POVERTY REDUCTION FOR OLDER PEOPLE: THE CASE OF ACCESS TO HEALTH SERVICES IN TANZANIA

Benedict Mongula, Senior Lecturer, Institute of Development Studies, University of Dar es Salaam

Abstract

Poverty reduction is the overarching development policy today shaping both national and donor programmes and activities. The Copenhagen World Summit on Social Development, the Millennium Development Goals, the G8 Summit at Gleneagles on Debt Relief and Poverty, the Summit on Poverty and at national level the PRSP 2000 and now the National Strategy for Growth and Poverty Reduction clearly demonstrate both global and national commitments on poverty reduction. A number of sector specific initiatives also have significant bearing on poverty reduction. These include EFA at global level and in national terms, for Tanzania the Primary Education Plan and various policies and programs such as those of health, agriculture, local government, micro-financing, social security, youth, and older people among others.

Introduction

Political will on reducing poverty, as demonstrated by policy makers and other stakeholders is one thing and having workable plans or programmes that really reduce poverty is another. Africa, and in fact developing countries in general, are not short of unfulfilled plans, in fact the opposite is true, and that is why it is important to have workable plans with clearly defined poverty reduction indicators both quantitatively and qualitatively.

A major operational target under the goal 5 of the National Strategy for Growth and Reduction of Poverty (NSGRP) (viz. to ensure effective universal access to quality public services that are affordable and available) is that *100% of eligible older people are provided with free medical care and attended by specialized medical personnel by 2010*. Corresponding specific strategies were *improving accessibility to health services ..., household to be within 5 Km of health service units; eliminate all forms of barriers to health care by exempting the poor, pregnant women, older persons .. and removing unofficial charges and reduce distance to, and improve treatment; rehabilitation of health facilities...; ensure that older people are provided with identity cards to access free medical treatment; rationalize allocation of drugs and supplies at the facility and District level ...* Elsewhere, in relation to Goal 2 of the NSGRP (improved survival, health and well-being of vulnerable groups), is the strategy to *promote knowledge-based care among health workers for attending among others, people with disabilities and the elderly.*

This paper explores the prospects of poverty reduction with particular reference to health services to older people in Tanzania. Tanzania's National Ageing Policy raises a number of questions on the health of older people some of which are answered by the country's National Strategy for Growth and Reduction of Poverty. The purpose of this paper is to analyze and establish the prospects of improvement of health services to older people in spite of the NAP and NSGRP. We pose following questions: first, do the poverty reduction initiatives in the NSGRP sufficiently address the obstacles of access to health services by older people? Second, does the fact that the poverty reduction initiatives are being pursued hand in hand with measures to overcome past failures of the state in planning such as decentralization and participatory strategic planning in the local areas make a difference?

Effect of Cost-Sharing on Older People

During the years of socialist development strategy in Tanzania health services were available for free to all people. During that period the Government was committed to underwrite both investments and recurrent expenditures on health. Thus building new hospitals, health centers and dispensaries and paying

salaries of staff, supplying medicines and equipment and organizing immunization programmes were organized by the Government. Older people like any other disadvantaged social categories with little incomes did not have to worry about whether or not they could afford to get access to health services.

This obviously unsustainable "free health" era for a poor country like Tanzania ended with the coming of Structural Adjustment Programme (SAP) and, in particular the Health Sector Reforms of the 1980s onwards. The Government with pressure from the Donors, especially the World Bank, adopted the cost-sharing approach to health that required people to pay for health services. A new dimension became imminent with this approach, namely of people unable to access health services because they could not afford to pay for them. These were the poor people, which included older people.

The health sector-wide program and basket funding by donors that has considerably raised public funding of health provides some opportunity to address the problem of exclusion but to what extent it becomes implementable is the question. While the Government demonstrates commitment to eliminate barriers to health by exempting the poor, including older people (c.f. URT January 2005:34) we may wish to ask is this a practicable idea or a mere slogan? Are there mechanisms to put such a commitment to practice; more practically to what extent has such commitment found its way in the area and health sector plans of Local Government Authorities and the ongoing pilot Community Health Fund programmes?

