



Cash transfers and older people's access to healthcare:

A multi-country study in Ethiopia, Mozambique, Tanzania and Zimbabwe

HelpAge International is a global network of organisations promoting the right of all older people to lead dignified, healthy and secure lives.

Age International is the UK member of the HelpAge global network and a charitable subsidiary of Age UK.

Cash transfers and older people's access to healthcare:

A multi-country study in Ethiopia, Mozambique, Tanzania and Zimbabwe

Published by HelpAge International
PO Box 70156
London
WC1A 9GB
United Kingdom

Tel +44 (0)20 7278 7778
info@helpage.org
www.helpage.org

Registered charity no. 288180

Front page photo: Kate Holt/Age International
Delivering the pension in Zanzibar.

Copyright © HelpAge International 2017
This work is licensed under a Creative Commons Attribution-NonCommercial
4.0 International License, <https://creativecommons.org/licenses/by-nc/4.0>

ISBN 978-1-910743-24-9

Contents

3	Acknowledgements
4	Executive summary
6	Introduction
8	Health status of older people
9	Supply of health services
12	Barriers to accessing healthcare
17	Cash transfers and demand for health services
24	Conclusion
25	Policy recommendations
27	Endnotes

Acknowledgements

From 2014-2017, Age International and the UK Government's Department for International Development (DFID) funded a healthcare-focused programme in four African countries. This programme was implemented by HelpAge International. The overall aim was to improve healthcare and homecare for 360,000 people in later life in Ethiopia, Mozambique, Tanzania and Zimbabwe.

As part of the programme, a multi-country study was commissioned to review the link between cash transfers and older people's access to healthcare.

A research report was written by Silvia Stefanoni and Camilla Williamson of Development Action and Paul Bukuluki, Symon P. Wandiembe, Tinie Van Eys and Peter Lloyd-Sherlock.

The report benefited from input by stakeholders in Ethiopia, Mozambique, Tanzania and Zimbabwe, including national and regional governments, hospital staff and civil society organisations.

This policy report was then produced by Flavia Galvani of HelpAge International, Silvia Stefanoni and Camilla Williamson from Development Action with contributions and review by Charles Knox-Vydmanov of HelpAge International, and Ken Bluestone and Judith Escribano of Age International.

We would like to thank all who contributed to both pieces of research – in particular older people – for their patience, engagement and commitment during focus group discussions and interviews. Finally, we would like to thank DFID for its financial support for the studies.

Executive summary

This report presents the findings of the Social Protection and Access to Health Services for Older People in Ethiopia, Mozambique, Tanzania and Zimbabwe study into the relationship between cash transfers and older people's access to health services, carried out by Development Action on behalf of HelpAge International and Age International.

The importance of strong health systems and universal health coverage has been widely recognised by national governments and international organisations. In Africa, the World Health Organization (WHO) has also identified ageing and the health of older persons as an area of significant concern in the wider context of improved health for the whole population. Globally, the Sustainable Development Goals have reinforced this understanding that good health should be available to people of all ages. Achieving this requires a mixture of approaches that include both health-related and social protection interventions such as cash transfers.

The report discusses challenges related to healthcare provision in Ethiopia, Mozambique, Tanzania and Zimbabwe; offers older people's perspectives on the key barriers faced in accessing healthcare; and highlights ways in which cash transfers have helped them overcome some of these barriers.

Lack of health services

“We need training on geriatrics. The government needs to realise the time has come to look after older people. All doctors should be learning about the needs of older people.”

**Dr Omuchamba,
Health clinic, Tanzania**

Overall, the supply of health services in all four countries is low, with health expenditure well below regionally set targets. This lack of investment in health is reflected in the limited availability, accessibility, affordability and adequacy of health services.

The number of health facilities is insufficient in all countries, each of which also faces a critical health worker shortage. A direct consequence of the small number of health facilities is their poor accessibility, with people walking an average of 30-45 minutes to reach the nearest one. This situation is compounded by poor availability of transport and, for many older people, limited mobility.

Despite policies to reduce the costs of health services for older people across all countries surveyed (and only the poorest older people in the case of Ethiopia), the research found that out-of-pocket expenditure remains high. This is the result of inconsistent implementation of such entitlements – either because of lack of compliance by service providers or lack of availability of supplies, equipment and medication.

The adequacy of the health services for older people in particular is poor in all four countries, with under-investment in the resources needed to identify, treat and care for older people. With the exception of Zimbabwe, there are no geriatricians in-country and very little geriatric training is provided for health staff.

