Tanzania insights

The right to health and access to universal health coverage for older people

Global AgeWatch
Data and analysis on population ageing

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The right to health and access to universal health coverage for older people

Older person in Kibondo, Tanzania

Contents

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Abbreviations

CHF	Community Health Fund
COPD	chronic obstructive pulmonary disease
CSO	civil society organisation
CVD	cardiovascular disease
DALY	disability-adjusted life year
DHS	Demographic and Health Surveys
HSSP IV	Health Sector Strategic Plan IV
IHI	Ifakara Health Institute
LMICs	low- and middle-income countries
MDG	Millennium Development Goal
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
NBS	National Bureau of Statistics
NCD	non-communicable disease
NHIF	National Health Insurance Fund
NSSF	National Social Security Fund
SDG	Sustainable Development Goal
SNHI	Single National Health Insurance
SPA	Service Provision Assessment Survey
STEPS	World Health Organization STEPwise approach to surveillance
Tshs	Tanzanian shilling
UHC	universal health coverage
WHO	World Health Organization

Executive summary

In Tanzania, the proportion of disease attributed to non-communicable diseases (NCDs) doubled between 1990 and 2015; and in 2016 NCDs were estimated to account for just over one-third of all deaths. Predictably, the literature shows that the impact of NCDs in Tanzania is disproportionately high among people aged 50 and older. In the same way that the benefits of overall economic growth in Tanzania have not been spread evenly across sociodemographic and age groups, health status and access to healthcare have also been unevenly distributed. Older people were found to experience formidable barriers related to availability, accessibility and acceptability of good-quality healthcare services. This is despite the government's long history of political commitment to healthcare for its citizens, which stretches back to Tanzania's independence in the 1960s, and policies and recent reforms, all of which are notable.

Older people from active ageing clubs exercising in Kilosa, Tanzania

The health system in Tanzania needs to adapt to these epidemiological changes and address inequalities in access to ensure older people's right to health is realised. Access to universal health coverage (UHC), a global priority under the United Nations 2030 Agenda and the Sustainable Development Goals (SDGs), is a key part of the realignment of health systems required to ensure older people's right to health.

Tanzania Insights is a companion to the Global AgeWatch Insights report, *The right to health for older people, the right to be counted* (globalagewatch.org). It assesses the extent to which older people can realise their right to health and are included in UHC efforts in Tanzania. The findings are a result of literature and data reviews, as well as in-depth interviews and focus group discussions with older people and stakeholders in Tanzania.

Health insurance coverage

Health insurance schemes, either private or social, are available to a small proportion of older people, and these are complemented by a system of exemptions and waivers intended to ensure older people and certain other groups have access to affordable health services. Under a fee exemption scheme, people aged 60 and over, pregnant women and children under age five are entitled to free health consultations, treatment and medication in public health facilities. While recent government health reforms have seen the introduction of a cost-sharing scheme allowing health service providers to recover some of their costs from patients, some groups, including older people, enjoy an exemption. Additionally, there is a waiver system in operation. People living in poverty (regardless of their age) are entitled to fee waivers for health services and additional benefits, such as transport and accommodation for referrals. In practice, this should mean, for example, that a person aged 50, who is living below the poverty line, will receive a waiver for

health service fees and will be provided assistance if she or he has to travel to a health facility. A person aged 65 living above the poverty line, on the other hand, would be entitled to an exemption from health service fees, but not waivers for additional benefits such as transport and accommodation.

However, implementing exemptions and waivers has been difficult for healthcare workers. For instance, the absence of a birth certificate, which is common among the older population, makes it difficult to determine a person's age and whether they are eligible for exemptions. Equally, poverty status can also be difficult to determine. There are ongoing concerns that people who are eligible for waivers or exemptions are unaware of their entitlements. Older people report that there are high levels of bureaucracy involved in procuring an exemption card or recommendation letters for waivers. They also report stigma and discrimination when seeking exemptions, especially in healthcare institutions where providers are not motivated to administer the exemptions, or misunderstand the guidelines for exemptions.

The exemption policy should include all chronic illnesses, but healthcare providers report that the services are not all free of charge. This is the case with many medicines, which are often unavailable, and when they are, recipients may be given just a half or quarter of the prescribed dose. Many older people have reported dropping out of treatment due to the distance they have to travel and to a lack of medicines. In the latter case, they choose to buy medicines from nearby drug shops, which they have to pay for out of pocket. The lack of essential drugs at affordable prices is a particularly widespread problem, especially at primary-level facilities such as dispensaries.

Other health system reforms made through Structural Adjustment Programmes introduced alternative health financing systems. This includes the compulsory health insurance or healthcare prepayment arrangements schemes via the National Health Insurance Fund (NHIF), targeting civil/public sector servants. It also includes the National Social Security Fund (NSSF), which offers health insurance benefits to employees in the formal private sector, and the Community Health Fund (CHF) scheme, mainly targeting those employed in the informal sector. There are some voluntary insurance systems run by private-sector entities. The number of smaller (micro) insurance schemes has increased under the umbrella of the Tanzania Network of Community Health Funds, although few people seem to register with those insurers.

Overall these schemes benefit only a small proportion of the population (8 per cent). Arrangements are being made to establish the joint national social health security scheme, known as the Single National Health Insurance (SNHI) Fund, to offer high-quality health coverage to all people regardless of their occupational and demographic differences. The vision is that this will widen the risk-pooling potential of the respective health financing strategy and overcome challenges faced by previous schemes. While details of the SNHI Fund are yet to be published, it is intended to be mandatory, which should encourage large numbers of people to join and hence reduce the enrolment fee.

Additionally, there are significant inequalities in access to insurance schemes. The NHIF, for example, which covers the majority of insured people in Tanzania, is available to public employees and some formal private-sector employees and their dependents. As a result, there are higher levels of coverage among men than women, people under age 60, those in urban compared with rural areas and those with higher education. The regional and other variations in people registered under formal insurance schemes is a crucial point for policy-makers to address.

Both health insurance schemes and the system of exemptions and waivers are struggling to provide sufficient health protection for older people, and there is a pressing need for the SNHI to be approved and rolled out effectively.

Older people's access to NCD services

Findings show that older people living with certain NCD conditions do not have full access to the services they need. For example, nearly

two-thirds of people aged 50-64 have never been screened for high blood pressure, with older men less likely to have been tested than older women. The majority (87 per cent) of people aged 50-64 have never had their blood glucose tested. Qualitative evidence collected in Dar es Salaam sheds light on some of the barriers that older people face in access to services, such as lack of adequate income, poor health provision at lower-level facilities and lack of respect from health staff. The same is true in the rest of the country, and particularly in rural areas, where the majority of older people live and where accessibility is hampered by economic factors and poor infrastructure.

The findings also highlight inequalities within the older population in relation to access to health services and health coverage. Older people in rural areas and those with no education are more likely to be excluded. Screening for both high blood pressure and diabetes is much less likely among older people in rural areas, older people without college degrees and among those in low-income households. The majority (92.8 per cent) of older people in rural areas have never been tested for diabetes, whereas around two thirds (68.8 per cent) of older urban residents have never been tested. In relation to health insurance, older people with a university degree are 11 times more likely to have health coverage than those with no education (59 per cent and 5.4 per cent, respectively).

Gender inequalities reveal that while older men are more likely to have health insurance than women (12.7 and 10.6 per cent, respectively), women are more likely to access services. For example, just under a half (43.7 per cent) of older women were previously measured for hypertension, compared with around a quarter (25.8 per cent) of men.

Income is also a determining factor when accessing NCD services. Older people from the wealthiest households are more likely than those from the poorest families to have been previously screened for hypertension and diabetes. The difference is especially large for diabetes, as older men and women who are in the highest income quintile are twice as likely to be tested as older people in the lowest quintile (18.3 per cent and 8.1 per cent, respectively).

Health services

The government has committed to making healthcare facilities available to all, and today an estimated 90 per cent of the population has consistently reported living within 5km of a primary health facility.

NCD services are provided at different levels of healthcare facilities in the national health system, but by varying degrees. Nearly 80 per cent of facilities in a sample of 1,200 were found to provide NCD services; these included dispensaries, health centres, hospitals and health clinics. Each facility performed patient diagnosis and management of conditions and minor surgical services. Hospitals had more capacity for diagnosis and case management, followed closely by health centres, as compared with dispensaries and health clinics. Faith-based (mission) health facilities were found to provide diagnostic and case management services more than government/public, private-for-profit and parastatal (state-owned) facilities.

More NCD diagnostic and case management services are provided in urban than rural facilities. Although NCD services are provided at different levels of healthcare facilities in the national health system, some services, such as those needing more skilled diagnostic and surgical skills, are not available at lower-level facilities such as dispensaries and health centres. Therefore, patients are forced to go to higher-level facilities (such as hospitals), most of which are found in urban centres, while the majority of people live in rural areas or remote/peripheral parts of towns and cities. People in need of services have to travel long distances, which discourages health-seeking behaviour.

Official statistics indicate that Tanzania has a severe human resources crisis, with just over one-third of health force positions filled by qualified health workers. Moreover, among medical staff delivering services for diabetes management and cardiovascular disease (CVD), for example, very few have received appropriate training on the two conditions.

Testimonies from older people with NCDs and hospital-based staff reveal that when older people are able to access NCDs services they end up paying for at least some services despite eligibility for exemptions, which violates existing government policy. This is partly due to the serious problems in implementation of the waiver and exemption system, which are directly and disproportionately affecting older people. Despite the government's commitment to providing free NCD services to people aged 60 and over, three quarters of those aged 60-69 pay for health services themselves, according to national survey data.

Another reason is that, in some hospitals, health workers are urged to estimate the income they will generate in the forthcoming financial year. Interviews with social welfare officers revealed that this is leading to facility staff being resistant to serving too many patients who are eligible for exemptions. This is a form of cost recovery, which acts as a deterrent to older people receiving the services to which they are entitled.

The implication is that, in most cases, the only service many older people are able to access free of charge is doctors' consultations.

Action is needed

We recommend the following actions to ensure that older people can realise their right to health and that UHC includes older people from all backgrounds in Tanzania:

- The government must ensure explicit inclusion of older people in health and NCD policies, targets, programmes, data-gathering and reporting mechanisms. This includes monitoring morbidity, mortality and progress towards meeting the needs of people aged 70 and older.
- All levels of government must recognise, bring attention to and support age-related issues, ensure closer cooperation at different levels of the government and secure resources to address these challenges.
- Primary healthcare facilities must have basic diagnostic and prescriptive services for prevention and treatment of uncomplicated conditions, paying special attention to diagnosis and management of diabetes among older people in rural areas.
- Local health providers, with support from civil society and local governments, must be able to provide screening for and prevention, early diagnosis and management of NCDs for all population groups, with regular and targeted outreach services to reach older people wherever they live.
- The Ministry of Health should establish and strengthen specific disease registries within hospital management information systems, for cancer, diabetes as well as less prevalent NCDs.
- The Tanzania Bureau of Statistics should include specific indicators to monitor older people's health in the Demographic and Health Surveys (DHS).
- Medical store departments must continue and strengthen monitoring systems that ensure a steady supply of all necessary drugs at all levels of healthcare facilities. When prescribed medicines are not available, local social services should offer patients at least some reimbursement coupons to procure drugs from other sources.
- The Ministry of Health should review the national Trace Medicine List to include medications for most of the conditions affecting older people, thus ensuring drug availability at lower-level facilities.
- The Ministry of Health, social welfare offices, local governments and health providers must ensure that free services are compensated for either through government subventions or some form of health insurance.

- The Ministry of Health, with support from local authorities and health providers, must develop a more focused, sustainable plan and a programme to recruit healthcare workers and train them on key aspects of service provision, including for NCDs.

- The Ministry of Health, with support from academia and civil society, should strengthen training on geriatric care among all healthcare workers, through reviews of training curricula and on-the-job training.

- Local health providers, in partnership with civil society and academia and with support from local governments, must undertake public or community education and sensitisation about:

    — the risks of NCDs and the need for prevention and treatment, with a special focus on older people in rural areas; and

    — older people's right to health, ensuring that older people are aware of the government's exemption policy and waiver system, the policy's aims, how to claim or demand waivers or exemptions, eligibility criteria and how and when to appeal against malpractice or abuse.

- Social welfare offices and local authorities must ensure the effective implementation of both the exemption and waiver policies, ensuring that older people are aware of the services to which they are entitled and that local authorities fulfil their obligations to implement the scheme and do not deny access to eligible service users.

- Local authorities must issue identify cards in a systematic and transparent way to all eligible individuals, to ensure recipients can claim their benefits and rights.

- The Ministry of Health should establish a desk of social welfare officers at all levels of healthcare facilities, who would work closely with local government authorities to ensure all eligible people get the opportunity to receive free services.

- The Tanzanian government must continue its efforts to extend health insurance coverage for all by eliminating enrolment barriers.

Older person undergoing diabetes screening at Amri Abeid Arusha stadium, Tanzania

1. Introduction

The global prevalence of non-communicable diseases (NCDs) is increasing, with the largest rise expected in low- and middle-income countries (LMICs), where both infectious diseases and NCDs already have a disproportionate effect.[1] Worldwide there are an estimated 41 million deaths per year from NCDs, and 78 per cent of these occur in LMICs.[2] NCDs also cause significant morbidity and functional impairment.

In 2016, NCDs in Tanzania were estimated to account for 33 per cent of all deaths,[3] and the proportion of disease due to NCDs had doubled from 19 per cent of the total disability-adjusted life years (DALYs) in 1990 to 34 per cent in 2015.[4]

Global and national efforts, policies and intervention programmes to combat infectious diseases have improved wellbeing and dramatically increased life expectancy and decreased preventable deaths in many low-income countries. However, health conditions associated with NCDs continue to contribute to ill health among large numbers of people, with physical, psychological and financial costs.

Epidemiological records indicate that prevalence of NCDs is higher in older populations, but they are also exacerbated by exposure to environmental and behavioural risks.[5] As a key population group, older people merit special attention in countries striving to prevent and control NCDs.[6]

Most NCDs are chronic, and, while their severity may vary, case management can consume a large proportion of a household's income unless there are financial protections such as healthcare prepayment (insurance) systems.

Access to universal health coverage (UHC) is a central goal of Agenda 2030, and specific targets are set out in Sustainable Development Goal (SDG) 3. UHC is a goal supported by the World Health Organization, which defines UHC as ensuring that all people and communities receive the quality health services they need, and are protected from health threats, without financial hardship.[7] UHC underpins the right of every individual, regardless of age, sex, disability, race or other socioeconomic characteristics, to health. As countries strive to achieve UHC, they must prioritise NCDs in their health policies, plans and programme interventions. In the spirit of UHC, governments and national and international development partners need a platform for carrying out formative and implementation research to assess the barriers to and facilitators of older people's access to healthcare services. They also need to periodically review their progress to establish what has been learned and make recommendations for improving policies and management.

Tanzania Insights is a companion to the Global AgeWatch Insights report, *The right to health for older people, the right to be counted*, published in 2018 (available at globalagewatch.org). *Vietnam Insights* is also being published as a sister report to the present case study.

Global AgeWatch Insights analyses the realisation of older people's right to health in LMICs according to four components: availability, accessibility, acceptability and quality. The report found that older people's realisation of their right to health remains deeply unequal and often limited, and that gaps in the data needed for policy planning are a significant barrier to progress.

This report explores in greater depth, in a specific national context, some of the key issues identified in Global AgeWatch Insights that affect older people's enjoyment of their right to health. It assesses the progress in ensuring UHC for older people in Tanzania, identifying issues related to coverage and access, and making recommendations

to national stakeholders for actions that will support the realisation of older people's right to health.

More specifically, this report investigates: frameworks, policies and accountability mechanisms to support the realisation of UHC in Tanzania; the extent to which UHC has been achieved in Tanzania, particularly in relation to NCDs and the needs of people age 50 and older; and the extent to which the health and care needs of marginalised groups of older adults have been prioritised in Tanzania.

These topics were explored using a mixed-methods approach involving a literature review of secondary global and national qualitative and statistical data on population ageing and NCDs; analysis of secondary data from relevant surveys; and two in-depth interviews with social welfare officers and four focus group discussions with 42 older men and women with NCDs. While the study findings were limited by sample sizes and response rates to survey questions, a limited time-frame for data collection, and a limit to the breadth of stakeholders included in focus group discussions, the methodology and analyses were sufficiently robust to provide important insights, which are outlined in the remainder of this report.

This report presents the results of the literature review in sections 2-4, followed by the findings of the secondary data analysis and in-depth interviews and focus groups in sections 5-8. The final sections (9-11) synthesise the main findings from all sources and recommend actions that all stakeholders can take together.

2. Global perspectives on non-communicable diseases and universal health coverage

Although non-communicable diseases (NCDs) are increasingly being recognised as major barriers to health and human development, there are a number of challenges to addressing them. First, the prevalence of NCDs is underreported in policy and political documents, with policy-makers, decision-makers and researchers tending to report data on some diseases but not others, for reasons both known and unknown.[8] In addition, key groups, including older people, are often neglected by policy and management authorities, including line ministries and service providers.

2.1 International commitments related to NCDs

Governments have ratified United Nation's resolutions and responded to calls from the World Health Organization to adopt a series of political commitments to guide their response to this global challenge, with an ambitious global goal of reducing "premature deaths"† due to NCDs by 25 per cent by the year 2025.[10,11] This goal was agreed following global meetings in 2011 and 2014, after which a number of governments made national commitments to reduce the risks for developing NCDs, provide better care for people living with NCDs, and track trends and progress in the fight against NCDs.[10,12] The meetings resulted in the design of several strategies and adoption of resolutions aimed at helping countries to establish their own national plans, and to make NCDs an integral part of long-term national health planning and development through bold political and policy measures. Leaders and governments were also urged to ensure that, by 2015, their national NCD targets for 2025 would be consistent with the voluntary global targets outlined in Box 1. In the case of Tanzania, these policies explicitly include older people.