Although exemption of older people from paying for public health services has been decried for years already, the observation by CSOs dealing with older people and by older people themselves is that they have continued to be subjected to official and unofficial charges by public hospitals, health centers and dispensaries. In addition, unavailability of medicines and drugs in public health units means that older people have to purchase them from private medical stores.

But, several other constraints are also evident in the health sector today that confound the health prospects for older people such as insufficient health financing, HIV/AIDS pandemic, staffing levels and motivation in public health units, lack of specialized knowledge and instrumentation, health research, health management and administration, corruption and attitudes of the community and health staff. While acknowledging that health financing has grown considerably in recent years as donors have increased their funding and in response to greater commitment from the Government, it is nevertheless true that rural health units have continued to experience shortages of supply of medicines and drugs and skilled staff. The HIV/AIDS pandemic has also exacerbated health problems in society and for older people, without the knowledge of how to attend sick HIV/AIDS victims; this has exposed them to tremendous risk (HAI, 2004).

There is tremendous shortage of health staff both in numbers and specialization to cope with society's needs. In this regard, the needs of older people, such as specialization in gerontology, is absent in health or medical training and health units do not have the diagnostic facilities to detect age-related diseases. There is little attention to older people health research, which leaves both health staff and the general public uninformed of the challenges that older citizens are facing. Meanwhile, the problems of corruption and negative attitudes to older people and, above all, poor health management and administration in public health units, including low motivation of health staff, do also have negative impact on older people.

Prospects of Accessing Health Services by Older People

The Health Sector Policy, the National Ageing Policy, the National Strategy for Growth and Reduction of Poverty, the Guidelines to preparation of Medium Term Plans and Budget Frameworks: all of them call for free access to health services by older people, who are defined by NAP as people of 60 years of age and above. The NSGRP talks of access to free medical services for eligible older people

Thus, the NSGRP envisages elimination of all barriers of access to health services by vulnerable groups, one of which is older people, by reducing distances to health facilities (to 5 Km), exempting them from both official and unofficial charges, rehabilitation of health facilities, providing IDs to eligible people and rationalizing the supply of medicines and drugs at health facilities and district level. In fact it is the older people themselves and the CSOs engaged with them, who proposed the introduction of identity documents during the consultative phase of NSGRP. The bold expectation is that the new policies will provide older people with full and free access to health services.

While the long term objective of the Government to make free health services available to older people is not in doubt, it is not yet clear how the objective will be achieved. This paper argues that it is still some way into the future that such bold policies will be

translated into action backed by allocation of financial and human resources. Furthermore, the general national strategy for growth and reduction of poverty needs to be operationalized with sector and area specific programmes and plans, in this regard by Health ministry programmes and health plans of Local Governments.

When it comes for example to implementation of free access to health services by older people we see clearly a dichotomy between policy and practice. Public health units are yet to implement the policy. No clear procedures have been issued by the Ministry of Health to Regional and District health departments and to public health units on its implementation. Apparently, Government position on this matter still seems unclear as evident lately in NSGRP qualification of this provision. It talks of *free access to eligible older people* without going far enough to define which older people are eligible and which ones are not. NSGRP position reflects a contradiction in Governments position on how exactly to implement the free access policy.

It partly boils down to the problem of affordability, namely can resource scarce Governments of developing countries like Tanzania afford free access to health services to all older people? Social protection policies in developing countries varies between "universal" and "means-tested" provision of free services (HAI/Gorman, 2004). In this regard free access could either be extended to all older people or be targeted to the chronically poor of the older people without any means to pay. HAI/Gorman makes a detailed analysis and comparison of the two.

The issue is why do we want older people to have free access to health services? Furthermore, should all older people 60 years of age and above in Tanzania be eligible to free services as advocated by the NAP? If not, which are the eligible older people?