Barriers to accessing healthcare

Older people and their families face significant barriers to accessing health services. Older people across eight research areas in Ethiopia, Mozambique, Tanzania and Zimbabwe talked about the significant expenses they face in order to reach health facilities and the costs of receiving appropriate treatment. This was particularly true for the most vulnerable older people, those with limited mobility and least family support.

Costs associated with transport and carer support are significant and in many cases prohibitive. Transport costs are especially high for people in rural communities and for those needing to be accompanied by their carers to health facilities. Such costs can prevent older people from following through the required referral pathways and accessing regular treatment for chronic conditions, with major implications for the adequacy and quality of healthcare received.

Cost of medicine is also a key barrier to accessing healthcare across all four countries. Older people spoke about being unable to access medication prescribed, either because they were not available free of charge or, in many instances, not available at all. Older people also reported having to pay for diagnostic tests such as laboratory tests and x-rays.

Such costs pose a significant dilemma for older people as they weight their health needs against other competing household needs – including those of grandchildren.

Cash transfers and access to health services

Evidence from the study suggests that cash transfers play an important role in removing some of the demand-side barriers to healthcare for older people, particularly those related to out-of-pocket expenses. Older people use cash transfers to pay for transport to get to health facilities, consultation fees and treatment costs, health insurance and prescriptions.

Cash transfers also have a positive effect on older people's wellbeing, through improved access to food and sanitation as well as improved confidence in the importance of looking after their health, and self-esteem. Access to health promotion linked to cash transfers was also identified as an important factor in encouraging older people to seek healthcare when needed.

However, older people across all four countries felt that the monetary value of the cash transfers was insufficient to have a major effect on their ability to seek healthcare, or to persuade them to prioritise their healthcare in the face of other needs. In addition, coverage of the cash transfer schemes in these countries was very limited and the amounts disbursed were invariably too low even to cover recipients' basic needs.

Moreover, even when cash transfers helped older people to attend health facilities, poor-quality health services often meant they were still unable to access appropriate services.

Policy recommendations

1. Improve coverage and adequacy of cash transfers
2. Ensure health entitlements and service delivery include older people
3. Promote links between cash transfer programmes and other social protection and health promotion initiatives
4. Ensure age-disaggregated data and evidence on older age, social protection and health at all ages is available.

Introduction

Access to health services depends on the availability of suitable health services (health service supply) and the ability of people to recognise their health needs and reach and use health services (health service demand). According to the WHO, most health systems in the African region remain unprepared to respond sufficiently to the needs of older people. Health care facilities focussing on older people are lacking, infrastructure is not designed to their needs and health professionals are inadequately trained in providing care to older people. Furthermore, more than 80 per cent of older people in the region do not have health insurance.¹ Where health services are not free at the point of delivery or easily reached, their use depends on people's access to resources such as cash to pay for treatment, and transport to get to health facilities.

“Older people are more vulnerable. They are more likely to suffer from hypertension and other NCDs. If you're not trained in older people's needs, then you wouldn't be able to give them appropriate treatment. Also, older people are likely to forget to follow up or to take care of themselves.”

Nurse Saada, NCD clinic, Ethiopia

There is considerable evidence that in such contexts cash transfers can improve access. Evidence relating to the impact of cash transfers on older people's access to healthcare is not so abundant, though evaluations of social pensions in El Salvador, China, Mexico, Peru and the Philippines suggest positive impacts of social pensions on older people's access to healthcare. For instance, in El Salvador, 21 per cent of pension income was used for health expenses, increasing the likelihood of seeking medical attention by about 5 per cent. Similarly, in Mexico, households receiving a universal pension were 25 per cent less likely to avoid buying medicines because of cost.

Recent studies in South Africa and Uganda² tell a similar story, but gaps remain in our understanding of how cash transfers contribute to improved access to health for older people and their families. The Social Protection and Access to Health Services for Older People study, on which this report is based, aimed to build understanding by looking at the relationship between cash transfers and older people's access to health services in Ethiopia, Mozambique, Tanzania and Zimbabwe.³

The study identified key barriers faced by older people in accessing healthcare in these countries and analysed the role of cash transfers in removing some of them, particularly those related to scarce household resources. It found evidence of cash transfers supporting older people's access to healthcare, particularly by enabling older people to pay for transport to reach health services and for the treatment itself. However, the limited coverage and low-value payments of the cash transfer schemes available (and wider supply-side barriers to healthcare, such as lack of staff and supplies at health centres) reduced the schemes' impact.

This report starts with a brief description of the health status of older people in these countries, and healthcare provision challenges. It then presents older people's perspectives on the barriers they face to accessing healthcare and the ways in which cash transfers have helped them to overcome some of these barriers.

