Tanzania insights

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

Executive summary

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Data and analysis on population ageing

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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.

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.

Older people from active ageing clubs exercising in Kilosa, Tanzania

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.

A physiotherapist training older people on exercise in Morogoro, Tanzania

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