We would like to argue first of all that older people is not a homogeneous group when it comes to work ability, resources and incomes. Secondly, older people are not a disadvantaged group everywhere in the country and that in some parts or communities they come out more well off. Thirdly, could the problem of access to health services by older people be a manifestation of a wider problem; so that an attempt to solve it in isolation may not produce any results.

Undoubtedly older people is a broad category of people that covers a still active age group of people between 60 and 70 years and the less active ones beyond this age such as those of 75 years and above. It is not uncommon for instance to find in many parts of the country older men of 60 years engaged in new marriages. This is probably the reason why some countries target older people 75 years and above (in the case of Nepal) or 65/70 years in the case of India/ Brazil for pension rights. (HAI/Gorman, 2004).

At the same time older people are clearly not one and same in all communities as far as control of resources is concerned. It is older people that control key resources like cattle in pastoral communities or coconuts and cashew nuts in the Coastal belt in Tanzania, while other age groups go without any. In a Village Study we for example established that the youth in Kineng'ene village in Lindi District fought with older people over the control of resources – apparently the youth were being pushed to marginal lands. (RIPS/ Mongula, 2004). A similar trend was found in Kondoa and Magu District's pastoral communities where older people possessed large herds, say 20 or more herds of cattle as compared to youth with say 3 or no cattle at all.

In the same vein we find amongst older people retirees from formal employment with pensions and therefore social security although not quite secure, and owners of micro or small enterprises or who rent property, such as houses. But, there are also older people working on contract terms and some very highly paid consultants or business people, with considerable connections and other leverage. Some of the older people in rural areas receive financial transfers from daughters and sons in cities or towns while others are politicians, like members of Parliament and Councilors. At the local level we may find amongst older people, Village and Ward leaders. It is perhaps for such reason that countries like Bangladesh prefer to combine age limit with community selection of older people for pension benefits (HAI/Gorman, op.cit.).

How could you for example justify free access to health to older people who are still economically and socially active to the point in which they are even engaged in new marriages? This means if free services are going to be provided, this has to be preceded by a thorough needs assessment in order to come up with properly targeted assistance to older people so that the concept becomes acceptable to local communities. Now that we have Community Health Fund to which local communities are contributing the people are likely to be opposed to subsidizing people who are able to marry new wives for example or high income consultants, businessmen and politicians. HAI/Gorman concluded that " *the optimal strategy may be to begin with universal pension, offered at an advanced age,*

but providing a minimal level of benefits" They tended to agree with Schwartz (2003) that the size of the benefit and the age at which it is offered have to take into account competing needs for the fiscal resources, such as education, health, other social protection and infrastructure building.

The issue of eligibility to free services raises the other question, namely that of children living with the older people. Sometimes the older persons bare a huge burden of raising grandchildren. While we do not know the extent of prevalence of such cases, but African tradition in which older people demand to live with grandchildren and the practice of urban dwellers to dump their children with their rural-based grandparents makes the number not trivial at all. In the African tradition if an older person lives alone she/he is usually regarded a witch; because of HIV/AIDS orphans the number of children living with grandpas has increased considerably. (HAI, 2004).

Meanwhile, there is the debate on how to finance free access to health services, including whether or not older people are given pensions and in that regard whether those be "universal pensions" or "means-tested pensions" to only those without capacity, income or other resources. (HAI/Gorman op.cit.). Pensions seem to be preferred for a number of reasons including the fact that cash transfer to older people offers greater value than specific service tied assistance and the fact that they are easier to administer (ibid.). Cash receipts by older people could be used for the most pressing need whether food, health or even education needs of grandchildren. HAI/Gorman point out for example that children seem to benefit much from pensions to older people and that pension incomes may be easier to enforce than some directive like requiring public health units to provide free health services.

Apart from cost aspects and inability to pay is the question of being able to reach the health units, which is a problem especially for frail older people. The distance to the nearest public health unit in rural areas could be ten or more kilometers, a formidable distance for older people. Given that the major means of rural transport so far is walking, such distances should be reduced. The NSGRP in that respect maintains that for improving health services to older people, the distance to health units is going to be reduced to 5 Km.