Methodology

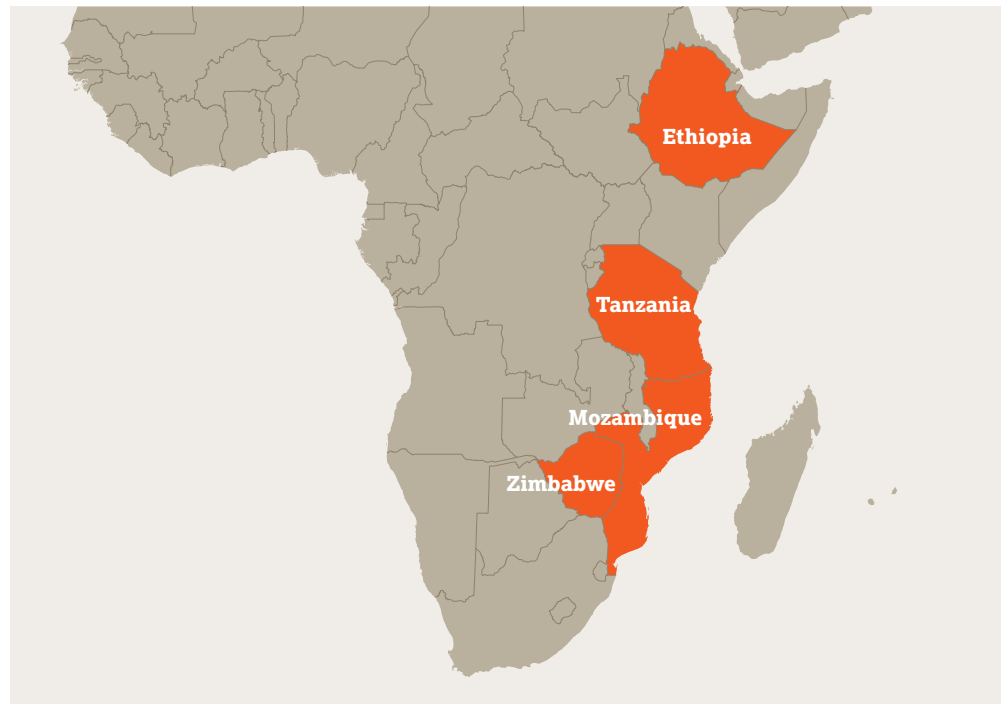
This study was carried out using a desk-based review of data and literature; qualitative research in all four countries; and a small-scale quantitative survey in Mozambique.

A total of 15 focus group discussions were conducted in rural areas and in urban outskirts in the four countries (three in Ethiopia and four in Mozambique, Tanzania and Zimbabwe), involving a total of 134 participants. The research team also conducted eight in-depth, semi-structured interviews with older people and 24 semi-structured interviews with key stakeholders, including representatives of the social protection and health departments both at local and national levels; and representatives of civil society and faith-based organisations.

Qualitative data was complemented by a quantitative sample survey in Mozambique. The survey covered the socio-economic and health status of older people, and their use of health services and cash transfers. A total of 212 older people were interviewed in 12 communities in the provinces of Maputo and Tete. Existing, accessible and relevant quantitative data from the other three countries was also analysed.

Research findings and recommendations were shared and discussed during consultative meetings in Ethiopia, Mozambique, Tanzania and Zimbabwe between March and April 2017.

Figure 1: Map of the countries studied



Key informant interviews were conducted with senior figures from civil society and national governments working in the areas of health and cash transfers to gather key information on programme contexts and the issues facing older people in accessing health services.

The limited scope of this research prevents the generalisation of findings to the entire population of older people in the countries studied, hence the results need to be read with a degree of caution. In addition, while measures were taken to reduce the risk of bias in the sampling of participants, it was not possible to select participants randomly.

Health status of older people

In Ethiopia, Mozambique, Tanzania and Zimbabwe, people over 60 years of age comprise 5-6 per cent of the population. This figure is expected to double by 2050, except in Mozambique, where it is projected to grow more slowly. Life expectancy at 60 in the four countries is between 77 and 78 years of age.⁴

Infectious diseases are still responsible for most deaths in these countries, but the incidence of non-communicable diseases (NCDs) is significant and rising.

“[The health clinic] is too far for me to walk to. It takes a day to get there on foot and I don’t have enough money to go by bus. If I am really sick and cannot walk, I just have to stay at home until I get better.”