2.2 The need for stronger, sustainable health systems and financing

Tackling the challenge of NCDs calls for more inclusive health policies, financing and service delivery programmes in line with the Agenda 2030 commitment to extend universal health coverage, including financial risk protection.[13] Access to health insurance is a mechanism for facilitating access and protecting people against catastrophic health costs in systems where health services are not free at the point of access. However, in many low- and middle-income countries (LMICs), only a small proportion of the population is insured.

2.3 Barriers to achieving universal health coverage and addressing NCDs

The East Africa NCD Alliance Post-2015 Initiative identified several barriers that have delayed local efforts to control NCDs. These included the absence of specific local targets and indicators in national plans, misalignment between the priorities of development partners and countries, weak implementation frameworks, limited capacity of health systems to manage chronic conditions, and the absence of strong monitoring and surveillance infrastructure.[11]

† HelpAge International challenges the use of the term "premature" mortality, because it suggests that mortality is acceptable at an older age. HelpAge recommends the use of the term preventable mortality. See HelpAge International's response to the web-based consultation on the first report of the WHO Independent High Level Commission on NCDs (May 2018) at http://origin.who.int/ncds/governance/high-level-commission/Help-Age.pdf

Country progress reports indicate variations in achieving universal health coverage (UHC) and control of NCDs, with some common challenges across different countries, including Tanzania. Without health insurance in the context of poor access to services, many adults or households are likely to continue facing high out-of-pocket expenditure and to be forced to make painful trade-offs such as cutting back on education and food for their children, leaving jobs to care for loved ones or selling off assets.[14] The cost of massively expanding access to healthcare globally is formidable, hindering the achievement of UHC. For example, the Disease Control Priorities Network estimates that low-income countries would, on average, need to raise their respective annual per capita health expenditure by US$53, and middle-income countries by US$61, to achieve coverage with the essential UHC package of 218 core interventions. This would be a sizeable burden compared with increases in average expenditure in recent years.[15] Economic reports from the World Bank and other sources reveal that direct out-of-pocket payments still represent more than 50 per cent of total health expenditures in a large number of LMICs.[5] Analysts have also noted that the health systems of LMICs are still oriented to addressing infectious (communicable) diseases, and are often severely underfunded and poorly prepared for the challenge of caring for people with NCDs, including cardiovascular diseases, diabetes, cancer and chronic respiratory disease.[16]

2.4 Universal health coverage as a human right

While experts have acknowledged some improvements in service delivery, they have identified gaps or shortages in many other areas of national health systems. These include the persistence or widening of inequalities in access to basic healthcare services between rich and poor countries, rich and poor individuals within countries, and people living in urban and rural settings.

UHC is fundamental for tackling these inequalities and the impacts of NCDs, and is a tool to achieve people's right to healthcare. This is in line with the United Nations definition of UHC:

A physiotherapist training older people on exercise in Morogoro, Tanzania

" … all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population."[17]

The Millennium Development Goals (MDGs) did not include goals related to NCDs or UHC. They focused on child mortality, maternal and reproductive health, and HIV and AIDS, therefore they led to little progress in relation to older people's health. This gap in the healthcare agenda led to the development of the more inclusive 2030 Development Agenda, including a commitment to achieve UHC by 2030. Since its launch, countries have been implementing pro-poor reforms to advance UHC. Progress is monitored through indicators that measure gains in financial risk protection and in access to quality essential healthcare services.[18]

Since the launch of the SDGs, NCDs have increasingly become part of the broad development policy and political agenda, rather than just an issue for the health sector, acknowledging their devastating social, economic and public-health impact.[19] This has led to the development of a Global Action Plan for the Prevention and Control of NCDs 2013-2020 (known as the Global Action Plan for NCDs), which includes nine voluntary global targets (Box 1) and a monitoring framework. Each World Health Organization member state was urged to adopt this plan if appropriate to its national context, but this was not prescriptive.[18] State leaders also unanimously agreed that ensuring availability, affordability, acceptability and uptake of appropriate technologies and medicines should be the route to achieving UHC for NCDs and equity in addressing NCDs.[20] While the overarching goal of the plan is to reduce preventable and avoidable deaths and disability due to NCDs for populations 'at every age', a number of indicators that measure progress on the global targets monitor specific age groups (e.g. people aged 30-70 dying from NCDs or women aged 30-49 screened for cervical cancer) and therefore they exclude a large proportion of the older population.

Box 1. The nine global targets of the Global Action Plan for NCDs

1: 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases

2: At least 10% relative reduction in the harmful use of alcohol as appropriate, within the national context

3: 10% relative reduction in the prevalence of insufficient physical activity

4: 30% relative reduction in the mean population intake of salt/sodium

5: 30% relative reduction in the prevalence of current tobacco use in people aged 15 and over

6: 25% relative reduction in the prevalence of raised blood pressure, or contain the prevalence of raised blood pressure, according to national circumstances

7: Halt the rise in diabetes and obesity

8: At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes

9: 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major non-communicable diseases in both public and private facilities

Source: Box 1.1. Voluntary global targets for prevention and control of non-communicable diseases to be attained by 2025[20]

Cataract patients wait for their operations

3. Non-communicable diseases and older people's right to health in Tanzania

While Tanzania has had overall economic growth, the benefits have been distributed unequally. More than a quarter of Tanzania's 53 million inhabitants live below the poverty line, and almost 10 per cent live in extreme poverty. In addition, 80 per cent of those living in poverty are in rural areas, where the fertility rate is almost double that in urban areas.

Health insurance schemes intended to reduce the financial costs of accessing healthcare often suffer from gaps in service provision. These gaps disproportionately affect people living in rural areas, and the poorest groups in society. They pay into the schemes, but the benefits they can receive are often limited to primary care services, which are largely unavailable in rural areas; the medicines they need may be unavailable; or they may need more sophisticated care for which they have to pay at higher service levels.[18,21-23]

3.1 Older people's access to quality health services in Tanzania

This section presents the results of a literature review of the pattern of non-communicable diseases (NCDs) among older people in Tanzania, with a special focus on those above age 50. The review focused on three diseases, which are the tracer NCD conditions used to track progress on delivery of universal health coverage (UHC) under Sustainable Development Goal (SDG) 3 of Agenda 2030: cervical cancer, hypertension and raised blood glucose (the test for fasting plasma glucose is used to diagnose diabetes).

Cervical cancer

Cervical cancer is estimated to account for 32.7 per cent of all cancers in women in Tanzania, with more than 9,772 new cases per year.[24]

The age-standardised incidence rate of cervical cancer in the country is estimated at 59.1 per 100,000 women per year, with more than 60 per cent of cases among women over the age of 50. The human papillomavirus (HPV) vaccination, early screening and treatment are key to preventing morbidity and mortality. However, inequalities in wealth and healthcare financing limit access to these services, and people on low incomes or below the poverty line are less likely to attend screening and more likely to present at late stages of the disease.

There is no national data on the burden of cancer in Tanzania, but cancer registries have recently been established at tertiary hospitals. For example, analysis of the first 200 cases seen at the Aga Khan Health Services showed that 60 per cent of all patients diagnosed with cancer were older than age 50. Many patients were diagnosed with late stages of the disease, with more than a third at stage IV.[25]

A retrospective cohort study at Ocean Road Cancer Institute looked at characteristics of women diagnosed with invasive cervical cancer. It showed a higher prevalence of invasive disease and lower treatment completion rates among older women with informal occupations and low levels of education.[26] Similar results were reported by Mlange, Matovelo, Rambau and Kidenya.[27] Their study showed that only 6 per cent of study participants had insurance coverage. Those without insurance were four times more likely to present with late-stage disease. Awareness of cervical cancer was reported to be high, but only a few patients had a history of cervical cancer screening, a finding that is supported by other studies.[28]

Studies are increasingly finding disparities in access to services between different income groups and between those living in rural

versus urban communities. For instance, a review of cervical cancer screening and treatment services in Tanzania demonstrated a high burden in underserved communities.[29]

Diabetes

The nationwide STEPwise approach to surveillance (STEPS) survey conducted in 2012 estimated overall prevalence of diabetes in Tanzania to be 9.1 per cent.[30] Studies of diabetes prevalence across age groups showed disproportionately high rates among people aged 50 and older. A hospital-based study by Ruhembe et al. reported a high prevalence of diabetes in people over the age of 50, and that people older than 40 years of age were seven times more likely to have diabetes than those under age 40.[16] Similar results were found in other studies.[31-33,37]

People with diabetes are also faced with comorbidities and poor quality of care, which further affect treatment outcomes. This was demonstrated by Kilonzo et al.[34] in a study of hypertension among diabetes patients attending a clinic at Bugando hospital. Although patients were accessing care, most did not reach the desired treatment outcomes. The majority (80 per cent) of respondents were older than age 50. More than 50 per cent did not reach the desired blood pressure treatment goal.† Only a third of the patients had access to insurance coverage, while others relied on out-of-pocket payments.

Healthcare facilities are still unable to cope with the increasing burden of diabetes. A study by Mwangome et al.[35] looking at providers' perceptions of diabetes care in rural Tanzania showed that primary care facilities still lack diabetes services and NCD services have not been incorporated into district health plans. Similar findings were reported in another study by the same authors,[36] which compared HIV care to diabetes care and concluded that HIV experiences and infrastructure can be used to strengthen diabetes and NCD care at large.

† Less than 140mmHg systolic and less than 90mmHg diastolic

Hypertension

The 2012 STEPS survey[30] reported a national prevalence of hypertension of 26 per cent. A similar pattern to that seen with diabetes emerged, with a disproportionately high burden of hypertension among those aged 50-64. The pattern of undiagnosed disease was also high, demonstrating the need to increase awareness and access to services in both rural and urban areas. Similar results were found in a number of other studies.[33,37-40]

If not treated properly, hypertension can lead to end organ damage. Putnam et al.[41] highlighted the burden of end organ damage in an examination of hypertensive patients over age 70. The prevalence of sustained hypertension was 52 per cent, 13.9 per cent had left ventricular hypertrophy, and 26.4 per cent had peripheral arterial disease.

Health systems need to be strengthened with respect to secondary and tertiary prevention to reduce the risk of long-term complications, as many people cannot access care and use community screening camps (outreach services) to access free care.

A cross-sectional study at a regional referral hospital in Songea revealed that many of the diagnosed hypertensive patients were not aware of associated risk factors and complications.[42] A study comparing the frequency of hypertension in primary care settings in Malta and in Buza, Tanzania, further highlights the need to improve services for hypertension care in Tanzania.[43] Age-standardised prevalence of hypertension in Tanzania was 48.8 per cent, compared with 32.8 per cent in Malta. The study also found low medication compliance in Tanzania of 8 per cent, compared with 48 per cent in Malta, and higher prevalence of hypertension in older age categories.

3.2 Barriers to older people realising their right to health

This section outlines the barriers to achieving UHC for NCDs among older people in the context of the four dimensions of health as a basic human right: availability, accessibility, acceptability and quality.[44]

Availability and quality of services

Inadequate supply of trained personnel

While NCDs occur among people of all ages, older people are more likely to suffer from comorbidities, which makes NCD management more complex and therefore requires personnel with more skills and experience. There is a scarcity of providers able to manage these complex cases,[45] with more severe shortages in rural compared with urban areas. The Tanzania NCDs Alliance advocates for measures to ensure that community health workers can reach older people at community level and support preventive services, but this has not yet been made a priority in practice. Healthcare workers' preconceived notions and negative attitudes about older people sometimes result in care rationing in such a way that care is limited or withheld entirely, with patients deemed too old for treatment rather than because of the expectation of poor treatment outcomes.[45] Some symptoms presented by older people are often overlooked by service providers, who perceive them as a normal effect of ageing. This is partly attributed to a lack of knowledge on the part of medical professionals and caregivers. The lack of trained physicians for attending older people has been identified as a significant challenge to managing NCDs in Tanzania.[45-47]

Unavailability of required medicines and equipment

While a large proportion of older people have NCDs, few can access effective treatment.[48] Evidence from a World Health Organization analysis suggests that providing multi-drug therapy for those at high risk of cardiovascular diseases is extremely cost-effective, at less than US$1 per person a year in low-income countries.[49] However, the Medical Store Department in Tanzania has been criticised for late supply of drugs and other medical supplies to healthcare facilities. This has greatly affected people who cannot afford services from private facilities, including many older people. Most of the prescribed drugs have been reported to be unavailable at the dispensing room because of insufficient budget allocations for purchasing drugs. Furthermore, inadequate funds have been allocated to the district health systems for purchasing drugs and other medical supplies at regional and district hospitals and lower-level healthcare facilities. This has made it very difficult for facilities to provide high-quality and efficient services in their respective catchment areas.[46]

A shortage of drugs and medical equipment has contributed to the failure to provide free health services to older people in most government-owned facilities. In most cases, the only free service available is doctors' consultations; the prescribed drugs are often out of stock, and older patients are asked to buy them from private pharmacies.[50-51] According to a report based on the 2010 Tanzania Demographic and Elderly Health Survey, 40 per cent of older people did not get the necessary medication in health facilities they had visited, and 25 per cent of men who had kidney problems failed to get kidney surgery at health facilities they contacted due to the high cost.

Accessibility

Costs to health service users

In many countries, cost is a major reason why people delay seeking care.[47] A multicountry survey found that the majority of older people struggled to afford healthcare.[52] In Tanzania, government financing through annual financial resource budget allocations for health has been increasing in nominal terms, not in real terms, and in several cases it has fallen below the recommended threshold. Equity of access to healthcare in the national health sector still depends on individual and household income. A recent small-scale cross-sectional study at Temeke Hospital in Dar es Salaam found that 58 per cent of older people who were interviewed were unable to access free healthcare services in public hospitals.[53] Case studies and evaluations have revealed that the national health system consistently provides unequal levels of service, delivering more and higher-quality services to people who are well-off compared with those who are not. This is causing the public to lose hope in the prospect of achieving access to UHC.[54,55]

Moreover, reports suggest that very few older people are covered by health insurance, with coverage mainly among those who were public employees and those with employed children. Although it is common in some countries, including Tanzania, for families to live with multiple generations in one household, formal insurance schemes do not cover extended family members, hence older people are likely to be left out.[56]

Without health insurance, an older person has to rely on personal or household savings and income to cover health-related costs, which can be high due to the complexity of conditions and comorbidity. In addition, other forms of social protection or adequate income might not be available to mitigate this financial risk. The most recent data on pension coverage in Tanzania is from 2008, when only 3.2 per cent of older people were reported to have received a pension.[57] A high level of employment among people of pensionable age in Tanzania indicates low levels of social protection and the need to work for income. According to data from 2014, employment among people aged 60 and older was very high: 86.6 per cent for people aged 60-64, and 62.6 per cent for those 65 and older.[58]

Barriers to implementing the exemption and waiver system for older people's healthcare

Tanzania has a policy of payment exemption for healthcare services for people aged 60 and older, children under the age of 5 and pregnant women, and fee waivers for people living in poverty. Social welfare officers administer the policy at many levels, from public district or municipal hospitals to higher-level facilities such as tertiary (for example, national) hospitals, but not at lower-level facilities such as a health centres and dispensaries. Even in areas where the exemption mechanisms are being administered, there have been complaints about the procedures involved in identifying and/or verifying eligible individuals. There are claims that the procedures are too bureaucratic, unclear and cumbersome, making administration inefficient and untrustworthy in the eyes of those who do not benefit from it.

There have been challenges in identifying the people who are eligible for waivers, including older people. There are no clearly written criteria for how community leaders and healthcare workers should determine which people should be exempt from paying for healthcare services. In addition, a lack of understanding among many older people may prompt them to visit government-owned healthcare facilities without bringing supporting documents, such as an identification card or a letter or recommendation from a village council, to prove their eligibility for free services.[46,50] This can discourage them from seeking further services.

Distance to access care

People living in urban areas have better access to private and public medical facilities than their counterparts in rural areas, where incomes are lower and there is less access to public healthcare providers.[59,60] Moreover, most older individuals have limited mobility, and there are persistent problems in rural areas with poor road infrastructure and limited means of transport, forcing many people to walk long distances to reach the nearest health facility.[56] More than

Older person waiting for free health screening in Arusha, Tanzania

60 per cent of health services are not easily accessible for the majority of older people, in most cases due to transport costs and lack of support from extended family members.[61] This contributes to delays in reaching service providers in formal healthcare facilities.[47] A 2013 review found that, although the majority of older people prefer healthcare facilities located nearer to where they live, some report a preference for more distant facilities when they feel this can provide better services, a range of care options, effective counselling and more convenient hours.[56]

Acceptability

Lack of supportive environment

Comorbidities among older people also contribute to reduced mobility for some. This can make it difficult to reach healthcare facilities and therefore may mean they require special attention from health workers when they eventually do access care.[46] Older people reported that they had to queue for long periods of time before receiving care, and transport difficulties meant they arrived late and then had to travel back home at late hours.[56] A lack of privacy due to the limited availability of consultation rooms deterred the clients from freely communicating about their symptoms or conditions, which discouraged them from visiting the health facility again.[62]

Respectful care is another important dimension when analysing health-seeking behaviour. Older people consistently reported feeling more comfortable if providers respected their privacy during counselling sessions, examinations and other procedures. The more a person was satisfied with the approach shown by the service provider, including the language used and the ability to maintain privacy and keep information confidential, the more she or he was likely to contact the provider again. Long waiting times between arriving at a health facility and receiving services was also cited as a major challenge among older people, particularly as their conditions can make it difficult to walk from one section of a facility to another.[47,53]

Interpersonal relationship

The interpersonal relationship between older patients and service providers was reported to be one of the most important factors for consulting a health facility. Older people preferred providers who used respectful language and behaved politely, communicated in a language the older person understood, paid attention to them, expressed or demonstrated a commitment to their work and assured the patient of confidentiality.[53,63] This group preferred providers who spent more time listening to their problems, provided clear instructions and gave them opportunities to ask questions. Some older people might prefer to use their vernacular to express how they feel, so when they meet a provider who is unfamiliar with their language it becomes an additional barrier.[56]

Discrimination

Age discrimination and age-related stigma are recognised as additional barriers to older people seeking care. Stigma is sometimes attached to health conditions that predominantly affect older people, particularly dementia, which hinders early diagnosis.[62] While data is limited, there is evidence that older people experience stigma and discrimination when accessing health services.[64]

4. Government policies

4.1 Universal health coverage and access to insurance

Tanzania's political commitment to ensuring universal primary healthcare to all its citizens goes back to its independence in the 1960s, when the newly formed government recognised health services as a fundamental right of all citizens. Regional and district local government authorities were given responsibility for health planning and resource allocation, as they were considered best placed to identify low-income populations and those living below the poverty line, and to understand and meet their needs in line with government policy.[18,64] After independence, the government committed to making healthcare facilities available to all within walking distance, and today an estimated 90 per cent of the population has consistently reported living within 5km of a primary health facility.[65]

New health reforms have seen the introduction of a cost-sharing system. This allows public healthcare facilities to recover part of the costs of providing services by charging modest fees to patients who are not eligible for exemptions or waivers, and continuing to provide certain services free of charge to specific groups. As outlined in the previous chapter, the national fee exemption scheme gives people aged 60 and over, pregnant women and under-5s free health consultations, treatment and medication in public health facilities, and the waiver scheme gives people living in poverty, of all ages, a waiver for health service fees and costs associated with travel and accommodation.