This ambitious target calls for enhanced capital investment and recurrent budget, the volume of which Tanzania Government alone cannot afford. For, here we are talking of doubling the number of dispensaries in the country and more than doubling the number of health staff. A concerted effort of the Government, Local Governments and donors is required to produce the necessary funds as well as local communities' contributions and capacity to execute construction work. Available evidence from the Primary Education Plan, popularly known as MMEM, shows that it is possible to mount an extensive construction operation across the country provided there is a good co-ordination of the efforts by Government, Local Government, donors and local communities. But, this does not everywhere need to boil down into new constructions. As far as older people is concerned the Government could also think of employing non-public facilities like privately owned dispensaries or those owned by faith organizations to channel health services. We see this in TB treatment for example.

But, perhaps the bigger challenge is in being able to step up the quality of services in health units, and in this regard services for older people. This is of course both a human factor, in terms of knowledge, skills and passion of health staff and a logistical issue in terms of having appropriate infrastructure, including diagnostic facilities. Clearly, this has been the crux of health problems in local rural dispensaries and health centers.

So far none of those are available in dispensaries, which means older people have to go to District hospitals and other referral hospitals for reliable diagnosis of age-related diseases. Thus the local dispensary, which has been targeted to be within 5 km for improved access to older people, still cannot be able to effectively handle older people, even if these were truly constructed and operational.

This raises the question, how can poor older people who do not have money to meet travel costs to the District hospital or other referrals get access to medical services, even though these may be available to them for free in those hospitals? This therefore calls for evaluation of the rural public dispensaries capacities to provide health services to older people and upgrading skills and facilities as appropriate, and if possible mounting outreach services or mobile clinics for older people. Short training programmes on gerontology could be mounted.

We may also need to add here the problem of different kinds of inconveniences or harassments suffered by older people and other patients in public health units, like long queues, corruption and various sociological problems. Ways should be found to eliminate them including according older people a priority and even

While the need for properly disaggregated data or information is important for the administration of free medical services to older people, there is the more fundamental question of sector and area planning that recognizes and takes count of such policy target. Unless the broad national targets are translated into strategic and operational sector and area level targets, they are going to remain slogans and make no difference to the health status of the older. Thus, it is important to examine the conditions for translating the NSGRP health targets for older people into the Health Sector plan and budgeting as well as LGA area and health plans and budgeting and the kind of monitoring and evaluation to make the plans and budgets effective.

Perhaps we should ask ourselves, what should be the roles of the Ministry of Health and donors supporting the health sector in order for disadvantaged older people to have access to medical services? Then, what should LGAs, which are nearest and the ones immediately responsible for older people under Tanzania's decentralized system, do in order to ensure their access to medical services? Moreover, for success in addressing older people's health problems there is also the question of how the Ministry of Health and Local Governments collaborate or cooperate to realize the common goal. Undoubtedly, given their limited capacities, there is very little chances for the LGAs to effectively be able to provide access to health services to older people. There is also the choice to make of whether to employ pension payments or rely on directives to health units to provide free access to health services. The donor community has to clearly be more forthcoming to social protection and older people in particular as part of their commitment to Millennium Development Goals and the Madrid International Plan of Action on Ageing.[1]

Area planning as regards health services has clearly been one of the problem areas in Tanzania needing extensive capacity building. (Mwangu,). There is a range of problems including lack of basic data or information, capacity to plan and monitor plans, as well as resources for planning. A major prerequisite for improving the health of older people is having the money or budget to cover older people's medicines and drugs, to invest in specialized services for older people, new dispensaries, equipment, human resources, and management and administration. There is need to monitor the health needs of older people, to undertake regular home visits for the ailing older people and to improve public health delivery to older people. To be sure, this should be part of a holistic improvement of health services and not something that singles out older people services to be effective.