**Chaussauca, 89,
Mozambique**

The most prevalent infectious diseases among older people are respiratory tract infections and urine infections, though typhoid and diarrhoea are also common illnesses for this age group. The incidence of HIV/AIDS is also significant, and although data for this age group is still limited, recent studies show that 8.5 per cent of people between 50 and 65 years of age in Mozambique, and 5.4 per cent in Tanzania, are living with HIV/AIDS.⁵

Data on NCDs is patchy, but there is considerable evidence that older people are disproportionately affected by NCDs such as hypertension and other cardiovascular diseases, diabetes, cancer, general body pains (especially arthritis), urine and faecal incontinence, and eye and hearing problems (see Table 1). The survey of older men and women in Mozambique found that three-quarters of respondents had at least one chronic disease, most commonly arthritis (75 per cent), hypertension (40 per cent) and eye problems (38 per cent). The prevalence of self-reported chronic diseases significantly increased after the age of 64, as did self-reported depression.⁶ Older people are also affected by a range of mental health conditions, especially dementia and depression, although these are often unrecognised.

Table 1: Percentage of older people who report being affected by non-communicable diseases (NCDs)

Conditions	Ethiopia			Mozambique			Tanzania			Zimbabwe		
	Men	Women	Total	Men	Women	Total	Men	Women	Total	Men	Women	Total
Arthritis	32	46	40	75	75	75	27	40	33	19	23	21
Hypertension	19	21	20	45	34	40	28	32	29	10	19	16
Eye problems	32	26	30	39	36	38	44	36	39	20	12	15
Asthma	9	12	11	17	5	12	8	11	9	N/A	N/A	N/A
Diabetes	14	6	10	N/A	N/A	N/A	15	8	10	3	6	5

Sources: Hall S, Better health for older people in Africa – mid-term review, London, HelpAge International, 2016. For Zimbabwe, CCDS, Better health for older people in Africa – mid-term review in Zimbabwe, London, HelpAge International, 2016.

Supply of health services

Access to health services is greatly influenced by their supply – i.e. their availability, accessibility and affordability, and the adequacy of health facilities and treatment. The supply of health services is shaped by the policies, institutions, organisations and processes that govern a country’s health system and regulate access to services.

Overall, the supply of health services in all four countries was found to be very limited. As shown in Table 2, per capita health expenditure was much lower than the US\$60 per capita spending recommended for Africa by the World Health Organization (WHO).⁷ The situation is particularly worrying in Ethiopia, with the country spending less than half of this amount (US\$27 per capita). Similarly, the percentage of gross domestic product (GDP) expenditure on health is significantly below the regional target of 15 per cent set by the 2001 Abuja Declaration.⁸

Table 2: Health expenditure per capita and as percentage of GDP

	Ethiopia	Mozambique	Tanzania	Zimbabwe	Recommended by WHO
Health expenditure per capita (2014)	US\$27	US\$42	US\$44	US\$56	US\$60
Health expenditure as % of GDP (2014)	5%	7%	6%	6%	15%

Sources: World Bank, Health, Nutrition and Population Statistics 2014, <http://datatopics.worldbank.org/hnp/HNPDash.aspx>. For Ethiopia, African Health Observatory, Analytical summary – country profile: Ethiopia, 2016, www.aho.afro.who.int/profiles_information/index.php/Ethiopia:Analytical_summary_-_Service_delivery

“We need more staff in the clinic. We are so overworked. You have seen the queue of patients that was waiting outside today. We also need a glucose monitor here. This is a big problem. It would be good to have another clinic like this one.”

Dr Issan, NCD clinic, Ethiopia

Availability

Despite healthcare facility expansion in recent years, particularly in Ethiopia and Tanzania, health service availability remains limited across all four countries. The number of health facilities is inadequate and there is a severe shortage of health staff at all levels, as shown in Table 3. All four countries face a “critical shortage” of health workers according to WHO’s definition (fewer than 2.28 health workers per 1,000 population). In Tanzania there is a shortage of between 50 and 70 per cent of qualified health workers at all levels.⁹ While the indicators are better for Zimbabwe, availability of health services in the country is deteriorating, partly due to the economic crisis in the country.

Table 3: Healthcare worker availability

		Ethiopia	Mozambique	Tanzania	Zimbabwe	Recommended by WHO
Accessibility	Physicians per 1,000 population	0.025	0.04	0.031	0.083	2.28
	Nurses per 1,000 population	0.21	0.34	0.35	0.72	2.28

Sources: World Health Organization, http://gamapserver.who.int/gho/interactive_charts/health_workforce/PhysiciansDensity_Total/atlas.html and www.afro.who.int/en/

Availability is particularly limited in rural areas where the vast majority of older people live. Older people interviewed for this research voiced concern about the lack of availability of secondary healthcare provided by medical specialists, given their need for treatment of non-communicable diseases and chronic illnesses. This situation is aggravated by a general lack of essential equipment and supplies.

