awareness of medical insurance within the informal sector is high however take-up is low
- Persons in the informal sector mainly meet their medical bills by paying for them at the time of need
- The major challenge that has been sited in the informal sector, in as far as meeting medical bills is the inconsistency of revenue

1.16. Answer to research questions Delete this section. Not making sense at all.

- What is the extent of impact that the transition of moving from the formal economy into the informal economy has had on the informal economy participants' to afford medical insurance?

  Participants were earning more as a result their ability to afford would have been enhanced.

- What is the appetite for and the level of take-up of health insurance cover?

The appetite to take-up medical insurance cover is rather high as individuals in the informal sector believed that the medical insurance cover is important. However, take-up was low due to aspects which included product design which did not specifically address their needs. In addition inconsistent revenues meant that individuals in the informal sector would find it difficult to make consistent subscriptions.

- What are the drivers of, and barriers to the take-up of medical insurance within the informal sector?

The major barriers were cited as the cost of medical cover, low acceptability insome healthcare facilities, the magnitude of short payments and inconsistencies of revenues streams in the informal sector

- What is nature and level of formal healthcare institutions that informal sector players have greater access to and those that they have a lesser level of access to?
    - The majority of players in the informal sector access healthcare services from Government Hospitals, Municipal clinics and Pharmacies.
    - Access to private hospitals, specialists and foreign treatment was limited

1.17. Contributions

5.4.1 Theoretical contribution

The research made theoretical contributions in respect to the informal sector, financial inclusion and healthcare access within the informal sector.

5.4.2 Methodological Contribution

The research made methodological contributions in as far as the study of the informal sector is concerned.

5.4.3 Empirical Contribution

The study has made empirical contribution to the informal sector, financial inclusion and healthcare access in Zimbabwe

1.18. Policy Recommendations

National Health Insurance (NHI) – There is a gap in the informal sector that can be filled by establishing a National Health insurance. There is appetite to take up the product within the sector and it comes in environment were the majority of the population within the informal sector are using Government facilities. Thus NHI, will help raise the necessary funding to further develop and equip Government healthcare institutions. It also covers the individuals in instances where revenue streams are not consistent.

Capacity Building in Government Healthcare facilities – The majority of the population resort to Government institutions for medical assistance, as such investing in building the optimal capacity in these facilities is most ideal.

Financial education- There is need to embark on developing the financial education especially in respect to smoothening of revenue through savings and insurance. The aspect of revenue inconsistencies has been a major concern. There is need to impart knowledge on how to manage finances to avoid financial stress in times where revenues are low. There is also need to come up with various financial programs that addresses social security at the time of retirement.

1.19. Managerial recommendations

Strategic business partnerships to foster financial inclusion – The level of penetration for various financial services within the informal sector is at different levels. For instances banking services, mobile money and funeral cover have made significant strides within the

informal sector. Thus, for medical insurance cover, it can be beneficial to ride on partners who have already made huge strides in as far as capturing the informal market is concerned.

Medical insurers should develop tailor made products for the informal sector- There is need to offer products that best suits the structures within the informal sector. Major considerations in design medical insurance products for the informal sector should consider the pricing, the payments pattern (revenues in the sector are not consistent this should be considered), the benefits/ level of cover is also key (considerations of the major healthcare facilities that are used within this market should be considered)

1.20. Generalisation of Findings

The findings can be generalised to the formal sectors within Zimbabwe's informal sector. The sample was a fair representation of Zimbabwe's informal sector and the conditions that affect the Zimbabwean economy which has given rise to the informal sector are universal throughout the country.

There is need to make a further study on the relations between industrial capacity utilisation and earning levels within the informal sector. This can be instrumental in making inferences of the findings of this study to economies with various levels of industrial activity

1.21. Areas of further research

Further research can be carried out in the following areas:

- How to transform informal trade into fully fledged commercial formal entities
- How to consolidate the informal sector into the nation's tax base, especially in as far as income tax is concerned
- How to ensure social security for players in the informal sector
- Does the growth of the informal sector promote the eradication of poverty?
- Taxation and the informal sector

1.22. Research limitations

The research main limitations included:

- The study was limited to Harare
- Due to time limitations of the study, the research was carried over a short period of time.
- Participants may withhold some information due to lack of trust emanating from the fear of regulatory authorities like ZIMRA

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(Article date – 04 June 2018) Website accessed – 30 August 2018