Other reforms made through Structural Adjustment Programmes so far include the introduction of alternative health financing systems. This includes the compulsory health insurance or healthcare prepayment arrangements schemes via the National Health Insurance Fund (NHIF), targeting civil servants/public-sector emnployees. It also includes the National Social Security Fund (NSSF), which offers health insurance benefits to employees in the formal private sector, and the Community Health Fund (CHF) scheme, mainly targeting those employed in the informal sector. There are some voluntary insurance systems run by private-sector entities. The number of smaller (micro) insurance schemes has increased under the umbrella of the Tanzania Network of Community Health Funds, although few people seem to register with those insurers.[23] Arrangements are being made to establish a joint national social health security scheme, known as the Single National Health Insurance (SNHI) Fund, to offer high-quality health coverage to all people regardless of their occupational and demographic differences. The vision is that this will widen the risk-pooling potential of the respective health financing strategy and overcome challenges faced by previous schemes.[18]

4.2 National strategy for the control of non-communicable diseases

The Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) recently produced a Strategic and Action Plan II for the Prevention and Control of NCDs in Tanzania, for the period 2016-2020. Through this ministry, the government continues to use sentinel and health management information data to evaluate the status of diseases and progress made towards their control. The national plan is aligned with the objectives of the Global Action Plan for the Prevention and Control of NCDs 2016-2020, which Tanzania ratified, namely: (1) to advocate for NCD prevention and control as a national priority by 2020; (2) to strengthen leadership, governance, multisectoral collaboration and accountability for prevention and

control of NCDs by 2020; (3) to strengthen and reorient health systems to address NCDs though promotive, preventive, curative and rehabilitative services by 2020; and (4) to strengthen national capacity for NCD surveillance, research for evidence-based planning, monitoring and evaluation by 2020.[54,66] It is important to note that the national plan applies to all age groups, including older people.

Older person having an eye test in Tanzania

5. Health insurance coverage and financial protection of older people

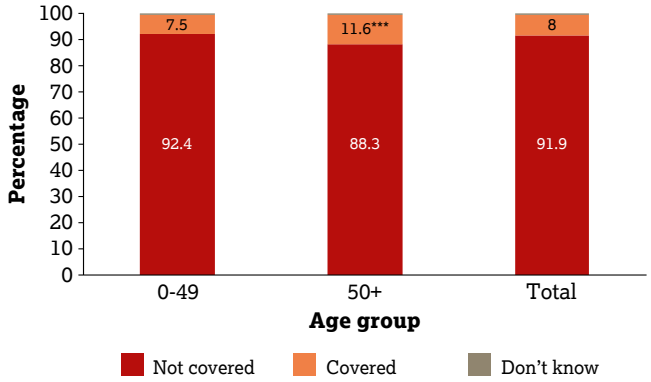
5.1 Health insurance coverage

Only 8 per cent of all Tanzanians have health insurance (Figure 1), and less than 8 per cent of respondents under age 50 and about 12 per cent aged 50 years or older were covered by some form of insurance. Health insurance coverage is complemented by a system of exemptions and waivers intended to ensure older people's access to health services. In practice, as described elsewhere in this report, there are issues with the implementation of both waiver and exemption schemes.

Among those who have insurance, two schemes, the Community Health Fund (CHF) and National Health Insurance Fund (NHIF), jointly provided more than 80 per cent of coverage. The CHF targets informal-sector works and is more likely to cover those under age 50 than older people (56 per cent and 40 per cent, respectively). The NHIF is compulsory for public-sector employees and their dependents, and is more likely to cover those above age 50 than younger cohorts (48 per cent and 33 per cent, respectively), as older people may register as retired civil servants or parents of civil servants. The role of other types of insurance such as private, employer- or community-based is very small (Figure 2).

Table 1 presents the pattern of health insurance coverage of a sample of 7564 people aged over 50, categorised by type of insurance system and socioeconomic/demographic characteristics, based on data from the Demographic and Health Survey (DHS) 2015/16.[59] Only 11.6 per cent of respondents had health insurance. Of these, 47.9 per cent were covered by the NHIF, which is a compulsory insurance system for public-sector employees and their dependents; 1.7 per cent were covered by the National Social Security Fund (NSSF), which is

Figure 1: Percentage of people with health insurance, by age group



Source: Tanzania Demographic and Health Survey 2015/16 [59]

Notes:

*** p-value <0.0001,‡ n=64,880

‡ P-values indicate the likelihood that a statistical difference has occurred because of a true difference within a population, rather than simply by chance. If it reflects a true difference, it is considered to be statistically significant. The smaller the p-value, the more likely it is that the difference is significant. P-values of less than 0.05 are considered significant

specifically for those employed in the private sector and their dependents; 40 per cent were covered by the CHF; 3 per cent were covered by other employer-based insurance arrangements; and 4.2 per cent were covered by other community-based insurance systems under mutual arrangements. The least common schemes included privately purchased and commercially oriented insurers and other (unspecified) arrangements.

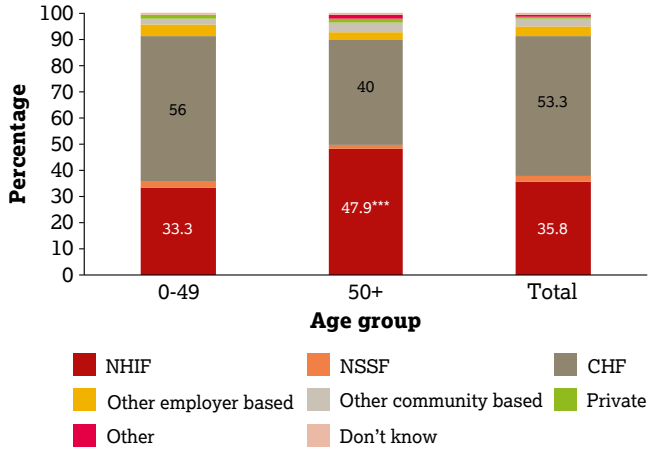
There were differences in coverage based on gender, age, location and level of education. Older men were significantly more likely to have health insurance (12.7 per cent) than women (10.6 per cent). People aged 50-59 were also more likely to be insured (13.2 per cent) and have enrolled in the NHIF scheme (53.4 per cent) than older cohorts. While only 18.5 per cent of urban older residents had any type of health insurance, they were still more likely to be covered than people living in rural areas (9.7 per cent). People in rural areas who had insurance were most likely to be enrolled in the CHF scheme (55 per cent). Finally, older people with a college education had a significantly higher coverage (59 per cent) than individuals with lover levels of education. There was no statistically significant difference in coverage based on levels of income.

5.2 Healthcare financing by sources of payment

Table 2 presents evidence on how older patients paid for their healthcare. The majority (73.6 per cent) paid for services themselves (out of pocket). Only 19.4 per cent had free-of-charge treatment, and 5.5 per cent of services were covered by insurance. Despite the government's commitment to providing free NCD services to people aged 60 and over, the data shows that 74.6 per cent of those aged 60-69 paid out of pocket.

The proportion of people who received free treatment or were covered by insurance dropped to less than 2 per cent when they returned for a second treatment, suggesting that the great majority had to pay for the second round of care. The pattern was similar across gender, location, age groups and education levels. There is no data on types of health facilities or the reasons why some patients received free treatment.

Figure 2: Health insurance coverage, by type of insurance and age



Source: Tanzania Demographic and Health Survey 2015/16[59]

Notes:

*** p-value <0.0001, n=5,171

Table 1: How health insurance coverage varies by sociodemographic factors for older people

	Covered by health insurance		NHIF		NSSF		CHF		Other employer-based		Other community-based		Private		Other		Don't know	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Sex																		
Male	454**	12.7**	222	48.9	9	2.0	172	37.9	19	4.2	16	3.5	6	1.3	5	1.1	5	1.1
Female	423	10.6	198	46.8	6	1.4	179	42.3	7	1.7	21	5.0	7	1.7	4	1.0	1	0.2
Age group																		
50-59	466**	13.2**	249***	53.4***	9	1.9	163	35.0	22	4.7	11	2.3	8	1.7	2	0.4	2	0.4
60-69	258	11.9	128	49.6	4	1.6	101	39.2	3	1.2	15	5.8	3	1.2	1	0.4	3	1.2
70-79	113	9.3	33	29.2	2	1.8	65	57.5	1	0.9	7	6.2	2	1.8	3	2.7	0	0
80+	40	6.2	10	25.0	0	0.0	22	55.0	0	0.0	4	10.0	0	0.0	3	7.5	1	2.5
Education																		
None	170	5.4	29	17.1	0	0.0	121	71.2	0	0.0	15	8.8	1	0.6	3	1.8	1	0.6
Primary	475	13.1	199	41.9	10	2.1	218	45.9	8	1.7	22	4.6	4	0.8	4	0.8	4	0.8
Secondary	183	27.6	155***	84.7***	5	2.7	12	6.6	9	4.9	0	0.0	1	0.6	1	0.6	1	0.6
College	49***	59.0***	37	75.5	0	0.0	0	0.0	9	18.4	0	0.0	1	2.0	1	2.0	0	0
Wealth quintile																		
Lowest	161	11.7	73	45.3	2	1.2	67	41.6	8	5.0	8	5.0	0	0.0	1	0.6	2	1.2
Second	140	10.9	69	49.3	1	0.7	55	39.3	3	2.1	8	5.7	2	1.4	2	1.4	0	0
Third	131	10.9	62	47.3	2	1.5	53	40.5	3	2.3	7	5.3	3	2.2	1	0.8	1	0.8
Fourth	137	10.9	64	46.7	8	2.6	63	46.0	2	1.5	2	1.5	6	2.0	0	0.0	1	0.7
Highest	305	12.6	151	49.5	15	1.7	112	36.7	10	3.3	12	3.9	4	1.3	4	1.3	2	0.7
Living area																		
Urban	306***	18.5***	225***	73.5***	10	3.3	36	11.8	21	6.9	5	1.6	3	1.0	4	1.3	2	0.7
Rural	571	9.7	195	34.2	5	0.9	315***	55.2***	5	0.9	32	5.6	10	1.8	5	0.9	4	0.7
Overall	**877**	**11.6**	**420**	**47.9**	**15**	**1.7**	**351**	**40.0**	**26**	**3.0**	**37**	**4.2**	**13**	**1.5**	**9**	**1.0**	**6**	**0.7**

Source: Tanzania 2015-16 Demographic and Health Survey[59]

Notes:

* p-value <0.05, ** p-value <0.001, *** p-value <0.0001, n=7,564

Table 2: How health financing varies by sociodemographic factors for older people

	Free treatment		Health insurance		Own cash		Got assistance		Differed by provider	
	n	%	n	%	n	%	n	%	n	%
First treatment*										
Sex										
Male	29	17.3	9	5.4	127	75.6	2	1.2	1	0.6
Female	45	21.1	12	5.6	154	72.3	1	0.5	1	0.5
Age group										
50-59	34	19.4	11	6.3	128	73.1	0	0.0	2	1.1
60-69	23	18.9	6	4.9	91	74.6	2	1.6	0	0.0
70-79	14	25.5	3	5.5	38	69.1	0	0.0	0	0.0
80+	3	10.3	1	3.5	24	82.8	1	3.5	0	0.0
Education										
None	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Primary	15	11.5	8	6.1	107	81.7	1	0.8	0	0.0
Secondary	6	16.7	5	13.9	25	69.4	0	0.0	0	0.0
College	0	0.0	1	25.0	3	75.0	0	0.0	0	0.0
Living area										
Rural	48	19.8	11	4.5	181	74.5	1	0.4	2	0.8
Urban	26	18.8	10	7.3	100	72.5	2	1.5	0	0.0
Overall	**74**	**19.4**	**21**	**5.5**	**281**	**73.6**	**3**	**0.8**	**2**	**0.5**

Source: National Panel Survey 2014/15, wave 4

Notes:

* n=381, ** n=54

continued on next page

Patient and household expenditure on care

Table 3 presents data from the National Panel Survey 2014/15, Wave 4, indicating the median expenditure by older people and households with an older person on medical care received at healthcare facilities. This includes the costs of medical consultations, lab screening, drugs and hospitalisation as well as the costs incurred for care not related to the older person's illness.

The amount paid by an individual patient 'on the spot' ranged from Tanzanian shillings (Tshs)3,500 for older

Table 2
continued

	Free treatment		Health insurance		Own cash		Got assistance		Differed by provider	
	n	%	n	%	n	%	n	%	n	%
Second treatment**										
Sex										
Male	0	0.0	0	0.0	18	100.0	0	0.0	0	0.0
Female	1	2.6	1	2.6	36	92.3	1	2.6	0	0.0
Age group										
50-59	1	3.7	1	3.7	25	92.6	0	0.0	0	0.0
60-69	0	0.0	0	0.0	14	100.0	0	0.0	0	0.0
70-79	0	0.0	0	0.0	9	90.0	1	10.0	0	0.0
80+	0	0.0	0	0.0	6	100.0	0	0.0	0	0.0
Education										
None	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Primary	0	0.0	0	0.0	15	100.0	0	0.0	0	0.0
Secondary	0	0.0	0	0.0	7	100.0	0	0.0	0	0.0
College	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Living area										
Rural	0	0.0	0	0.0	32	97.0	1	3.0	0	0.0
Urban	1	4.2	1	4.2	22	91.7	0	0.0	0	0.0
Overall	**1**	**1.8**	**1**	**1.8**	**54**	**94.7**	**1**	**1.8**	**0**	**0.0**

Source: National Panel Survey 2014/15, wave 4

Notes:

* n=381, ** n=54

people in rural areas, to Tshs14,200 (US$1.60- 6.50) for college-educated users. On average, the amount of money paid out of pocket by individual households in the last four weeks was Tshs8,000 (US$3.60). Hospital stays cost between Tshs33,500 and 160,000 (US$15.20-72.80). These differences were not found to be statistically significant.

Unfortunately, data on the incomes of older people and households was not available. Information on pensions can provide some measure of the magnitude of health expenditure. However, this interpretation has to be made carefully due to the very limited coverage of social protection cited earlier. According to the report on *Social Security Programs through the*

Table 3: Median expenditure on health by older people and households by sociodemographic factors (Tshs)

	Amount spent by patient[a]	Amount spent by household in the past 4 weeks[b]	Amount spent by households in the last 4 weeks for care not related to illness[c]	Total cost for hospitalisation/ stay in a medical facility[d]
Sex				
Male	5,000	9,750		55,000
Female	5,000	10,000	8,000	41,000
Age group				
50-59	5,000	10,000		40,000
60-69	5,000	10,000	8,000	45,000
70-79	4,000	7,500		40,000
80+	3,750	5,750		160,000
Education				
None				
Primary	5,400	10,000	8,000	33,500
Secondary	5,000	10,000		136,500
College	14,250	14,250		60,000
Living area				
Rural	3,500	7,000	8,000	40,000
Urban	10,000	11,000		86,000

Source: National Panel Survey 2014/15, wave 4

Notes:

Respondents were asked:

a. How much did [Name] spend when he/she visited [Provider]? The question was analysed for older people aged 50 and over who visited a health provider in the last four weeks

b. How much in total did the household spend on [Name] in the past four weeks for all illnesses and injuries, including for prescription medicine, tests, consultations and inpatient fees, if any? The question was analysed for households with an older person who visited a health provider

c. How much in total did the household spend on [Name] in the past four weeks for medical care not related to an illness, including preventive health care, pre-natal visits, check-ups, etc., if any?

d. What was the total cost of [Name]'s hospitalisation(s) or overnight stay(s) in a medical facility? The question was analysed for older people aged 50 and over who were hospitalised or stayed overnight in a medical facility during the previous 12 months

World: Africa 2017, the minimum pension level in Tanzania is 40 per cent of the legal monthly minimum wage, which ranges from Tshs100,000 to 400,000 depending on the sector.[60] Older Tanzanians who are eligible for a pension might expect to receive between Tshs40,000 and 160,000. Thus individuals' monthly expenditure would constitute between 8.8 and 35.6 per cent of the lowest pension (Tshs40,000) and between 2.2 and 8.9 per cent of the highest pension (Tshs160,000).

Tables 2 and 3 show that people aged 60 years or older still pay for medical services out of pocket despite the government policy mandating free-of-charge services.

Older person in Kibondo, Tanzania

6. Older people's access to healthcare services

The following section examines older people's access to screening services and medication for hypertension and diabetes, and the extent to which non-communicable disease (NCD)-specific services are provided by health facilities at different levels. It also looks at accessibility to health facilities and older people's satisfaction with services.