“Ill health and poverty are inter-related. You cannot get to a hospital if you cannot afford to travel. When older people go to the dispensary, sometimes there are no drugs or they are expected to pay when their medicines should be free.”

Peter, Project Co-ordinator, Tanzania

Accessibility

The low number of health facilities in all four countries directly leads to poor health service accessibility, with people having to walk (on average) for 30-45 minutes to reach their nearest health service. In Ethiopia, 25 per cent of urban and 68 per cent of rural households have no health facilities within walking distance.¹⁰

For patients requiring regular treatment, the necessity to travel more than five kilometres or walk for 30 minutes or more to reach health services is considered an important barrier to accessing health services, and can have a significant impact on health outcomes. This situation is compounded by limited availability of transport and, in the case of a many older people, limited mobility.

Table 4: Distance to health facilities

	Ethiopia	Mozambique	Tanzania	Zimbabwe	Recommended maximum to enable easy access
Average distance to health services	Data not available	10 km	8 km	10 km	5 km

Sources: Mozambique: WHO Country Profile available at www.who.int; Tanzania: Kadovera, D et al (2012) The effect of distance to formal health facility on childhood mortality in rural Tanzania; Glob Health Action; Zimbabwe: USAID, (2010) Zimbabwe Health Assessment available at www.hfgproject.org/zimbabwe-health-system-assessment-2010/

Affordability

The affordability of health services depends on the ability of health service users to pay for the services offered. In all four countries there is a series of policies in place aimed at reducing the costs of health services for older people, as shown in Table 5.

Table 5: Older people’s health entitlements

	Access to health for older people	Health insurance	Other provision
Ethiopia	Indigent Fee Waiver programme provides the poorest patients with free access to specific health services in government health centres and hospitals.	Community-Based Health Insurance (CBHI) provides financial protection in case of illness for informal sector employees and rural residents. Kebeles (local neighbourhoods) decide collectively to establish CBHI schemes, but the decision to enrol is taken by at household level.	
Mozambique	Older people (females over 55, males over 60) are entitled to free inpatient admittance in general and central public hospitals; free outpatient services; and free access to most drugs at health centres.	Health insurance is only available to those in formal employment.	Older people are exempt from queuing at health facilities.
Tanzania	Free healthcare for older people at government facilities when a free health card is presented.	A government community-based health insurance is available, costing 10,000 TZS (US\$4.47) providing coverage for five members for one year.	Designated rooms at health centres for older people.
Zimbabwe	Free access to healthcare in first level government health units through the Assistant Medical Treatment Orders (AMTOs).	Health insurance is only available to those in formal employment.	Older people are exempt from queuing at health facilities. The government provides food for older people on medication requiring specific food, e.g. people receiving antiretroviral (ARV) treatment.

However, this research found that implementation of these entitlements is not consistent – the result of either a lack of compliance by service providers, or a lack of supplies, equipment and medication. In general there are insufficient accountability mechanisms to ensure health entitlements are implemented.

“We have the policy ‘free medical access to healthcare for older persons’ but the health system has a lot of challenges, e.g. sometimes no medicines. So even if services are free, if there are no medicines, there are no services.”

Key informant interview, Tanzania

“It’s boring. Every time you tell the doctor what’s wrong, they always give you paracetamol.”

Maria, 72, Mozambique

Adequacy

Health services for older people are inadequate in all four countries, and lack specific health policies and programmes for older people and specialist personnel. The situation is compounded by limited monitoring and lack of data on older people’s health status and needs.

Of the four countries only Zimbabwe possesses any in-country geriatricians (see Table 6), and only Mozambique provides geriatric training for health staff (the Ministry for Health, supported by HelpAge Mozambique, recently started a 5-day in-service training for health professionals in geriatric care).

In addition to this lack of specialist staff, there is a general underinvestment in the resources needed to identify, treat and care for older people. For instance, in Mozambique, the official list of essential drugs from the Ministry of Health does not include drugs for NCDs such as diabetes and hypertension, thereby increasing the risk of not finding adequate drugs in public pharmacies.¹¹ The situation is similar across all four countries.

Table 6: Geriatricians and geriatric training

		Ethiopia	Mozambique	Tanzania	Zimbabwe
Adequacy	Number of geriatricians in the country	Zero	Zero	Zero	5 to 9
	Geriatric training	No geriatric training	Geriatric care included in training of health workers	No geriatric training	No geriatric training

Data source: Dotchin C L, Akinyemi R O, Grey W K, and Walker R W, (2013) Geriatric medicine: services and training in Africa, *Age Ageing* 42 (1): 124-128.