How much should the budget be is the next question, but the other is how do you ensure that such budget, whatever the volume may be is both properly expended and is sustainable over time? What are the best options for example: Is it offering pension payments so that older people could participate by paying for services or perhaps, is issuing a directive to all public health units more effective and efficient?

Conclusion

From the discussion above, access to health services by older people needs not be viewed simply in terms of Government commitment but what is practically feasible. Implementation of the good pieces in the policies relating to older people demands both passion and commitment of the institutions and individuals involved with planning and budgeting of health services and in health delivery. This relates to Health ministry and LGA planning and budgeting and to dispensaries and hospitals.

The starting point therefore is to draw the passion and effective commitment of the responsible institutions and individuals, namely, the Health ministry, Local Governments, donor organizations, CSOs and faith-based organizations as well as planners, medical personnel, and the general public. This requires an effective communication strategy that is able to send clear messages about the health needs of older people, the government policy and the roles of different institutions, individuals in their various capacities as well as communities.

Based on an increased understanding and appreciation of the health problems of older people the Health ministry, Local Governments, donor organizations and CSOs will assume various roles in planning, budgeting, advocacy and monitoring for supplies and investment for older people medical needs. Specific outcomes will include studies to determine eligibility for free health services and the best manner to administer them, reliable supplies of medicines and drugs, retrained medical/health staff who are competent in gerontology, installed facilities for the detection of age-related diseases, construction and rehabilitation of dispensaries, and compassion and better handling of older people in health units.

In the framework of Opportunities &Obstacles to Development which is the new area planning approach that fully involves local communities, older people should be effectively involved in order to be able to

address their needs. Effective involvement of older people in O&OD planning and LGAs involvement of CSOs engaged with older people will help to inform on the health needs of older people during the planning and securing appropriate targets. Community based monitoring and advocacy, especially that by older people themselves and by CSOs engaged with older people could be an important avenue to ensure that the interests of older people are taken on board in the area plans. In this regard the challenge is to strengthen participatory planning, community based monitoring and advocacy skills. At the Health ministry and in LGAs strengthening of planning, budgeting and monitoring and in CSOs dealing with older people strengthening of advocacy on older people's health will be important.

Last and the most important is that the sustainable solution to older people's health needs is a growing economy in which the older people become an active participant. Thus, it is important to continue to find ways for rapid growth of the economy, especially the rural economy. The Government and Local Government should therefore promote increased agricultural productivity, explore opportunities for better prices for farmers, promote entrepreneurship and increase income security to enable active older people attain higher incomes.

In July 2005, the Government produced a communication strategy for NSGRP with a view to enhance the strategy's implementation by different stakeholders. Poverty reduction in terms of increased access to health services by older people will be enhanced by increased information and debate on how to raise such access. CSOs could play an effective role to promote increased communication, awareness, debate, passion and effective action toward increased access to health services.

Corresponding address: mongula@uccmail.co.tz

References

HelpAge International (Tanzania) (2004), The Cost of Love.

HelpAge International/ Mark Gorman (2004), Age and Security. HelpAge International, London.

Mongula (2004), A Village Study: A Report Submitted to RIPS. Regional Administrative Secretaries, Lindi and Mtwara, Tanzania.

Schwartz, A. (2003) Old Age Security and Social Pensions. World Bank, Washington D.C.

United Republic of Tanzania, Planning and Finance Ministries (2005), The National Strategy for Growth and Poverty Reduction

United Republic of Tanzania(2005), Poverty Audit.

United Republic of Tanzania (2005), Poverty Communication Strategy.

United Republic of Tanzania (1998), Local Government Reform.

United Republic of Tanzania( ) National Health Policy.

United Republic of Tanzania (2002), The National Ageing Policy.

(Footnotes)

[1]To quote HAI/Gorman, in the words of Professor Joseph Stiglitz, the Nobel Prize Winner and former Chief Economist of the World Bank,
there is no subject of greater importance than the ageing of the population and provision of social protection to older people.