6.1 Access to and provision of services for non-communicable diseases

Hypertension

Table 4 shows access to services for hypertension. Overall, only 34.5 per cent of people aged 50-64 had ever been screened for high blood pressure. Inequality in access to services was observed in relation to gender, residence, level of education and income. Older men were less likely than women to have previously been tested (25.8 per cent and 43.7 per cent, respectively). Similarly, older urban residents were twice as likely to have been screened as rural residents (56.9 per cent and 27.3 per cent, respectively). The proportion of older people without education and those living in low-income households who had previously been tested are 29.5 per cent and 25.5 per cent, respectively, compared with 64.8 per cent and 43 per cent among college graduates and high-income households.

Being diagnosed with high blood pressure was strongly associated with living in an urban setting. There was no association with other socioeconomic characteristics, apart from a weaker association with being female. Similarly, greater use of medication did not depend on specific characteristics of a group of older people, apart from a weaker association with being a female or belonging to the third income quintile.

Diabetes

Table 5 shows access to diabetes services. Overall, only 13 per cent of people aged 50-64 had ever had their blood glucose tested. Significant inequality in access to screening was observed in relation to residence, education and income. Urban residents (31.2 per cent), older people with a college education (38.9 per cent) and those living in the wealthiest households (18.3 per cent) were more likely to have been previously tested for diabetes. There were no observed differences by gender across all services, unlike services for hypertension. All patients diagnosed with diabetes and hypertension should receive lifestyle advice, but the data shows that, in most cases, service coverage was below 50 per cent. This suggests that key services are not accessed by the majority of the eligible population, posing a challenge to the achievement of universal health coverage policy objectives.

Whatever the case, the data shows that the population eligible to receive the recommended services has not received them.†

† Significant differences within a socioeconomic group may or may not imply a lack of policy in relation to access to services and medication. When research reveals inequalities in access to services, this may be due to services not being delivered at all, or when services are delivered, such findings may be due to the recipient not understanding the question or not remembering (recall bias)

Table 4: How access to hypertension services varies by sociodemographic factors for older people

	Had blood pressure measured before		Was diagnosed with high blood pressure before		Had access to high blood pressure medicine in the last 12 weeks		Received advice on balanced diet		Received advice to reduce weight		Received advice or treatment to stop smoking		Received advice to start or do more exercise	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Sex														
Male	202	25.8	69	34.2	18	26.1	38	55.1	17	24.6	18*	26.9*	25	36.2
Female	322***	43.7***	144*	34.2*	64*	44.4*	77	53.5	35	24.3	18	12.5	41	28.5
Age group														
50-59	328*	34.7*	127	38.7	46	36.2	59	46.5	31	24.4	14	11.0	38	29.9
60-64	196	34.2	86	43.9	36	41.9	56**	65.1**	21	24.4	22**	25.6**	28	32.6
Education														
None	221	29.5	91	41.8	37	40.7	53	58.2	17	18.7	14	15.4	20	22.0
Primary	208	33.9	76	36.5	27	35.5	35	46.1	23	30.3	12	15.8	30	39.5
Secondary	60	59.4	32	53.3	15	46.9	19	59.4	6	18.8	5	15.6	10	31.3
College	35***	64.8***	14	40.0	3	21.4	8	57.1	6	42.9	5	35.7	6	42.9
Wealth quintile														
Lowest	67	25.5	25	37.3	14	56.0	15	60.0	5	20.0	7	28.0	5	20.0
Second	66	26.6	30	45.5	14	46.6	15	50.0	9	30.0	4	13.3	7	23.3
Third	66	36.3	24	36.4	13*	54.2*	14	58.3	6	25.0	4	16.7	7	29.2
Fourth	24	33.8	13	54.2	1	7.8	9	69.2	6	46.2	2	15.4	9	69.2
Highest	245***	43.0***	94	38.4	27	28.7	51	54.3	23	24.5	17	18.1	30	31.9
Living area														
Rural	314	27.3	113	36.0	43	38.1	54	47.8	21	18.6	18	15.9	18	15.9
Urban	210***	56.9***	100**	47.6**	39	39.0	61*	61.0*	31*	31.0*	18	18.0	48***	48.0***
Overall	**524**	**34.5**	**213**	**40.6**	**82**	**38.5**	**115**	**54.0**	**52**	**24.4**	**36**	**16.9**	**66**	**31.0**

Source: 2012 Tanzania STEPwise approach to chronic disease risk factor surveillance[30]

Notes:

* p-value <0.05, ** p-value <0.001, *** p-value <0.0001, n=1,519

Table 5: How access to diabetes services varies by sociodemographic factors for older people

	Had blood glucose measured before		Was diagnosed with raised blood glucose before		Currently on insulin/oral drugs for raised blood glucose		Received advice on balanced diet		Received advice to reduce weight		Received advice or treatment to stop smoking		Received advice to start or do more exercise	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Sex														
Male	96	12.3	32	33.3	15	46.9	24	75.0	17	53.1	12	37.5	21	65.6
Female	102	13.8	26	25.5	13	50.0	18	69.2	15	57.7	7	26.9	16	61.6
Age group														
50-59	132*	14.0*	39	29.6	20	51.3	26	66.7	21	53.8	10	25.6	23	59.0
60-64	66	11.5	19	28.8	8	42.1	16	84.2	11	57.9	9	47.4	14	73.7
Education														
None	65	8.7	23	35.3	10	43.5	15	65.2	11	47.8	9	39.1	12	52.2
Primary	83	13.5	21	25.3	11	52.4	15	71.4	13	61.9	5	23.8	15	71.4
Secondary	29	28.7	5	17.2	3	60.0	4	80.0	1	20.0	0	0.0	2	40.0
College	21***	38.9***	9	42.9	4	44.4	8	88.9	7	77.9	5	55.6	8	88.9
Wealth quintile														
Lowest	21	8.1	7	33.3	4	57.1	5	71.4	5	71.4	4	57.1	4	57.1
Second	19	7.9	5	26.3	1	20.0	4	80.0	4	80.0	3	60.0	2	40.0
Third	22	12.3	5	22.7	5	40.0	5	100.0	3	60.0	2	40.0	4	80.0
Fourth	11	16.4	7	63.6	5	71.4	4	57.1	4	57.1	3	42.9	6	85.7
Highest	103***	18.3***	25	24.3	12	48.0	17	68.0	11	44.0	6	24.0	14	56.0
Living area														
Rural	83	7.2	26	31.3	15	57.7	19	73.1	12	46.2	9	34.6	13	50.0
Urban	115***	31.2***	32	27.8	13	40.6	23	71.9	20	62.5	10	31.3	24*	75.0*
Overall	**198**	**13.0**	**58**	**29.3**	**51**	**30.0**	**42**	**72.4**	**32**	**55.2**	**19**	**32.8**	**37**	**63.8**

Source: 2012 Tanzania STEPwise approach to chronic disease risk factor surveillance[30]

Notes:

* p-value <0.05, ** p-value <0.001, *** p-value <0.0001, n=1,519

Missed opportunities for care

Services for hypertension

Table 6 demonstrates significant differences in access to regular hypertension screening, but differences in access to other services were not statistically significant. More than half (54 per cent) of people aged 50-64 had never been tested for high blood pressure, and 74 per cent were newly diagnosed.

Inequalities related to gender, location, education and income had a strong association with lack of access to regular screening. Older men were less likely than women to have been tested for hypertension before (60 per cent and 48 per cent, respectively). Similarly, older rural residents were much less likely (61 per cent) to have had the test than urban residents (35 per cent). Older people without any education and those in the lowest-income households had the least access to screening compared with better-educated and wealthy cohorts.

Services for raised blood glucose

Table 7 examines access to services and control of diabetes. Similar to the results for hypertension, there are significant inequalities in relation to residence and weaker significance in relation to income: 71.7 per cent of newly diagnosed older rural residents and 87.5 per cent of those in the second poorest households had never before been screened.

Health service provision in relation to non-communicable diseases

Data from the Service Provision Assessment Survey 2014/2015 indicates that NCD services have been provided at different levels of healthcare facilities in the national health system, but by different degrees (Table 8 on page 27). Of the 1,200 healthcare facilities sampled, 953 (79.4 per cent) were found to provide such services: 66.5 per cent of dispensaries, 90.3 per cent of health centres, 95.1 per cent of hospitals and 49.2 per cent of health clinics. Each of the providing facilities performed patient diagnosis and management of conditions. Hospitals had more capacity for diagnosis and case management, followed closely by health centres, as compared with dispensaries and health clinics. In terms of the type of ownership of facilities, faith-based (mission) health facilities seemed to have been involved in the provision of diagnostic and case management services more than government/public, private-for-profit and parastatal (state-owned) facilities, despite their coverage being smaller than the number of government facilities.

In terms of location, more NCD diagnostic and case management services were being provided in urban than rural facilities.

Looking at specific NCD conditions, it is clear that diabetes had the lowest rates of diagnosis and management (68.8 per cent), compared with cardiovascular disease (CVD) (77.9 per cent). The gap in service delivery between urban and rural areas is larger for diabetes than CVD (14 and 5.4 percentage points, respectively). This could potentially explain the low testing rates for diabetes highlighted in an earlier section. Table 8 illustrates that hospitals, followed very closely by health centres, have been the leading providers of diagnostic and treatment services for specific chronic NCD conditions, particularly CVD, chronic respiratory disease and diabetes. Comparing the provision of diagnosis, case management and treatment of these conditions, faith-based facilities had the highest capacity, followed by government facilities. The majority (more than 60 per cent) of all types of facilities studied were delivering preventive and curative services related to NCDs.

Facilities in urban centres had more capacity to provide services for diabetes and CVD than those in rural settings.

Data from the Service Provision Assessment Survey 2014/2015 shows the percentage of healthcare workers involved in the diagnosis and treatment of chronic conditions related to NCDs who have undergone long-term training or an on-the-job refresher course (Figure 3 on page 28).

Table 6: How missed care opportunities vary by socio-demographic factors for older people with raised blood pressure

	Newly diagnosed never measured		Newly diagnosed previously measured		Previously diagnosed on treatment, not controlled		Previously diagnosed on treatment, controlled		Previously diagnosed not on treatment		Newly detected	
	n	%	n	%	n	%	n	%	n	%	n	%
Sex												
Male	211***	60.3***	74	21.1	13	3.7	4	1.1	48	13.7	285	81.4
Female	186	47.6	75	19.2	42	10.7	15	3.8	73	18.7	261	66.8
Age group												
50-59	219	51.1	94	21.9	30	7.0	11	2.6	75	17.5	313	73.0
60-64	178	57.1	55	17.6	25	8.0	8	2.6	46	14.7	233	74.7
Education												
None	216***	59.2***	65	17.8	24	6.6	11	3.0	49	13.4	281	77.0
Primary	151	53.9	58	20.7	20	7.1	5	1.7	46	16.4	209	74.6
Secondary	16	25.8	17	27.4	10	16.1	3	4.8	16	25.8	33	53.2
College	14	41.2	9	26.5	1	2.9	0	0.0	10	29.4	23	67.6
Wealth quintile												
Lowest	79**	68.1**	15	12.9	10	8.6	2	1.7	10	6.6	94	81.0
Second	64	56.1	19	16.7	7	6.1	6	5.3	18	15.8	83	72.8
Third	43	52.4	17	20.7	9	11.0	1	1.2	12	14.6	60	73.2
Fourth	11	37.9	6	20.7	2	6.9	1	3.5	9	31.0	17	58.6
Highest	142	47.2	77	25.6	17	5.7	6	2.0	59	19.6	219	72.8
Living area												
Rural	323***	61.3***	93	17.7	30	5.7	14	2.7	67	12.7	416	78.9
Urban	74	34.6	56	26.2	25	11.7	5	2.3	54	25.2	130	60.7
Overall	**397**	**53.6**	**149**	**20.1**	**55**	**7.4**	**19**	**2.6**	**121**	**16.3**	**546**	**73.7**

Source: 2012 Tanzania STEPwise approach to chronic disease risk factor surveillance[30]

Notes:

* p-value <0.05, ** p-value <0.001, *** p-value <0.0001, n=741

Table 7: How missed care opportunities vary by socio-demographic factors for older people with raised blood glucose

	Newly diagnosed never measured		Newly diagnosed, ever measured		Previously diagnosed on treatment, not controlled		Previously diagnosed on treatment, controlled		Previously diagnosed not on treatment		Newly detected	
	n	%	n	%	n	%	n	%	n	%	n	%
Sex												
Male	54	61.4	4	4.6	10	11.4	5	5.6	15	17.1	58	65.9
Female	53	61.6	7	8.1	8	9.3	5	5.8	13	15.1	60	69.8
Age group												
50-59	58	55.8	6	5.8	11	10.6	6	5.8	23	22.1	64	61.5
60-64	49	70.0	5	7.1	7	10.0	4	5.7	5	7.1	54	77.1
Education												
None	62	68.1	5	5.5	8	8.8	4	4.4	12	13.2	67	73.6
Primary	32	55.2	5	8.6	7	12.1	3	5.2	11	19.0	37	63.8
Secondary	7	58.3	0	0.0	1	8.3	1	8.3	3	25.0	7	58.3
College	6	46.2	1	7.7	2	15.4	2	15.4	2	15.4	7	53.8
Wealth quintile												
Lowest	15	60.0	1	4.0	2	8.0	3	12.0	4	16.0	16	64.0
Second	28*	87.5*	0	0.0	2	6.3	1	3.1	1	3.1	28	87.5
Third	11	57.9	3	15.8	1	5.3	1	5.3	3	15.8	14	73.7
Fourth	2	22.2	0	0.0	2	22.2	0	0.0	5	55.6	2	22.2
Highest	36	57.1	4	6.4	8	12.7	4	6.4	11	17.5	40	63.5
Living area												
Rural	81**	71.7**	6	5.3	7	6.2	3	2.7	16	14.2	87	77.0
Urban	26	42.6	5	8.2	11	18.0	7	11.5	12	19.7	31	50.8
Overall	**107**	**61.5**	**11**	**6.3**	**18**	**10.3**	**10**	**5.7**	**28**	**16.1**	**118**	**67.8**

Source: 2012 Tanzania STEPwise approach to chronic disease risk factor surveillance[30]

Notes:

* p-value <0.05, ** p-value <0.001, *** p-value <0.0001, n=174

Table 8: Proportion of health facilities that diagnose or manage NCDs by type, ownership and area

	Diagnose or manage NCDs		Diabetes		Cardiovascular		Chronic respiratory disease	
	n	%	n	%	n	%	n	%
Level								
Dispensary	330	66.5	245	49.4	313	63.1	293	59.1
Health centre	343	90.3	305	80.3	342	90.0	333	87.6
Hospital	250***	95.1***	248***	94.3***	250***	95.1***	250***	95.1***
Clinic	30	49.2	27	44.3	30	49.2	28	45.9
Ownership								
Government/public	610	77.9	503	64.2	596	76.1	582	74.3
Private-for-profit	145	77.1	138	73.4	143	76.1	133	70.7
Mission/ faith-based	180***	88.2***	167***	81.9***	178*	87.3*	173**	84.8**
Parastatal	18	72.0	17	68.0	18	72.0	16	64.0
Living area								
Urban	364***	82***	345***	77.7***	361 *	81.3*	347	78.2
Rural	589	77.9	480	63.5	574	75.9	557	73.7
Overall	**953**	**79.4**	**825**	**68.8**	**935**	**77.9**	**904**	**75.3**

Source: Service provision assessment survey 2014/15[59]

Notes:

* p-value <0.05, ** p-value <0.001, *** p-value <0.0001, n=1,200

Around 40 per cent of medical staff delivered services for diabetes management in both rural and urban areas. However, only about 10 per cent of such workers had an opportunity to be trained on diabetes issues. About 55 per cent of staff diagnosed and treated CVD, but only about 7-8 per cent had an opportunity to receive training on CVD management. By comparison, 46-47 per cent of healthcare workers were trained to diagnose and treat chronic respiratory disease.

6.2 Accessibility of health services

Table 9 presents older people's experiences when using health services. The majority of respondents (75.9 per cent) did not have difficulties accessing services. The most commonly reported problems were long waiting times and lack of medicine, experienced by 7.9 per cent and 7.6 per cent of older people, respectively.

Results were similar across demographic and socioeconomic groups. A shortage of medicines was more acute for those aged 70-79 (18 per cent) than for any other age group. The differences were not found to be statistically significant. In relation to the cost of the visit to a health facility, it was described as too expensive by 5.4 per cent of people aged 50-59, 6 per cent of those aged 60-69, 6 per cent of those aged 70-79 and 11.5 per cent of people aged 80 and older. These figures represent a general reflection on a visit to a health facility in the previous four weeks, and the data might not capture those individuals who either deferred or could not access services. Section 7 aims to bring more nuance to this discussion by examining specific issues in the provision of NCD services and in access to them.

Figure 4 shows that the majority of households with older persons (83 per cent) lived within 5km of a hospital, compared with nearly 17 per cent living further afield. Not unexpectedly, the proportion of the population living more than 5km from a health facility, which would require them to walk, cycle or take an animal cart, is higher in rural areas (20.5 per cent).

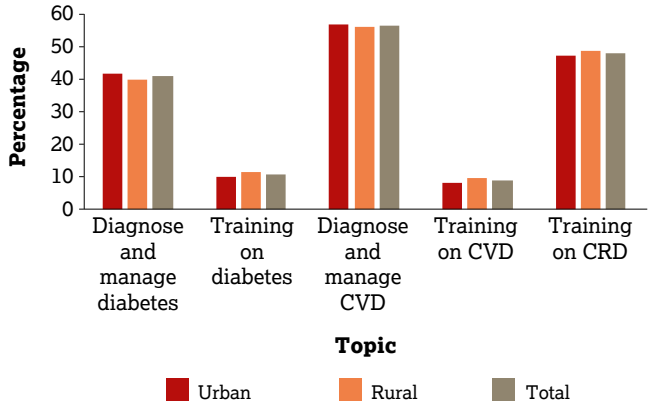
More detailed data on the modes or means of transport used by the respondents is shown in Table 10 on page 30.

Overall, 15 per cent of respondents travelled by private car; about 4 per cent used public transport; 0.2 per cent used animal carts; 13.5 per cent used bicycles; and the majority (67 per cent) walked to reach a facility. The degree and pattern of use of these means of transport was similar across genders and age groups, and there were no statistically significant differences. However, there was a strong association between having a college degree and taking a car (41 per cent), and between residing in a rural area and walking (68 per cent).