Barriers to accessing healthcare

“It’s a real challenge when someone cannot afford the medicine. Sometimes they just go back home.”

Elisha, NCD Project Manager, Tanzania

In this context of limited supply, older people and their families face significant barriers to accessing health services. Focus group discussions and key informant interviews in Ethiopia, Mozambique, Tanzania and Zimbabwe identified significant challenges for older people in finding the means and money to reach health services, and in accessing treatment.

Observations and experiences shared by study participants indicated that despite the existence of policies and programmes guaranteeing free healthcare for older people (or only indigent older people in the case of Ethiopia), in reality the costs of accessing healthcare are still very high. Older people talked about the significant expenses they face in order to reach health facilities and the costs of receiving relevant treatment. This was particularly true for the most vulnerable older people, those with limited mobility and little family support.

People living in countries with a low level of public investment in health generally face high out-of-pocket health expenses – Table 7 shows that private and out-of-pocket expenditures are high in all four countries surveyed.¹²

Table 7: Private and out-of-pocket health expenditure

	Ethiopia	Mozambique	Tanzania	Zimbabwe
Private health expenditure as % of total health expenditure	41%	44%	54%	62%
Out-of-pocket health expenditure (% of total) (2014)	32%	9%	23%	36%

Data source: World Bank ‘Health, Nutrition and Population Statistics’ 2014. Available at <http://datatopics.worldbank.org/hnp/HNPDash.aspx>

“There are many needs, so you have to prioritise the most pressing need, even if it means sleeping in darkness or enduring some pain untreated.”

Male focus group discussion participant, Tanzania

Most older people in these countries have no regular source of income, as the majority are not formally employed and old age pension coverage is very limited. Many reported that out-of-pocket costs therefore pose an important dilemma for them when weighing their health needs against many other competing household priorities – especially for older people caring for grandchildren.

“It depends on the money that one has. Sometimes you have no food and the children have no uniform to go to school. You use the little [money you have] to buy the food and uniform, and it is gone. There are many needs all depending on the same meagre resources. So you have to prioritise the most pressing need, even if it means sleeping in darkness or enduring some pain untreated.”

Male focus group discussion participant, Mbarali district, Tanzania

“They see that the person has already grown old and ignore his suffering. There is little that can be done to improve the health of the old man and yet a lot of money has to be spent. Sometimes that money has to be borrowed or children will withdraw from school.”

Male focus group discussion participant, Manhiça, Mozambique

Older people also talked about the consequences of postponing the decision to seek care because of the costs of travelling to a health facility for treatment. For some, when they finally decided that their illness would not go away, they were too sick and unable to travel alone, thus increasing the cost of transport; others talked about spending money on self-medication, to no avail.

Reaching health facilities

In the four countries studied, outreach healthcare is very limited, so for the overwhelming majority of people, accessing healthcare means reaching a health facility. As discussed previously, health facilities, especially in rural areas, are few and far between. Add to this the limited availability of transport and the additional mobility difficulties often experienced by older people, and the journey to the health centre becomes a major deterrent to people seeking help. The costs associated with transport and carer support are significant, and in many cases prohibitive.

“We get free health services but [you have to use] the health centre where one is registered. Sometimes, you find you are registered at a health centre further away, even when there is a nearer one. Some of us have to travel long distances, which not only increases the costs of transport but can often motivate us to delay the decision to travel in the first place. For some of us the distance is about 4km, but for others it is 7-10km to the health centres where we are registered. At our age, that is a long distance [to travel].”

Male focus group discussion participant, Mbarali district, Tanzania

Availability and cost of transport

Transport costs pose a major barrier to poor and marginalised people accessing healthcare. Walking to health facilities is not an option for many older people, not only because of the great distances to travel, but also because of mobility problems – for instance, about two-thirds of older people surveyed in Mozambique reported some level of difficulty walking.

In all four countries surveyed, older people talked of difficulties faced in arranging transport to reach health facilities, and the high costs involved. In Mozambique, 16 per cent of older people surveyed had to pay transport fares the last time they visited the health centre (even though they are entitled to free transport) either because they did not have ID cards – which cost 280MTs (US\$4.29), or because public transport was not available where they live. They paid on average 50MTs (US\$0.76) for transport. The proportion of respondents paying transport fares increased with age and corresponding difficulty in walking.

“It is good to go for check-ups and treatment, but we cannot afford the transport costs. This makes it difficult.”