6.3 Satisfaction with the quality of health services

Table 11 presents results of older people's satisfaction with available health services. Of the total sample of 949 individuals, 630 (66.4 per cent) were highly satisfied, 148 (15.6 per cent) were moderately satisfied, and 171 (18 per cent) reported a low level of satisfaction. A similar pattern was observed

Figure 3: Proportion of medical staff involved in diagnosis and treatment of chronic conditions who received training or a refresher course

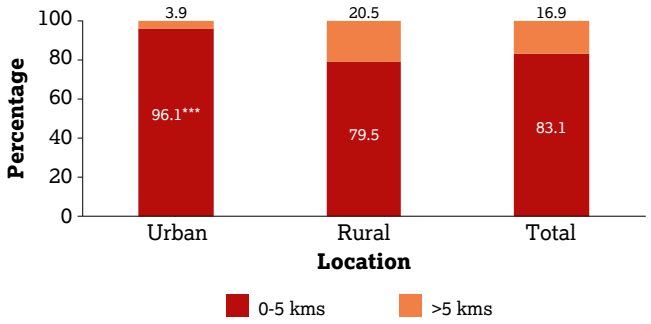


Source: National Panel Survey 2014/15, wave 4

Notes:

Chronic conditions include diabetes, cardiovascular disease (CVD) and chronic respiratory disease (CRD)

Figure 4: Households with an older person, living 5+km from a hospital and having to travel by animal cart, bicycle or on foot



Source: Tanzania Demographic and Health Survey 2015/16[59]

Notes:

*** p-value <0.0001, n=7,564

Table 9: How the types of problem faced while visiting a health facility vary by socio-demographic factors for older people

	No problem		Poor building		Long waiting time		Inadequately trained staff		Too expensive		Lack of medicines		Others	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Sex														
Male	126	74.1	3	1.8	16	9.4	3	1.8	7	4.1	13	7.7	2	1.2
Female	154	77.4	1	0.5	13	6.5	1	0.5	15	7.5	15	7.5	0	0.0
Age group														
50-59	148	79.1	2	1.1	12	6.4	2	1.9	10	5.4	11	5.9	2	1.1
60-69	79	74.5	1	0.9	12	11.3	2	1.9	6	5.7	6	5.7	0	0.0
70-79	34	68.0	1	2.0	3	6.0	0	0.0	3	6.0	9	18.0	0	0.0
80+	19	73.1	0	0.0	2	7.7	0	0.0	3	11.5	2	7.7	0	0.0
Education														
None	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Primary	105	80.2	3	2.3	9	6.9	2	1.5	3	2.3	8	6.1	1	0.8
Secondary	24	75.0	0	0.0	2	6.3	0	0.0	4	12.5	2	6.3	0	0.0
College	1	50.0	0	0.0	1	50.0	0	0.0	0	0.0	0	0.0	0	0.0
Location														
Rural	178	75.4	3	1.3	15	6.4	4	1.7	15	6.4	20	8.5	1	0.4
Urban	102	76.7	1	0.8	14	10.5	0	0.0	7	5.3	8	6.0	1	0.8
Overall	**280**	**75.9**	**4**	**1.1**	**29**	**7.9**	**4**	**1.1**	**22**	**6.0**	**28**	**7.6**	**2**	**0.5**

Source: National Panel Survey 2014/15, wave 4

Notes:

n=369

across genders, location, age and education. People aged 80 and over were the least satisfied (24.4 per cent). While this data represents satisfaction with general availability of health services in 2014 and appears to reflect the government's efforts to make health facilities available within walking distance, the next section shows that older people's experience of accessing NCD services is more challenging.

Table 10: How travel arrangements to the nearest health facility vary by socio-demographic factors for older people

	Car/motorcycle		Public transport		Animal/animal cart		Walking		Bicycle		Other	
	n	%	n	%	n	%	n	%	n	%	n	%
Sex												
Male	557	15.5	118	3.3	6	0.2	2,376	66.2	518	14.4	14	0.4
Female	582	14.6	150	3.8	7	0.2	2,716	68.3	505	12.7	15	0.4
Age group												
50-59	543	15.3	124	3.5	6	0.2	2,381	67.3	468	13.2	18	0.5
60-69	311	14.5	75	3.5	4	0.2	1,474	68.1	293	13.5	8	0.4
70-79	179	14.7	47	3.9	3	0.3	812	66.8	173	14.2	2	0.2
80+	106	16.5	22	3.4	0	0.0	425	66.1	89	13.8	1	0.2
Education												
None	420	13.2	114	3.6	10	0.3	2,084	65.7	532	16.8	14	0.4
Primary	564	15.5	102	2.8	0	0.0	2,499	68.7	458	12.6	15	0.4
Secondary	120	18.1	50	7.5	2	0.3	460	69.4	31	4.7	0	0.0
College	34***	41.0***	2	2.4	1	1.2	45	54.2	1	1.2	0	0.0
Location												
Urban	362	21.9	106	6.4	6	0.4	1,078	65.3	89	5.4	10	0.6
Rural	777	13.1	162	2.7	7	0.1	4,014***	67.9***	934	15.8	19	0.3
Distance												
0-1 km	253	7.6	116	3.5	8	0.2	2,805	84.4	137	4.1	6	0.2
2-95 km	886	20.9	152	3.6	5	0.1	2,287	54.0	886	20.9	23	0.5
0-5 km	854	13.6	242	3.9	10	0.2	4,599***	73.1***	572	9.1	12	0.2
6-95 km	285	22.4	26	2.0	2	0.2	493	38.7	451	35.4	17	1.3
Overall	**1,139**	**15.1**	**268**	**3.5**	**13**	**0.2**	**5,092**	**67.3**	**1,023**	**13.5**	**29**	**0.4**

Source: Tanzania Demographic and Health Survey 2015/16[59]

Notes:

* p-value <0.05, ** p-value <0.001, *** p-value <0.0001, n=7,564

Table 11: How satisfaction with health services varies by socio-demographic factors for older people

	High satisfaction		Moderate satisfaction		Low satisfaction	
	n	%	n	%	n	%
Sex						
Male	297	66.9	68	15.3	79	17.8
Female	333	65.9	80	15.8	92	18.2
Age group						
50-59	302	71.2	67	15.8	55	13.0
60-69	184	64.8	33	11.6	67	23.6
70-79	101	62.0	32	19.6	30	18.4
80+	43	55.1	16	20.5	19**	24.4**
Education						
Primary	227	68.4	45	13.6	60	18.1
Secondary	61	71.8	15	17.7	9	10.6
College	7	71.5	1	12.5	0	0.0
Living area						
Rural	411	64.8	98	15.5	125	19.7
Urban	219	69.5	50	15.9	46	14.6
Overall	**630**	**66.4**	**148**	**15.6**	**171**	**18.0**

Source: National Panel Survey 2014/15, wave 4

Notes:

* p-value <0.05, ** p-value <0.001, *** p-value <0.0001, n=949

7. What older people say about access to quality services for non-communicable diseases

As part of this study, two social scientists conducted four focus groups at community centres in Kinondoni district, with participants suffering from any NCD. Two groups were recruited in Tegeta Nyuki and two in Tandale. There were 8-12 people in each group, which were single-sex groups, to enhance freedom of expression. In total, 42 older people took part; each discussion lasted about 2 hours.

7.1 Demographic characteristics

Most participants had received some primary education, but while all of the male participants had attended at least some school, many female participants were illiterate (for example, 6 of the 10 females in Tandale). Most men were married, and more women were widowed. The age range of participants was 50-92 years.

Most participants had a combination of NCD conditions, most commonly eyesight problems, numbness with burning and pain, and hypertension (Table 12). Among these conditions, women suffered more from numbness and hypertension. A few participants had other CVDs and diabetes. Others had asthma, back pains, hernia, constipation, hydrocele, kidney problems, frequent urination and prostate and stomach problems. However, a majority did not have their condition diagnosed by a health practitioner.

7.2 Participants' understanding and perceived prevalence of non-communicable diseases

All participants were aware of what NCDs are, as suggested in the following quote:

" … when I hear the word NCDs in my mind it comes an idea that these diseases are brought by God as they can't be transmitted from one person to another."

Man, Tandale

Participants' understanding was substantiated by mentioning different types of NCDs and associated symptoms, such as hypertension, diabetes, eye problems, numbness, kidney problems and hernia. In both localities, participants perceived the prevalence of NCDs to be very high, particularly the feeling of numbness, burning and pain sensations, hypertension, diabetes and eye problems. The following quotes support these findings:

"For us old people the main problems are numbness of the lower limbs, backache … these conditions are [a bigger] threat than HIV/AIDS because with HIV you can get some medicines."

Woman, Tegeta

"These diseases [NCDs] have high prevalence. The communicable diseases are not problems among us. But these NCDs like hypertension, diabetes are big problems, and eye problems resulting from high blood pressure and numbness are prevalent all the time."

Man, Tandale

"In my view, NCD among old people is a leading problem because we hear everybody complaining of them; if she or he doesn't have hypertension then she or he must have diabetes."

Woman, Tandale

Table 12: Health profiles of focus group participants

	Tegeta Nyuki		Tandale	
	Males	Females	Males	Females
Number of participants (n)	12	12	8	10
Age group	60-83	50-81	66-86	50-92
Health conditions (n)	Numbness with burning and pain (8) Eye problem (6) Hypertension (2) Diabetes (2) Hernia (2) Ascites and kidney enlargement (1) Constipation (1) Hydrocele (1) Ribs ache (1)	Numbness with burning and pain (9) Hypertension (5) Eye problem (5) Headache (1) Diabetes (1) Ear problem (1) Stroke (1) Lung disease (1) Stomach problem (1) Tooth problems (1)	Numbness with burning and pain (6) Hypertension (4) Stroke (1) Diabetes (1) Head ache (1) Asthma (1) Heart problem (1) Worms (1) Prostate problems (1) Frequent urination (1)	Numbness with burning and pain (9) Hypertension (5) Eye problems (4) Diabetes (4) Ribs ache (1) Pneumonia (1) Back ache (1) Asthma (1)

However, one participant from Tandale said that even though older people suffer more from NCD conditions, there is also an increase among other age groups, with many young people complaining of hypertension, for example.

Participants felt that, despite older people suffering more from NCDs than other age groups, they are not given high priority. They strongly expressed the belief that they had contributed to the country's economy when they were more energetic and therefore should be given priority in their old age:

> *"The government without us elderly can't move. Nowadays, the youths who are elected to lead us are the ones killing us as they don't give us a priority. Surprisingly, these young leaders can dare even to say 'these old people are crazy'."*
>
> Man, Tegeta

Participants' understanding of risk factors for non-communicable diseases

The participants cited modern lifestyle factors as contributors to many NCDs. For example, they said that in the past, people's diets involved more natural ingredients, such as oils extracted from natural sources, sorghum and cow's milk, and there were no NCDs:

> *"Personally I think that diseases like hypertension, we get them from food we eat. For example, we Nyaturus … used to eat sorghum that was natural. But nowadays even when you plant maize you have to use chemicals to [ensure] growth. Salt we use nowadays is not natural; in the past we were using natural[ly] extracted salt … the cooking oil[s] we are using are unsafe, different from the past where we were using oil from sunflowers, sesame,*

Table 13: Understanding of NCD risk factors among focus group participants

Tegeta	Tandale
Cholesterol	Preservatives in drinks and foods
Blood vessel constriction	Cooking oil (e.g. korie)
Food types, such as broilers	Flour (which is perceived to contain iron particles from machines, due to wear and tear)
Pesticides applied to vegetable crops	Age
Artificial spices	Chloride for water purification
Unsafe cow's milk (contaminated with medicines)	Food types
Non-iodized salt	Air contamination
Unsafe cooking oil (e.g. korie oil, which has high cholesterol, and the use of transformer oil)	Artificial fertilisers used on vegetable crops
Poor nutrition (lack of vitamins)	Pesticides used on maize crops
Food insecurity (not always getting 3 meals a day)	
Food flavours	
Iodized salt (causes problems even for young people)	

coconut oil, etc. Even the soft drinks [soda] are not safe for our health. We eat fake stuff which contributes to a wide range of health problems."

Man, Tegeta

Table 13 shows that in Tegeta, participants focused more on chemicals and pesticides in food items, particularly vegetables and animals such as broilers and cows, as contributors to NCDs. In Tandale the focus was on preservatives in foods and drinks and pesticides on crops such as maize.

"The farmers usually use insecticides … [on] their vegetables but they don't give it an interval before [they] start selling them; as a result we are directly affected by the … insecticides as they are still active …"

Woman, Tegeta

"… more investigations are needed especially … [on] these broilers. Just imagine a chicken is harvested within two weeks. What type of chicken is that! And they tell us not to eat their bones because all the chemicals for rapid growth are deposited there …"

Man, Tegeta

Cholesterol and age were perceived as additional risk factors in Tegeta and Tandale, respectively. There were variations in responses within the same group regarding the quality of salt. While participants mentioned non-iodised salt as a risk factor for NCDs, some highlighted iodised salt as causing more problems among young people. Food insecurity and poor nutrition were more commonly cited as risk factors in Tegeta than Tandale.

7.3 Health-seeking behaviour

Most participants at both sites attended lower-level health facilities when they experienced health problems related to NCDs. However, when symptoms persisted, they received referrals to higher-level facilities, and sometimes self-referred. A few participants first visited private facilities, but due to the higher costs they subsequently went to government facilities and followed the referral system. While attending clinic sessions, a majority of participants reported dropping out of treatment due to the distance and a lack of medicines. In the latter case, they chose to buy medicines from drug shops. Only one participant reported that she did not consult any health facilities, despite suffering from numbness of the lower limbs. Some participants were referred to higher-level facilities, but were hesitant to go despite having an exemption card as they thought the card would not be accepted:

"My main problem is hernia. I have been referred to Mwananyamala hospital as I need to be operated [on], but I had the thinking that the exemption card could not

cover the operation costs. It only covers medicines; so I have just decided to stay at home … "

Male, Tegeta

This quote highlights the lack of information many patients have about their rights and entitlements to free health services, but equally it may suggest that health facility personnel are not providing services free of charge to those with exemptions.

None of the participants consulted traditional healers, as they feared they would contract an infection by sharing medical instruments. However, some people reported independently using local herbs as supplements, such as moringe and graviola leaves, alongside Western medicines.

7.4 Quality of services

Table 14 reports that participants visited different levels of health facility, namely dispensaries, health centres and hospitals. The fact that dispensaries did not provide services at night worried some participants, as these facilities would be unreliable in the event of an emergency.

Interpersonal relationship with healthcare providers

While in Tegeta participants did not voice any complaints about their relationships with healthcare providers, Tandale participants were dissatisfied:

"The language used by care providers differs depending on the visitation day … some days you can be attended well while in other days doctors can just write the prescription without listening [to] the full story or asking questions."

Man, Tandale

"I escorted my wife to Tandale dispensary, but care providers used harsh language and told her 'you are HIV positive'. When we were back home my wife committed suicide … "

Man, Tandale

In Tegeta, participants praised care providers, who were said to have a 'good heart'. Participants said that the current government has made providers accountable; they receive patients well and provide advice and treatment as necessary.

"In the health facilities I visited, I did not face any harassment from care providers. They received me very well. The waiting time … is due to long queuing as there are many patients, and this is unavoidable. Personally, I am not disappointed."

Man, Tegeta

Medicines and diagnostic services

Slightly over two thirds of older people complained of medicines being unavailable. Participants with exemption cards said that they were either given partial doses or were directed to buy medicines from private pharmacies. Simple medicines such as paracetamol and antimalarial medications were reported to be available. One third of respondents who were satisfied with the availability of medicines consisted of 12 male participants in Tegeta and a female in Tandale. Participants said that most diagnostic services were not available at lower-level facilities, and vital signs such as blood pressure and weight were not examined.

Availability of a special consultation room and specialists for older people

None of the participants had been into a special consultation room or seen a special doctor for dealing with older people at any level of health facility. However, they were aware of a special place for keeping files for people eligible for exemption, including older people. They also mentioned that there were specialists for dealing with diabetes and hypertension/heart problems at Mwananyamala hospital, who worked with all age groups. While participants acknowledged a need for a special doctor to care for older people, they noted that it would be difficult for a single doctor to manage all NCD conditions affecting

Table 14: Focus group participants' perceptions of service quality

Variables	Tegeta Nyuki	Tandale
Interpersonal	Good relationship	Good relationship for the majority
Medicine availability	Inadequate	Inadequate
Waiting time	Lack of priority service for older people	Lack of priority service for older people, except for asthma patients
	Long waiting time because of so many patients	Long waits due to large number of patients
Special rooms for older patients	At Mwananyamala, for file-keeping only (not for consultations)	None
Care providers	No specifically trained doctors for older people	No specifically trained doctor for older people
	Inadequate number of care providers	At Mwananyamala hospital, specialists for diabetes and heart problems only
Distance	Nearby dispensaries are available	Nearby dispensaries are available, but transport is still needed because of clients' health conditions
	Referral hospital is very far (Mwananyamala or Muhimbili)	
Diagnostic facilities/ services	Mostly unavailable at dispensary level	Major services were unavailable at lower-level facilities
	All available at Mwananyamala hospital	Available at Magomeni and Mwananyamala

older people. They noted that there were special consultation days allocated to older people and children suffering from NCDs, which was an improvement aimed at reducing waiting times. Although the policy of treating older people first was not honoured at any facility, participants noted that patients suffering from asthma were given high priority, receiving treatment as soon as they arrived.

Distance

All participants reported that there were dispensaries near to where they lived. Referral hospitals were perceived to be very far away, especially for participants from Tegeta. The main complaint was about transport costs, as most older people have no income. Even when facilities were nearer, poor mobility meant that people were unable to walk and were forced to find some form of transport. Participants noted that not having someone to accompany them to a health facility made their life more difficult.

> ***"The available dispensary serves Boko and Pwani streets. Where we are now [Pwani] is very far to reach Ununio and … will take time. We are …[asking] to be provided with [a] first-aid kit with important medicines for elderly NCD conditions."***
>
> Man, Tegeta

7.5 Universal health coverage

Most participants had not heard the phrase 'universal health coverage' before attending the focus group.

Costs of healthcare services

When asked how they met their health costs, participants referred to their use of cash prior to 2018. Exemption cards were provided in 2018, and, since then, the cards had been used to access services by 7 of the 8 participants.

Services covered

Though exemption cards have been made available, participants were not always certain which health services were covered under the scheme. Participants believed they only covered consultations. They thought that most prescribed medicines were not available and that they would have to contribute to the costs of diagnostic services.

> ***"The system is not yet clear because a person can have an exemption card but she or he still has to purchase medicines [and] pay for diagnostic services such as x-rays. Personally, I am not happy about that."***
>
> Man, Tegeta

> ***"I am an asthmatic patient. I went to the hospital and because I had the exempted card they gave me [a] half dose [a single injection instead of two]; as a result my condition did not improve as I was expecting. If I could have my cash, I could be given the whole dose."***
>
> Man, Tandale

Furthermore, exemption cards were only valid at government health facilities. When participants were referred to higher-level facilities, fewer services seemed to be covered by the card, which was confusing.

> ***"I was suspected to have a heart problem at Tandale dispensary so I was referred to Mwananyamala hospital for further investigation. At Mwananyamala I was required to pay for the investigation services but I told them that I don't have money as I am exempted. They told me 'all people exempted are paying for that service, why not you?' Because I had no money, I had no option [… other] than going back to Tandale. At Tandale dispensary I was asked, 'why have you escaped from Mwananyamala?' I responded that I didn't escape, rather I was told to pay for the services that I couldn't afford. The clinician told [me] to [… ask the] grandchildren to cover the costs … "***
>
> Man, Tandale

Participants said that services at higher-level health facilities such as Muhimbili and Mloganzila are very expensive. One person commented that, when patients who cannot afford to pay are sent to these facilities, they do not receive services. This is known as being 'dumped':

> ***"The situation is not good. Services are very expensive and at Mloganzila hospital, specialists are very few. Sending your patient to Muhimbili or Mloganzila is like dumping her or him."***
>
> Man, Tegeta

Participants were unclear which services were covered by exemption cards and at which levels of health facility. They expressed concern that their inability to purchase the drugs they were prescribed or to pay for diagnostic services would result in their health conditions deteriorating and lead to other associated conditions.

Older person undergoing diabetes screening in a mobile clinic in Zanzibar

Lack of priority given to older people

Participants reported that little attention was paid to older people with exemption cards. Some reported being ignored by care providers, or that providers did not recommend even basic diagnostic tests as they knew the patients could not pay for them.

> ***"I was referred to Mwananyamala hospital for x-ray services because I had a heart problem, but it was difficult for the doctor to recommend x-ray for me. He told me 'I am not writing this because you cannot pay 40,000Tshs.' We discussed and finally he wrote [it]. When I went to the x-ray unit the provider ask[ed] me to pay 40,000Tshs. I replied that I am exempted. He sent me back to [the] doctor to bring another form. The next day I was back for x-rays. I queued for the service but those with cash payment were first served, until … I complained again, and finally I was attended."***
>
> Man, Tandale

Participants felt that their needs should be prioritised similarly to those of children and pregnant mothers. Very few participants had health insurance cards. Some were willing to join the National Health Insurance Fund (NHIF), but said that cumbersome enrolment procedures were a barrier to joining. In particular, enrolment requires them to be members of a community group, such as a registered savings and credit cooperative society (SACCOS) or village community bank (VICOBA). They were likely to be ineligible to join such groups due to their age. Participants who had no exemption or other insurance cards complained of having to make cash payments, with a majority depending mainly on their children and other relatives for money.

Resource allocation for health

None of the participants reported having allocated financial resources at the household level to cover healthcare services, mostly because they had no source of income.

> ***"You can have an intention to allocate some money for health services, but due [to] poverty you end up using it to purchase other items such as food."***
>
> Woman, Tandale

Most people said they were depending on their children for survival and for healthcare services. Men were cited as the main decision-makers at the household level. In rare cases, women had the final say:

> ***"Some male partners are there just [in] name; everything depends on mothers. For example, if a child is sick you can hear a husband directing a child to her mother."***
>
> Woman, Tandale

Receipt of medical advice

Most participants received medical advice from care providers, for example, on alcohol use, smoking, avoidance of salt, sugar and fatty meat, the use of small amounts of cooking oil, eating of unrefined food and drinking lots of water.

> ***"I was an asthmatic patient so the doctor advised me to use white bed sheets, avoid using firewood and sleeping in a room with big windows …"***
>
> Woman, Tegeta

At some facilities, especially Ocean Road Hospital, there were special health education sessions in the morning. However, many participants said it was difficult to follow the advice they were given because they were dependent on their children and grandchildren for their survival, and therefore unable to control their diets.

8. What healthcare workers say about non-communicable disease services for older people

Two in-depth interviews were conducted with social welfare officers at one of the district and referral hospitals in Dar es Salaam. At the district hospital, a nurse and a second social welfare officer joined the interview. The aim was to explore their perceptions, experiences and understanding of older people's access to healthcare services related to non-communicable diseases (NCDs). Interviewees had been working at the hospital in the same positions for at least three consecutive years.

8.1 Main non-communicable disease conditions and their associated risk factors

Diabetes and hypertension were cited as the most common diseases among older people, with women having more cases of hypertension. Lifestyle and poverty were named as the main risk factors. Healthcare providers noted that harassment from irresponsible children attributed to more stress among older people:

> ***"In this area many youths are unemployed and are also drug users. They don't contribute anything to their parents; instead they demand them to sell their properties such as houses. The old people also take care of their grandchildren who have been abandoned by their parents. Just imagine at the age of 60-70, children are still depending on their parents for survival. Old people are not happy with this situation as it causes them to develop hypertension."***
>
> Social welfare officer, district hospital

Other social determinants included a lack of care homes for older people with limited social support. Without this institutional support, some older people are forced to live in the streets, as beggars. Respondents also mentioned that a lack of preparedness for old age leaves many people without enough income, so they are dependent on their children and other relatives.

8.2 Hospital budgeting for activities related to meeting the needs of older people

Participants reported that social welfare officers take part in drawing up hospital plans, to make sure that people exempted from paying for services are considered. This involves allocating funds for the following:

- Pharmacies and laboratories, to ensure the availability of medicines and lab equipment/reagents needed to address conditions experienced by older people, with medicines for hypertension and diabetes given high priority;
- Food for displaced older people and other patients who have been abandoned; and
- Transport for those who are displaced and would like to reunite with their families (family reunification).

In about 80 per cent of cases, the proposed activities are endorsed and included in the budget. However, obtaining and using the funds is a highly bureaucratic process. For example, the tendering process for hiring food vendors or caterers in some facilities is a challenge. Participants noted that religious institutions provided some support for meals and other necessities at hospitals for people with limited or no income and those exempted from paying for services.

8.3 Policies and guidelines for older people

Participants reported that village councils, which are responsible for identifying people who qualify for waivers, do not follow the criteria for enrolment. As a result, all older people are registered regardless of their economic status. Social welfare officers are then forced to spend time determining eligibility. This has led to disappointment and delays in older people receiving services.

> ***"The trust with the village [street] government to identify eligible elderly individuals is worrisome, as all are enrolled. Once the old people arrive … [at] the exemption desk, as a social welfare [officer] I must assess them again based on the stipulated criteria, and sometimes I do convince them to contribute partly. This tendency adds more complaints … [at] the exemption desk."***
>
> Social welfare officer

One social welfare officer reported that some people who were exempted from paying for services had vehicles and were escorted by relatives who would not be categorised as poor.

8.4 Targets set for each care provider

At the hospital, health workers reported being urged to estimate the income they would generate in the forthcoming financial year. As a result, staff at the facility, especially within diagnostic units, complained to the social welfare officers if there were many exempted cases.

> ***"'You are bringing only exempted people; what will I report if I … [do] not meet my estimation?' … if I have sent three or four [people] for x-ray[s], other … [people] with … [a] good position … I … convince … to pay or contribute partly or tell them to come [the] next day … the aim is to maintain [a] good relationship between the social welfare officer and staff providing other services. To me this is not fair, but what should I do? Every day, each provider must state how much she or he has generated in their respective departments, so the income generated from those purported to be exempted is not termed as income from the exemption, rather the general income in the respective department."***
>
> Hospital staff member

The policy mandates that extremely poor older people should not only receive healthcare services free of charge, as all older people should under the exemption system, but they should also have fees waived, or otherwise receive meals and accommodation through the support of the government, families and communities (village/street government). There are shortcomings, however, in applying the national policy at village level. One participant expressed great concern about this:

> ***"The village [street] government and the family have abandoned the elderly. Just imagine the village government is not even responsible … [for] ensuring that they adhere to the criteria of enrolling the 'real poor'. They … provide letters/exemption cards to all. … the village government [should use] … their own [resources, so] they can support the very poor in enrolling … in the improved community health fund. But this is not done."***
>
> Hospital staff member

8.5 Healthcare providers' perceptions of the lack of priority given to older people

Participants reported that some government funding sent to the village (street) level does not consider the needs of older people.

"Although this group is unable to participate in … income-generating activities, the 'village' government leaders could have given the loan to the relatives/caretakers, but this is not considered."

Social welfare officer

The exemption policy was reported to include all chronic illnesses, but due to implementation challenges, limited resources and medicine shortages, the services are not all free. The social welfare officer reported that the exemption card ends up covering the consultation only and not the rest of the recommended or prescribed services. That is, all other services are entered in the cost-sharing block, and they will therefore charge for all other services. If the individual patient claims to have no money, he or she will go back to the social welfare officer, who, based on an assessment of the patient, can endorse free services. This was supported by the following quote:

"Sometimes the inpatient is asked to contribute half of the total costs; if found … completely unable to pay, we do waive but there are various procedures to follow before [issuing a] waiver. For the outpatients, all costs are placed under credit, and in case the patient decides to go home without paying, the next visit [he or she] will be asked … why he or she … [left] without clearing the bill. Once found to be really poor … the waiver is provided."

Hospital staff

8.6 Availability of medicines

Pharmacists have tended to provide an incomplete dose to exempted patients. This is because, when there is limited availability of medicines, the available doses are shared among all clients. Some pharmacists advise patients to come back once they finish the dosage they have been given, or to buy more using their own money. However, the pharmacist will advise patients to purchase medicines from a pharmacy near to where they live if they estimate that the transport costs of returning to the hospital would be higher than those of purchasing the medicine locally. Despite the lack of availability of medicines in the dispensing room, clients who pay cash or are covered by insurance receive a full dose.

"As a social welfare officer, I do visit the pharmacy to know the type of medicines available for elderly disease conditions, especially for diabetes and hypertension, and I will relay such information to the clinician in the clinics so that he or she can prescribe the available medicines. Sometimes you may find that the medicines are in the store, but the pharmacist can continue prescribing [an] incomplete dosage or directing them to buy them outside the facility instead of going to pick them [up] from the store. This is [irresponsible]. It is important that … each day, the pharmacist ensures that all drugs are in the pharmacies based on the estimation of clients per day."

Social welfare officer

8.7 Healthcare providers' perceptions of provider relationships with older patients

One interviewee reported that the local hospital had a consultation room for older people in the outpatient department, but it was staffed by a single clinician. However, at clinics specialising in NCDs, where most clients are older people with hypertension and diabetes, some hospitals have assigned specialists who are also older, rather than assigning younger clinicians. Clinicians were said to treat patients well and to use appropriate language. The respondent cautioned, however, that older people entering the clinician's room tend to have "lots of stories", so the clinician needs to be patient. Some older people are hearing-impaired, so the clinician must talk to them carefully when providing instructions. This is why relatives or caregivers are advised to escort older people to the hospital to ensure that instructions given by the clinicians are followed. The

interviewee noted that, in the past, a provider in the pharmacy department used harsh language with patients, but that has changed.

8.8 Waiting times

At clinics specialising in NCDs, one respondent noted that patients had no complaints about waiting times, but in outpatient departments they were unhappy about having to move from one section of the facility to another.

> ***"There is a policy for the severe cases and elders [are] to be served first. But other patients … complain by saying ' … you are receiving healthcare services free of charge, [so] you are adding burden and loss to the government'. … the elders are disappointed and [feel] disrespected."***
>
> Hospital staff member

8.9 Universal health coverage in practice

One interviewee (a social welfare officer in charge of facilitating patient exemptions) was familiar with the concept of universal health coverage (UHC) and the government commitment to ensure that older people and special groups are exempt from paying for services, so that all individuals receive care when they need it. Other measures cited as being part of efforts to ensure UHC were allocating a consultation room and clinician especially for older people, increasing the availability of medicines, creating a section for social welfare officers and improving the Community Health Fund (CHF). The interviewee said that 10 per cent of older people are covered by the national health insurance system, 10 per cent pay cash, and 80 per cent are under exemption. He said that there is a new guideline for identifying 'needy' patients, which is likely to set strict criteria for those who are eligible, but it is yet to be implemented.

The healthcare workers who were interviewed made several specific suggestions:

- Older people should join the CHF to prevent unnecessary harassment and contradictions, and for those who are not able to pay to be assisted by the village government or organisations, such as TASAF.
- Politicians should clearly advocate for the Ministry of Health 1997 cost-sharing guidelines to avoid confusion and unnecessary conflicts.
- Village governments should adhere to the stipulated criteria for enrolling individuals for exemption.
- The national health insurance scheme should have a special package for older people, as it does for children and students, as older people are ineligible due to poor mobility and/or age to join groups that can provide them with insurance.
- Health facility infrastructure should be improved to make it user-friendly for older people.
- There is a need for more education by healthcare staff to explain the association between hypertension/diabetes and eye problems.

9. Discussion

Achieving universal health coverage (UHC) is vital for ensuring access to high-quality, equitable health services for all. It should be viewed as a basic human right. In Tanzania, strategies to ensure UHC began after independence. Over time, it has led to reforms such as a payment waiver and exemption system for people who are poor and for older people, as well as prepayment schemes such as public and private insurance.

9.1 Barriers to older people's access to healthcare

The government has developed policies and an action plan for the prevention of non-communicable diseases (NCDs). Despite these efforts, older people still face barriers to accessing healthcare services for NCDs at different levels, from primary up to tertiary facilities. There are inequalities in access to essential NCD services, with more access in urban than rural settings, for wealthier individuals, those with more education and in terms of gender, though in some cases women were better able to access services than men, and in other cases the opposite was true.[49]

The root causes of these inequalities in access were not explored in this report. However, the wider literature demonstrates that inadequate access to financing (health insurance) affects access to health services and contributes to poorer health outcomes. Limited service provision can also be attributed to a lack of motivation on the part of service providers or to understaffing and patient overcrowding in healthcare facilities.

A shortage or lack of key diagnostic facilities (such as medical devices and chemical reagents) and trained healthcare workers, especially at primary healthcare facilities, are also factors limiting the achievement of UHC in the context of preventing and controlling NCDs in low- and middle-income countries.[49] This is supported by our study findings. Analysis of data from the 2014/2015 Service Provision Assessment Survey indicated that, although NCD services have continued to be provided at different levels of healthcare facilities in the national health system, some services, such as those needing more skilled diagnostic and surgical skills, were not available at lower-level facilities such as dispensaries and health centres. Therefore, patients were forced to go to higher-level facilities (such as hospitals), most of which are found in urban centres, while most people live in rural areas or remote/peripheral settings of towns and cities. People in need of services have to travel long distances, which discourages health-seeking behaviour.[56]

Additional analysis undertaken as part of this study but not included in the main report indicates that the number of health facilities providing NCD services varies from one region to another and within the regions, by type of ownership, highlighting another source of inequality in coverage of essential services to populations of different regions. We also found an imbalance in the rural/urban distribution of healthcare workers with the knowledge and skills needed for carrying out diagnostic, surgical and case management procedures for specific NCDs.

The statistical data reveals that older people living with certain NCD conditions do not have full access to the services they need. Qualitative evidence collected in Dar es Salaam indicated that older people face barriers including lack of adequate income, poor health provision at lower-level facilities and lack of respect from health staff. The same is likely to be true for the rest of the country and rural areas, where economic and infrastructure issues are greater. Clearly, more concerted efforts are needed to achieve UHC.

Our analysis revealed a combination of systemic, social and geographical barriers to older people's access to services. These include: the bureaucracy involved in procuring an exemption card/recommendation letter; the stigma and discrimination experienced by people who demand the exemptions to which they are entitled, in healthcare institutions where providers are not motivated to administer the exemptions, misunderstand the guidelines for exemptions, or have been instructed by the authorities not to offer exemptions;[67] the distances involved in reaching healthcare facilities that provide recommended services; lack of skilled service providers and capacity of healthcare institutions to deliver at least some of the key services, sometimes due to poorly constructed buildings that cannot accommodate the needs of patients; and the lack of essential drugs at affordable prices and diagnostic facilities, especially at primary-level facilities such as dispensaries.

9.2 Delivering financial protection and health service for older people

When an existing policy is believed or proven to be vague or unclear, it is less likely to be implemented properly or at all. This was demonstrated through interviews with key informants, including older people with NCDs and hospital-based staff, particularly in relation to confusion in the interpretation of exemptions and waivers. Waivers are meant for people who are unable to pay and who have met eligibility criteria as assessed by the authorities and cross-checked by frontline health service providers or social welfare officers. However, exemptions are meant for children under age five, pregnant women, people with chronic conditions and people aged 60 or older, regardless of their ability to pay.[22,68] Our research with key informants proves that people eligible for exemptions end up paying for at least some services, which is not in line with existing government policy.

Due to government policy, service providers have an incentive to try to recover part of the service provision costs. In the absence of practical compensation arrangements with the government, vulnerable groups are likely to continue being charged for services that should be free, creating conflicts between service providers and their clients.