Focus group discussion participant, Maputo, Mozambique

The costs of transport are especially high for people in rural communities, and those needing a carer to accompany them to a health facility. In Zimbabwe and Mozambique there was a noticeable disparity in access to health services between rural and urban areas. Older people living in rural areas faced larger distances, particularly in cases where more specialised healthcare is required, and more limited transport options. Public transport is very limited in rural areas and bicycles are the most common means of transport – an unsuitable means of transporting people who are unwell, frail or have mobility issues.

Particular health issues such as sight problems, arthritis and other mobility problems made it difficult for many older people to move from home to healthcare centres without a carer. In these cases, transport costs doubled. As the journeys to and from health facilities are normally long, older people also have to consider costs related to food for the day – for them and for their carers.

“Transport costs range from 2,000TSh (US\$0.89) but [adding] 4,000TSh (US\$1.79) for food it means you pay 6,000TSh (US\$2.68) per trip.”

Female focus group discussion participant, Umbaruku, Tanzania

Transport costs can also prevent older people being properly referred and accessing regular treatment for chronic conditions. This has major implications for the adequacy and quality of healthcare received, and consequently the health and wellbeing of older people. For instance, in Ethiopia, focus group discussion participants recalled several instances where health centres were unable to give the necessary treatment and therefore referred them to hospital, but they were unable to go because they could not afford the transport costs.

“We get free health services but [you have to use] the health centre where one is registered. Sometimes, you find you are registered at a health centre further away, even when there is a nearer one. For some of us the distance is about 4km, but for others it is 7-10km to the health centres where we are registered. At our age, that is a long distance [to travel].”

Male focus group discussion participant, Tanzania

“Though health services are said to be free at public health facilities, the reality is different. In fact, public health services have widely collapsed.”

Key informant interview, Zimbabwe

“In hospitals, there is a shortage of medicines as well as supplies.”

Salama, Secretary of Older People’s Association, Zanzibar

Paying for the cost of treatment

Consultation

Older people are exempt from consultation fees in government health facilities in Mozambique, Tanzania and Zimbabwe (see Table 4). However, older people spoke of many obstacles that blocked their access to these entitlements.

In Zimbabwe the main issue is that the Assistance Medical Treatment Order (AMTO), under which older people can access free medical treatment, has not worked well in practice as a result of the government being under severe economic pressure and struggling to pay providers. Moreover, given the limited availability of government services, many older people reported needing to resort to private healthcare. Older people talked about having to pay about ZIM\$20 (US\$20) for a consultation at private health facilities.

“Though health services are said to be free at public health facilities, the reality is different. In fact, public health services have widely collapsed.”

Key informant interview, Zimbabwe

In Tanzania, nearly all older people who participated in focus group discussions confirmed having free health cards entitling them to free consultations. Their main concern was paying for fees for other family members, particularly children under their care– they found it very difficult to pay for community health fund (CFH) fees that total 10,000TSh (US\$4.47) per year for five members.

In Ethiopia, where no such entitlements are in place, older people reported paying 70-80 Birr (US\$3.05-US\$3.49) for consultations and 400 Birr (US\$17.48) for hospitalization. Over two-thirds of older people in Ethiopia reported being unable to pay for healthcare costs.¹³

Medication

Lack of availability and cost of medicine are key barriers for accessing healthcare across all four countries. Older people spoke about being unable to access medication prescribed either because they were not available free of charge or, in many instances, not available at all.

“When we go to hospital we get free check-ups – but the medicines are not there, so we have to go and buy outside the hospital in private.”

Female focus group discussion participant, Mbarali, Tanzania

“If you have money you go and buy medicine – if you don’t have it, you just leave and go back home.”

Male focus group discussion participant, Mbarali, Tanzania

In Mozambique, 22 per cent of survey respondents were to get the prescribed medication during their last visit to a health centre. The main reasons were: (i) medication was not available at the health facility (39 per cent); (ii) the patient could not afford it (37 per cent); or (iii) the patient could not afford transport costs to collect the prescribed medication at another health facility (19 per cent).

Lack of free medication from healthcare centres is a serious deterrent to older people seeking treatment.

“Whenever I go to the doctor about any issue, the doctor gives me a prescription and tells me to go and buy the medicine. Only paracetamol is given free and the rest I have to pay for. That is why I find it boring to go back to the doctor. I just remain home and buy the paracetamol from here because even when I go to the doctor, it is the only one I am going to get. Why would I go all the way [to the doctor] to pick up paracetamol?”

In-depth interview, female, Manhica, Mozambique

“[W]e are told services are free yet when we go there, all they do is write [a prescription for] the medicines and ask you to go and buy them from other health facilities. It defeats the logic of saying that the services are free because even the transport to come [has had to be scraped together]. If the medicines are not there, we go back home with our heads in our hands and resort to traditional medicine, which we were [hoping to leave] behind in the first place.”