While most older people in our analysis reported satisfaction with the services they received, they cited various inconveniences, particularly long waiting times, lack of some drugs and high cost of some drugs. We found no evidence of significant differences in the pattern of NCDs in terms of the costs borne by respondents with different sociodemographic characteristics. However, older people reported paying out of pocket for various medical services, even though government policy recommends that these services be free of charge. For example, the exemption policy is reported to apply to all chronic illnesses, but the services are not all free, as most medicines are not available, and when they are available, recipients are given only a half or quarter of the prescribed dose. This highlights a key challenge in addressing NCDs that is supported by the results from our interviews and focus group discussions, and from the review of the literature. This situation has been described by other researchers as critical, since it reveals systemic factors contributing to inequalities in access to primary healthcare and contravenes the policy and efforts aimed at achieving UHC.[69]

9.3 Making UHC age-inclusive

This study clearly demonstrates that there is still a long way to go to achieve UHC for older people with NCDs under existing healthcare prepayment arrangements and current levels of enrolment in health insurance schemes. While offering citizens multiple and alternative sources of health insurance can be beneficial, national health insurance policy authorities need to reconsider the current insurance programmes. This includes re-examining benefit packages of prepayment systems in both the formal and informal sectors; learning lessons from the good and bad practices in approaches to membership mobilisation; defining benefit packages; risk-pooling approaches; and putting management structures and accountability systems in place to ensure the creation of more inclusive, cost-efficient, equitable, well-managed and sustainable insurance schemes. The report also shows that the system of health

insurance schemes, exemptions and waivers does not offer adequate coverage and financial protection of older people, and there is a pressing need for a nationwide prepayment scheme that offers high-quality coverage to all.

The analysis indicates inequalities in access, with more men than women covered by the formal insurance system, and higher levels of insurance coverage among people under age 60, those in urban compared with rural areas and those with more and formal education. The regional and other variations in people registered under formal insurance schemes is a crucial point for policy-makers, considering the equity implications of the existing health financing system for the achievement of access to essential NCD services in Tanzania. The imbalanced share of women and men in the insurance system reflects culturally rooted gender imbalances that have disadvantaged women in many dimensions of development, including those related to health.[70] This calls for continuing efforts to reduce gender inequalities, including sociocultural values and beliefs that disempower women in general and limit their right to access essential health services.

9.4 Missed opportunities in statistics on ageing

The study highlights a number of national-level data sources that collect data on older people, their health status and utilisation of health and care services. However, even with this available data there are limitations. The STEPwise approach to surveillance (STEPS) survey conducted by the World Health Organization and the Tanzania Ministry of Health and Social Welfare on the prevalence of NCDs and access to health services excludes people aged 65 and over. The second dataset used in this study is the Tanzania Demographic and Health Survey (DHS). While the DHS has an optional module on NCDs, it was not included in the 2015 survey. This means that certain groups of older people (for example, aged 65 and older) continue to be invisible in the nationally representative datasets. Additional gaps include the paucity of recent data on older people's pensions and income. This information is important to accurately measure catastrophic health expenditures incurred by older men and women.

10. Conclusions

Every person has the right to adequate, good-quality and affordable health services. The global commitment to universal health coverage (UHC) is the pathway to realising this right. Governments in low- and middle-income countries are struggling to ensure the right to health for all, in part due to the rapid demographic and epidemiological changes taking place in their countries. This report examined how the Tanzanian government is addressing these challenges through its efforts to achieve UHC, and explored inequalities in access and care quality experienced by older people, and the actions required to achieve UHC.

The report found that, overall, there are low rates of insurance coverage and financial protection among older people in Tanzania. Only around one in eight people aged 50 and over have insurance, and nearly three quarters (73.6 per cent) still incur out-of-pocket expenses for health services despite government policies mandating fee exemptions for this population. Focus group discussions revealed that older people suffering from non-communicable diseases (NCDs) could not afford to put aside financial resources to cover health-related costs. Most older people (94.7 per cent) who returned to receive a second treatment had to pay for it themselves, potentially increasing the risk that they and their families would be faced with catastrophic health expenditure. A system of exemptions and waivers aims to complement health insurance schemes by ensuring older people have access to affordable health services. However, in practice, it does not provide sufficient protection due to problems with identifying eligible beneficiaries, inadequate service coverage, expectations of out-of-pocket expenditure, and administrative barriers to implementation of waiver and exemption schemes. Due to these systemic challenges, people who are able to pay for services out of pocket are given priority for medication and treatment.

Access to NCD services remains low: around one in three people (34.5 per cent) aged 50-64 had ever had their blood pressure measured, and only one in eight (13 per cent) were tested for diabetes. While all older people who were consulted for this study knew about NCDs and their causes, it is not clear whether they were aware of and took measures to prevent the onset of NCDs before they developed conditions. Data shows that 79 per cent of health facilities diagnose or manage chronic conditions. But nearly all hospitals (95 per cent) provide these services, compared with around half (49 per cent) of clinics. Research participants reported that few diagnostic services are available at lower-level facilities, and when they are referred to a hospital, they have to travel long distances and incur additional costs.

Two thirds (66 per cent) of people aged 50 or older who received health treatment reported being satisfied with the quality of health services. However, this varied by age, with around a quarter of those aged 80 and older reporting a low level of satisfaction, and one in eight (11.5 per cent) citing high treatment costs as a problem. During focus group discussions some older people reported a lack of consideration and respect from health staff when they visited a facility, which could be a result of ageism and lack of training on age-related health and care. In fact, only 1 in 10 medical providers who diagnose diabetes had training on diabetes.

The report also shows stark inequalities within the older population, with less access to services and health coverage among those in rural areas and those with no education. The majority (92.8 per cent) of older people in rural areas had never been tested for diabetes, whereas around two thirds (68.8 per cent) of older urban residents had never been tested. Older people with a university degree were 11 times more

likely to have health insurance than those with no education (59 per cent and 5.4 per cent, respectively).

Gender-based gaps show that while older men are more likely to have health insurance than women (12.7 per cent and 10.6 per cent, respectively), women are more likely to access services. For example, just under a half (43.7 per cent) of older women were previously measured for hypertension, compared with around a quarter (25.8 per cent) of men. Income is also a determining factor when accessing NCD services.

Focus group discussions with older people and health providers revealed a multilayered problem. First, there is a lack of cohesion between local-level authorities (village councils) and social welfare officers with regard to issuing waivers for health services, leading to errors in enrolment and a need for additional resources to correct these errors. Second, government policy direction to health providers to generate income and recover costs puts pressure on doctors to either decline services that older people are entitled to receive for free, or to provide inadequate treatment, such as incomplete medication dosage. Third, there are shortages of medication. Fourth, the process for enrolling in insurance schemes (for example, the National Health Insurance Fund) is cumbersome.

The wider implication of these systemic failures is that older people are unclear about the services they are entitled to receive for free and at which facilities. In 2014 the general satisfaction with health services among older people was relatively high (66 per cent); people aged 80 and over were least satisfied (24 per cent). However, in relation to access to NCD services, the qualitative evidence from this study showed that older people are frustrated with health provision and worry about their health deteriorating further because of the barriers they face in accessing services. Some respondents were deterred from seeking treatment due to lack of awareness of their right to health, limited services and medication covered by health insurance (for example, the Community Health Fund) and an expectation that they would be asked to pay for some services.

11. Actions we can take together

The Global AgeWatch Insights report, *The right to health for older people, the right to be counted* has identified the key elements that make a health system fit for purpose in an ageing world. *Tanzania Insights* has revealed eight action areas that the government and other stakeholders can pursue to ensure that the health service meets the needs of its older population, ensures their right to health and works towards universal health coverage for all.

11.1 Leadership and governance

- The Tanzanian government must ensure explicit inclusion of older people in health and NCD policies, targets, programmes, data gathering and reporting mechanisms. This includes monitoring morbidity, mortality and progress towards meeting the needs of people aged 70 and older, who are currently excluded from the World Health Organization non-communicable disease (NCD) targets and STEPwise approach to surveillance survey.

- The government at national, district and local levels must recognise, bring attention to and support age-related issues, ensure closer cooperation at different levels of the government and secure resources to address these challenges.

11.2 Service delivery

- Primary healthcare facilities must have basic diagnostic and prescriptive services for prevention and treatment of uncomplicated conditions. Special attention should be paid to diagnosis and management of diabetes among older men and women in rural areas.

- Local health providers, with support from civil society and local governments, must be able to provide screening for and prevention, early diagnosis and management of NCDs for all population groups, with regular and targeted outreach services to reach older people wherever they live.

11.3 Health information systems

- The Ministry of Health should establish and strengthen specific disease registries within hospital management information systems, for diseases such as cancer and diabetes as well as less prevalent NCDs, to enable the country to monitor the pattern and progress of NCD interventions.

- The Tanzania Bureau of Statistics should include specific indicators to monitor older people's health in the Demographic and Health Surveys.

11.4 Access to essential medicines

- Medical store departments must continue and strengthen monitoring systems that ensure a steady supply of all necessary drugs at all levels of healthcare facilities, to avoid patients having to purchase drugs or diagnostic services elsewhere. When prescribed medicines are not available, local social services should offer patients at least some reimbursement coupons to procure drugs from other accredited sources, such as private pharmacies.

- The Ministry of Health should review the national Trace Medicine List to include medications for most of the conditions affecting older people. This would ensure medicines required by older people are available at lower-level facilities.

11.5 Financing

- The Ministry of Health, social welfare offices, local governments and health providers must ensure that free services are compensated for either through government subventions or some form of health insurance to ensure that risks are pooled among a wider population. This will help to overcome the financial pressures to recover costs or generate income that prevent older people from receiving the health services to which they are entitled.

11.6 Health workforce

- The Ministry of Health, with support from local authorities and health providers, must develop a more focused, sustainable plan and a programme to recruit healthcare workers and train them on key aspects of service provision, including but not limited to those aimed at preventing, treating and controlling NCDs.

- The Ministry of Health, with support from academia and civil society, should strengthen training on geriatric care among all healthcare workers, through reviews of training curricula and on-the-job training.

11.7 Strengthen access to information and accountability

- Local health providers, in partnership with civil society and academia and with support from local governments, must undertake community or public education and sensitisation efforts related to the risks of NCDs and the need for prevention and treatment, with a special focus on older people in rural areas.

- Local health providers, in partnership with civil society and academia and with support from local governments, should undertake community education and sensitisation about older people's right to health. Specifically, they must ensure that older people are aware of the government's exemption policy and the waiver system, the policy's aims, how to claim or demand waivers or exemptions, eligibility criteria and how and when to appeal against malpractice or abuse, for example, on the part of healthcare providers or officers.

11.8 Health insurance

- Social welfare offices and local authorities must ensure the effective implementation of both the exemption and waiver policies. The government needs to ensure that older people are informed about the exemption scheme and the services to which they are entitled under the scheme, and that local authorities fulfil their obligations to implement the scheme and do not deny access to eligible service users. There also needs to be more clarity so that older people understand the criteria they must meet to access both schemes, and so that local authorities know the criteria they must use to facilitate users' access to these schemes.

- Local authorities must issue identity cards in a systematic and transparent way to all eligible individuals, to ensure recipients can claim their benefits and rights.

- The Ministry of Health, Community Development, Gender, Elderly and Children should establish a desk of social welfare officers at all levels of healthcare facilities, who would work closely with local government authorities in the respective localities to ensure all eligible people get the opportunity to receive free services. These workers should be periodically trained and assessed to ensure full implementation of the exemption policy and accountability, and to reduce confusion between the administration of waivers and exemptions.

- The Tanzanian government must continue its efforts to extend health insurance coverage for all by eliminating enrolment barriers.

Glossary

Catastrophic health expenditure

Many families worldwide suffer undue financial hardship as a result of needing healthcare. One of the aims of universal health coverage (UHC) is to address "catastrophic spending on health", which it defines as out-of-pocket spending (without reimbursement by a third party) exceeding a household's ability to pay.[71]

The incidence of catastrophic spending on health is reported on the basis of out-of-pocket expenditures exceeding 10 per cent and 25 per cent of household total income or consumption. This is the approach adopted for the SDG monitoring framework. Across countries, the mean incidence of catastrophic out-of-pocket payments at the 10 per cent threshold is 9.2 per cent. Incidence rates are inevitably lower at the 25 per cent threshold, with a mean of 1.8 per cent.

Raised blood glucose

Measuring fasting plasma glucose is used to diagnose diabetes. The prevalence of raised fasting blood glucose (≥126 mg/dl) is one of the tracer indicators on health service coverage that measure achievement of UHC through the index computed by WHO.[72]

Universal health coverage

UHC is defined as ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship.[7]

Older person having an eye test at Mount Meru Hospital in Arusha, Tanzania

Endnotes

1. Allen L and Feigl A B, 'Reframing non-communicable diseases as socially transmitted conditions', *The Lancet* 5(7), 2017, pp.644-646, doi: 10.1016/S2214-109X(17)30200-0
2. World Health Organization, *NCD fact sheet, 1st June,* Geneva, World Health Organization, 2018, https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases (15 January 2019)
3. World Health Organization, *Noncommunicable diseases country profiles 2018*, Geneva, World Health Organization, 2018, https://www.who.int/nmh/publications/ncd-profiles-2018
4. Institute for Health Metrics and Evaluation, *GBD Compare | Viz Hub: Tanzania both sex, all ages DALY'S-1990-2016*, 2017, https://vizhub.healthdata.org/gbd-compare
5. World Health Organization, 'Global status report on noncommunicable diseases', in *Chapter 2 NCDs and Development*, Geneva, World Health Organization, 2010, https://www.who.int/nmh/publications/ncd_report_chapter2.pdf
6. Dewhurst M J et al., 'The high prevalence of hypertension in rural-dwelling Tanzanian older adults and the disparity between detection, treatment and control: A rule of sixths?', *Journal of Human Hypertension* 27(6), 2013, pp.374-80, doi: 10.1038/jhh.2012.59
7. World Health Organization, *Universal Health Coverage and Ageing*, Geneva, World Health Organization, 2018, https://www.who.int/ageing/health-systems/uhc-ageing (10 March 2019)
8. Beaglehole R et al.,'Priority actions for the non-communicable disease crisis', *The Lancet* 377(9775), 2011, pp.1438-1447, doi: 10.1016/S0140-6736(11)60393-0
9. HelpAge International, *HelpAge International response to the web based consultation on the first report of the WHO Independent High Level Commission on NCDs*, London, HelpAge International, 2018, http://origin.who.int/ncds/governance/high-level-commission/HelpAge.pdf
10. United Nations, *Political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases*, A/RES/73/2, 2018, https://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/73/2
11. NCD Alliance, *NCD Alliance Priority Recommendations for the 2018 UN Political Declaration on NCDs: Ensuring the UN High-Level Meeting on NCDs Counts for All People*, Geneva, NCD Alliance, 2018, https://ncdalliance.org/sites/default/files/NCDA%20Priority%20Recommendations%20for%20the%202018%20HLM%20Outcome_FINAL_0.pdf (10 January 2019)
12. World Health Organization, *Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013 – 2020*, Geneva, World Health Organization, 2013, https://www.who.int/nmh/events/ncd_action_plan
13. Gupta J and Vegelin C, 'Sustainable development goals and inclusive development', *International Environmental Agreements: Politics, Law and Economics* 16(3), 2016, pp.433-448, doi: 10.1007/s10784-016-9323-z
14. Kumar B et al., 'Consumption displacement in households with noncommunicable diseases in Bangladesh', *PLoS ONE* 13(12) e0208504, 2018, pp.1-12, doi: 10.1371/journal.pone.0208504
15. Bloom D et al.,'The promise and peril of universal health care', *Science* 361(6404), 2018, doi: 10.1126/science.aat9644
16. Kruk M et al., 'Redesigning primary care to tackle the global epidemic of noncommunicable disease', *American Journal of Public Health* 105(3), 2015, pp.431-437, doi: 10.2105/AJPH.2014.302392
17. United Nations General Assembly, *Political declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases, resolution A/RES/66/2*, 19 September 2011, https://www.un.org/Docs/asp/ws.asp?m=A/RES/66/2
18. Wang H and Rosemberg N, 'Universal health coverage in low-income countries: Tanzania's efforts to overcome barriers to equitable health service access', *Universal Health Coverage Study Series No. 39*, Washington, DC, World Bank Group, 2018
19. United Nations Economic and Social Council, *United Nations Interagency Task Force on the prevention and control of non-communicable diseases*, E/2013/L.23, 2013
20. World Health Organization, *Noncommunicable diseases global monitoring framework: indicator definitions and specifications*, Geneva, World Health Organization, 2014, https://www.who.int/nmh/ncd-tools/indicators/GMF_Indicator_Definitions_FinalNOV2014.pdf
21. Mubyazi G, 'The Tanzanian policy on helath-care fee waivers and exemptions in practice as compared with other developing countries: evidence from recent local studies and international literature', *East African Journal of Public Health* 1(1), 2004, pp.11-17
22. Mubyazi G et al., 'User charges in public health facilities in Tanzania: effect on revenues, quality of services and people's health-seeking behaviour for malaria illnesses in Korogwe district', *Health Services Management Research* 19(1), 2006, pp.23-35
23. Mtei G and Makawia S, *Universal health coverage assessment Tanzania*, Global Network for Health Equity, 2014, http://gnhe.org/blog/wp-content/uploads/2015/05/GNHE-UHC-assessment_Tanzania1.pdf (10 January 2019)
24. Bruni L et al. *Human papillomavirus and related diseases in Tanzania*, (Summary report), Barcelona, HPV Information Centre, 2018, https://hpvcentre.net/statistics/reports/TZA.pdf
25. Alidina A et al., 'Cancer registry analysis of the first 200 cases seen at the Aga Khan health services, Tanzania (AKHST)', *Journal of clinical oncology* 33(15), 2017, doi: 10.1200/jco.2015.33.15_suppl.e12635
26. Gard A C et al., 'Most women diagnosed with cervical cancer by a visual screening program in Tanzania completed treatment: evidence from a retrospective cohort study', *BMC Public Health* 14(910), 2014, doi: 10.1186/1471-2458-14-910
27. Mlange R et al., 'Patient and disease characteristics associated with late tumour stage at presentation of cervical cancer in northwestern Tanzania', *BMC Womens Health* 16(5), 2016, pp.1-6, doi: 10.1186/s12905-016-0285-7
28. Vandervort E B and Kibusi SM, 'Cervical cancer awareness among women in Tanzania : an analysis of data from the 2011-12 Tanzania HIV and Malaria Indicators Survey', *International Journal of Chronic Diseases* 2018(2458232), 2018, doi: 10.1155/2018/2458232
29. McCree R et al., 'Expanding cervical cancer screening and treatment in Tanzania : stakeholders ' perceptions of structural influences on scale-up', *Oncologist* 20:6, 2015, pp.621-626, doi: 10.1634/theoncologist.2013-0305
30. World Health Organization, *STEPs Survey Report of Risk factors of Non communicable diseases*, Geneva, World Health Organization, 2013

31. Pallangyo P et al., *Diabetes awareness and control among urban dwellers of Kinondoni District, Dar es Salaam, Tanzania: A population-based study*, no date

32. Ploth DW et al., 'Prevalence of Chronic Kidney Disease, Diabetes, and Hypertension in Rural Tanzania', *Kidney Int Reports*, 3(4), 2018, pp.905-915, doi: 10.1016/j.ekir.2018.04.006

33. Chiwanga FS et al., 'Urban and rural prevalence of diabetes and pre- diabetes and risk factors associated with diabetes in Tanzania and Uganda Urban and rural prevalence of diabetes and pre-diabetes', *Global health action* 9(31440), 2016, doi:10.3402/gha.v9.314402016;9716(May)

34. Kilonzo SB et al., 'Control of hypertension among diabetic patients in a referral hospital in Tanzania : a cross-sectional study', *Ethiopian Journal of Health Sciences* 27(5), 2017, doi: 10.4314/ejhs.v27i5.5

35. Mwangome M et al., 'Perceptions on diabetes care provision among health providers in rural Tanzania : a qualitative study', *Health Policy and Planning* 32(3), 2017, pp.418-429, doi: 10.1093/heapol/czw143

36. Mwangome M et al., '"I don't have options but to persevere." Experiences and practices of care for HIV and diabetes in rural Tanzania: a qualitative study of patients and family caregivers', *International Journal for Equity Health* 15(56), 2016, pp.1-13, doi: 10.1186/s12939-016-0345-5

37. Njelekela M et al., 'Prevalence of hypertension and its associated risk factors among 34 ,111 HAART Naïve HIV-infected adults in Dar es Salaam , Tanzania', *International Journal of Hypertension* 2016(5958382), 2016, doi: 10.1155/2016/5958382

38. Mosha NR et al., 'Prevalence, awareness and factors associated with hypertension in North West Tanzania', *Global Health Action* 10(1), 2017, doi: 10.1080/16549716.2017.1321279

39. Katalambula LK et al., 'Dietary pattern and other lifestyle factors as potential contributors to hypertension prevalence in Arusha City , Tanzania: a population-based descriptive study', *BMC Public Health* 17(1), 2017, p.659, doi: 10.1186/s12889-017-4679-8

40. Kavishe B et al., 'High prevalence of hypertension and of risk factors for non-communicable diseases (NCDs): a population based cross-sectional survey of NCDS and HIV infection in Northwestern Tanzania and Southern Uganda', *BMC Medicine* 13, 2015, pp.1-21, doi: 10.1186/s12916-015-0357-9

41. Putnam H et al., 'Hypertension in a resource-limited setting: Is it associated with end organ damage in older adults in rural Tanzania?', *The Journal of Clinical Hypertension* 20(2), 2018, pp.217-224, doi: 10.1111/jch.13187

42. Mandago K and Mghanga F, 'Awareness of risk factors and complications of hypertension in Southern Tanzania', *Journal of Community Health Research* 7(3), 2018, pp.155-163

43. Camilleri N et al., 'Comparative study of the frequency of hypertension in a primary care setting in. Buza, Tanzania and Malta', *The Synapse* 14(1), 2015, pp.18-24, https://www.um.edu.mt/library/oar//handle/123456789/13999

44. HelpAge International, *Global AgeWatch Insights: The right to health for older people, the right to be counted*, London, HelpAge, 2018, http://globalagewatch.org/global-agewatch/reports/global-agewatch-insights-2018-report-summary-and-country-profiles

45. United Nations General Assembly, *Follow-up to the International Year of Older Persons: Second World Assembly on Ageing, Report of the Secretary-General, A/70/185,* 24 July 2015, https://digitallibrary.un.org/record/799864/files/A_70_185-EN.pdf (19 January 2019)

46. Frumence G et al.,'Facilitators and barriers to health care access among the elderly in Tanzania: a health system perspective from managers and service providers', *Journal of Ageing Research and Healthcare* 1(3), 2017, pp.1-10, doi: 10.14302/issn.2474-7785.jarh-16-1354

47. Schatz E et al., 'They 'don't cure old age': older Ugandans' delays to health-care access', *Ageing and Society* 38(11), 2018, pp.2197-2217, doi: 10.1017/S0144686X17000502

48. World Health Organization, *Study of global AGEing and adult health (SAGE),* 2006, Geneva, World Health Organization, www.who.int/healthinfo/survey/SAGESurveyManualFinal.pdf

49. World Health Organization, Regional Office for South-East Asia, *Noncommunicable Diseases in the South-East Asia Region, 2011: situation and response*, New Delhi, World Health Organization, Regional Office for South-East Asia, 2011

50. Munishi V, *Assessment of user fee system: implementation of exemption and waiver mechanisms in Tanzania: successes and challenges* (Dissertation), Cape Town, University of Cape Town, 2010, https://open.uct.ac.za/bitstream/handle/11427/11236/thesis_hsf_2010_munishi_v.pdf?sequence=1

51. Kapinga F, *Assessing performance of the exemption scheme: A case study of the Ocean Road Cancer Institute* (Dissertation), Dar es Salaam, Muhimbili University of Health and Allied Sciences, 2012, http://ihi.eprints.org/1576/1/Frida_Clemence_Kapinga.pdf

52. HelpAge international, *Insights on Ageing: a survey report*, London, HelpAge International, 2011

53. Ntahosanzwe M, *Challenges facing older people in accessing free health care services in public hospitals: the case of Temeke, Magomeni and Mwananyamala hospitals* (Dissertation), Dar es Salaam, Open University of Tanzania, 2013, http://repository.out.ac.tz/1060/1/N_TAHOSANZWE,_MA_SOCIAL_WORK.pdf

54. Umeh C, 'Challenges toward achieving universal health coverage in Ghana, Kenya, Nigeria, and Tanzania', *The International Journal of Health Planning and Management* 33(4), 2018, pp.794-805

55. Watkins D et al.,'Universal health coverage and essential packages of care' in Jamison D et al. (eds.), *Disease control priorities: improving health and reducing poverty*, Washington DC, The International Bank for Reconstruction and Development/The World Bank, 2017, https://www.ncbi.nlm.nih.gov/pubmed/30212154

56. Sanga G, *Challenges facing elderly people in accessing health services in government health facilities in Moshi Municipality area* (Dissertation), Dar es Salaam, Open University of Tanzania, 2013, http://repository.out.ac.tz/1014/1/DISSERTATION_-_SANGA_FINAL.pdf

57. International Labour Organization, World Social Protection Database, based on the Social Security Inquiry (SSI) 1 June 2017, http://www.social-protection.org/gimi/gess/RessourceDownload.action? ressource. ressourceId =54609 (16 March 2019)

58. International Labour Organization, *Employment-to-population ratio by sex and age*, https://www.ilo.org/ilostat (16 March, 2019)

59. USAID, *Tanzania 2015-16 Demographic and Health Survey,* https://www.dhsprogram.com/data/available-datasets.cfm (15 January 2019)

60. Social Security Administration, *Social security programs throughout the world: Africa, 2017*, 2017, pp.224-228, https://www.ssa.gov/policy/docs/progdesc/ssptw/2016-2017/africa/tanzania.html (16 March 2019)

61. Ministry of Labour, Youth Development and Sports, United Republic of Tanzania, *United Republic of Tanzania National Ageing Policy September 2003,* 2003

62. Vice President's Office, United Republic of Tanzania, *Ageing and poverty in Tanzania*, country position paper presented at the regional workshop on ageing and poverty in Africa, Dar es Salaam, Tanzania, pp.29-31, October 2003, http://www.tanzaniagateway.org/docs/Ageing_and_Poverty_in_Tanzania.pdf

63. Manthei R and Nourse R, 'Evaluation of a Counselling Service for the Elderly', *New Zealand Journal of Counselling* 32(2), 2012, pp.29-53, http://www.nzac.org.nz/journal/3_evaluation_of_a_counselling_service_for_the_elderly.pdf

64. Dominicus D A and Akamatsu T, 'Health policy and implementations in Tanzania', *The Keio Journal of Medicine* 38(2), 1989, pp.192-200, doi: 10.2302/kjm.38.192

65. Ministry of Health and Social Welfare, *Draft: Tanzania National eHealth Strategy 2012 – 2018*, Dar es Salaam, 21 May 2013, https://www.who.int/goe/policies/countries/tza_ehealth.pdf

66. The United Republic of Tanzania Ministry of Health, Community Development, Gender, Elderly and Children, 'National Survey on the Drivers and Consequences of Child Marriage in Tanzania', *Child Marriage in Tanzania at a Glance*, March, 2017, http://www.mcdgc.go.tz/data/Child_Marriage_Study.pdf

67. Maluka S O, 'Why are pro-poor exemption policies in Tanzania better implemented in some districts than in others?' *International Journal for Equity in Health* 12(1), 2013, p.80, doi: 10.1186/1475-9276-12-80

68. Newbrander W and Sacca W, *Cost sharing and access to health care for the poor: equity experiences in Tanzania,* Boston, MA, Management Sciences for Health, 1996

69. Shemdoe A et al., *An investigation into the burden of non-communicable diseases in older Tanzanian: research for better policy and practice*, London, HelpAge International, 2012, https://www.helpage.org/silo/files/ncds-on-older-tanzanians.pdf

70. Bintabara D et al., 'Improving access to healthcare for women in Tanzania by addressing socioeconomic determinants and health insurance: a population-based cross- sectional survey', *BMJ Open* 8(e023013), 2018, doi:10.1136/bmjopen-2018-023013

71. World Health Organization and International Bank for Reconstruction and Development/The World Bank, *Tracking Universal Health Coverage: 2017 global monitoring Report*, Geneva, World Health Organization and International Bank for Reconstruction and Development/The World Bank, 2017

72. World Health Organization, *The Global Health Observatory, Universal Health Coverage*, Geneva, World Health Organization, http://apps.who.int/gho/portal/uhc-cabinet-wrapper-v2.jsp?id=1010302 (10 March 2019)

Appendix: Methodology

The terms of reference for the study specified three research topics.

Research topics

A. A brief overview of frameworks, policies and accountability mechanisms to support the realisation of universal health coverage (UHC) in Tanzania, particularly in relation to non-communicable diseases (NCDs).

B. An appraisal of the extent to which UHC (services package, coverage, affordability and quality) has been achieved in Tanzania, particularly in relation to NCDs and the health and care needs of people aged 50 and older.

C. An overview of the extent to which the health and care needs of marginalised groups of older adults have been prioritised in Tanzania.

Data collection methods

The description of data collection methods has been provided by the academic consultants who conducted the research study.

We used a mixed-methods approach, which included: (i) a review of secondary global and national qualitative and statistical data on population ageing and NCDs; (ii) analysis of secondary data from institutions that have carried out relevant surveys; and (iii) in-depth interviews and focus group discussions.

We conducted a literature review, searching PubMed and Google Scholar for literature published between June 2007 and 2018, on NCDs in Tanzania and the pattern of NCDs among those aged 50 years and older. Search terms related to NCDs included those associated with burden, mortality and morbidity data, and the following specific diseases: cardiovascular disease (CVD), diabetes, stroke, cancer. We reviewed grey literature for information regarding policy, such as the NCD Action Plan and health service provision for older people in Tanzania. We conducted in-depth interviews and focus groups with key informants. We also contacted relevant offices for additional information, for instance, about policies.

We paid particular attention to examining: the priorities made for the different types and levels of service (prevention, promotion, palliative and rehabilitative); intentions for covering different segments of vulnerable populations; who makes the priorities for the services needed; how feasible and practicable the policies are or which guidelines are in place to facilitate the planning and/or provision of intended services to ensure UHC; how issues of inequality in access are addressed in policies and policy guidelines; how prepared the country is to achieve SDG 3.8; who should do what and the level of participation or engagement that is needed; the specified indicators of success and how realistic they are; and the lessons learned from field experiences.

The literature review and interviews were guided by a data collection guide prepared in advance to ensure that a standard approach was taken by all data collectors and analysts. Each guide was formatted in such a way that it has a flow of specific themes and a checklist of items or questions to be explored in accordance with the study objective(s). The interview data and review information were analysed and interpreted through a process of triangulation, based on key findings and analysts' knowledge and experiences.

Quantitative (secondary) data was gathered from different sources, including the National Bureau of Statistics (NBS), particularly the Service Provision Assessment Survey (SPA), Demographic and Health

Survey (DHS), Household Budget Survey (HBS) and Panel data; and from the National Institute for Medical Research (NIMR), particularly the STEPS survey. Additional data was requested from the database of the Muhimbili National Hospital (MNH) Diabetes Clinic.

Data management: process, analysis and interpretation

Quantitative data analysis process and presentation of result

Secondary data was analysed by age cohorts, sex, urban and rural location, levels of education and income quintiles. Pearson Chi square statistics tests were used to compare group differences for categorical variables. Analysis of variance and independent sample T-tests were conducted, and the results were used to compare the mean differences between variables. Where necessary, unadjusted and adjusted odds ratios were reported. Differences or associations between variables were taken to be statistically significant if the resultant p-value was less than 0.05.

GraphPad assigned statistical significance as follows: significant (*) if p-value < 0.05, very significant (**) if p-value < 0.001, and extremely significant (***) if p-value < 0.0001.

Data presented in Tables 4 and 5 was derived based on the following questions: whether or not one has: (i) ever had their blood pressure and blood glucose measured by a healthcare worker, (ii) ever been told by a healthcare worker that she or he has raised (high) blood pressure, (iii) used prescription drugs in the last 12 weeks for raised blood pressure/glucose, and received advice about, (iv) eating a balanced diet, (v) the need to reduce their weight, (vi) treatment of the disease condition one has or on smoking cessation, and (vii) the need to start or continue doing more exercise.

Except for questions about age, gender (sex) and residence, interviewees were required to say 'yes' or 'no' in response to each of the rest of the aforementioned questions. Answers to the first question asking one to state whether or not he or she has been measured for blood pressure was used as a reference for the subsequent questions, and validated by the investigators demonstrating how blood pressure is normally measured using a stethoscope; this was done to avoid recall bias on the part of the respondent.

The total (overall) sample of individuals enrolled in the assessment on types of service was 1,519. However, the responses to individual questions varied, hence our interpretations were done accordingly, and the varied sample sizes for analyses are noted in the tables in this report (with 'n' representing sample size in the analysis). Percentages in parentheses in front of each number of respondents under each question category are row totals and so will not generally add up to 100 per cent. For example, of the 1,519 interviewees, only 524 (34.5 per cent) responded to the question on whether one has had his or her blood pressure measured. Of these, 202 were men, of which only 34.7 per cent answered 'yes'. Of the 524 respondents, 196 were women, of which only 34.2 per cent answered 'yes'. The same pattern applies to the rest of the indicators and variables presented in the tables.

Qualitative data analysis

We conducted two in-depth interviews with health workers and four focus group discussions with older men and women to support the data analyses. In-depth interview participants included two social welfare officers, one at a district hospital and one at a referral hospital. At the district hospital, a nurse and a second social welfare officer joined the interview. A single interview session lasted 60-90 minutes, as did a single focus group discussion.

Two focus group discussions were held in Kinondoni district, one in a peri-urban area of Tegeta Nyuki and another in an urban setting of Tandale. Details about the age and number of respondents are presented in Table 12. The focus groups comprised individuals of both sexes, but were conducted with single-sex groups for privacy.

Both the interviews and focus groups were conducted by experienced and professional social scientists using prepared guides covering key themes of this research. Respondents were allowed to use either Swahili or English language. All interviews and focus group discussions were audio-recorded after receiving informed consent from the participants. The information was transcribed verbatim immediately after its collection in the language it was collected, and then was translated into standard English. Transcripts were checked against the original recording for quality of translation and transcription, involving a researcher who was involved and two independent reviewers/social scientists. Thematic analysis was done on the qualitative data, with important quotes taken to substantiate the findings. Comparison was made across and within each subgroup to explore relationships between themes and any similarities or disparities through use of matrices.

Study limitations

The sample sizes and response rates to certain study questions were small, limiting the ability to draw firm conclusions about some of the data. There was limited time to collect primary data, which resulted in a smaller data pool from which to draw conclusions. While the focus group discussions and interviews were illuminating, it would have been beneficial to involve stakeholders at different levels – from local to subnational and through to national levels. This may have given more evidence about the issues of exemptions, affordability of services for which patients pay out of pocket, availability and quality of services that are recommended, and the existing demand for these services. The analysis of which recommended health services had been provided to respondents focused only on a single service procedure, which may have left out other important elements of diagnosis for a given NCD. For diabetes diagnosis, for example, only blood glucose measurement was looked at as a primary tracer indicator variable, leaving out other possible indicator variables such as oral glucose tolerance, glycosylated haemoglobin (HbA_{1c}), fundal examination, testing foot vibration perception by tuning fork and testing foot vascular status by dropper. For CVD, the focus was on measuring blood pressure as a tracer, while other important diagnostic procedures could have been included (for example, electrocardiogram and lipids).[49]

Dr Munishi providing information on the importance of exercise among older people, Tanzania

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