Male focus group discussion participant, Mbarali, Tanzania

“Medical centres need more equipment to deal with more older people. We want to be able to test for health conditions here. At the moment, there are insufficient resources.”

Nurse Salme, Health clinic, Tanzania

Diagnostic tests and additional services

Older people in all four countries reported that they are often expected to pay for diagnostic tests such as laboratory tests and x-rays.

“The consultation is free [but] all additional services (tests, x-rays, spectacles etc.) have to be paid for.”

Focus group discussion participant, Goromonzi, Zimbabwe

Also, when admitted into hospital, a key concern for older people are the costs they face during their stay in hospital, including food for them and food and accommodation for their companions.

Discrimination

Older people also talked about how the discrimination they face in some health facilities can act as a major deterrent to them seeking help when ill. Limited knowledge of older people’s health on the part of staff and the lack of equipment and medications result in health staff being often unprepared to address older people’s health concerns. Some older people reported being ignored at the health centre because of their age and talked about how common it is for their health complaints to be explained away as ‘just old age’.

“Sometimes they say that you are suffering from old age. ‘When you get older, you are expected to have that disease,’ they say. So the older people are mostly ignored in the hospitals/health centres. We think we get this [attitude] because we get free treatment. The service is not bad, and it is not good – just fair.”

Male focus group discussion participant, Mbarali-Mbeya, Tanzania

Many people are unaware of older people’s health conditions. They go to the doctor and are told ‘you are just old’.”

Dr Catherine, Health clinic, Tanzania

“I feel I am really struggling to survive.”

Hazel, 50, lives with her 73-year-old husband and ten children.

Hazel's husband was a farm worker for many years, but now he is not able to work. Like most farm workers he was not in a pension scheme, so today he has no income. Hazel works washing clothes and making bricks. However, it is not regular and some clients do not pay the agreed amount. “One ends up receiving nothing while the work has been done,” she says.

Hazel says, “I feel I am really struggling to survive; one never knows if there will be something for the children to eat next day. I hoped to be included in the Cash Transfer Programme, but these young people came into the village only to ask many, many questions. They wanted to see inside our house, who was there, who earns money, how many chairs and tables we have, all these silly questions. But in the end my family was not considered [for the programme] and we don't know why.”

Hazel struggles with health problems. She went to the hospital to get treatment for hypertension and diabetes. “But now I don't go anymore,” she says, adding that “there is no money to pay for the medicines.”

Hazel thinks the future is not bright for herself and her family. She sees that her children and grandchildren are struggling and wonders: “What future will there be for them?”

Hazel, 50, Zimbabwe



Timie Van Eys/Development Action

Cash transfers and demand for health services

Cash transfers for poor and disadvantaged people can improve access to health services and health outcomes in two main ways – by helping them feel more secure in deciding to prioritise their health needs, and by reducing worry about the costs of reaching health facilities and paying for treatment and tests.

This study looked at the effects of existing cash transfer schemes (see Table 8) in removing barriers to older people’s demand for health services. Of the 134 focus group discussion participants, 51 per cent were receiving cash transfers – a much higher percentage than average because of the study’s focus on communities where a significant number of older people were receiving them.

Table 8: Cash transfer schemes in research areas

Research area	Type of cash transfer programme	Amount
Ethiopia – Bahrtseba (rural)	Cash transfer from a joint, 5-year programme run by UNICEF, HelpAge and the government (2011-2016) – some recipients have reportedly been transferred to the government’s Productive Safety Net Programme (PSNP) cash transfer scheme	155 Birr per month (US\$6.77) PSNP 137 Birr (US\$6) to 413 Birr (US\$18)
Ethiopia – Addis Ababa (urban)	Monthly cash transfer provided by the St George Welfare Association (see below)	Was 155 Birr per month (US\$6.77) and now 100 Birr (US\$4.40)
Mozambique – Manhiça (rural)	Government’s Basic Social Subsidy Programme (PSSB) cash transfer	310Mts (US\$4.75)
Mozambique – Maputo (urban)	Government PSSB cash transfer	310Mts (US\$4.75) reported but potentially from 250 Mts to 500Mts US\$4 to US\$8
Tanzania – Mbarali, Mbeya (rural)	Government’s Tanzania Social Action Fund (TSAF) cash transfer	Reportedly ranges from 10,000-50,000TSh per month depending on number of people in household (US\$4.47 -US\$22.36)
Tanzania – Ubaruku (urban)	Government TSAF–PSSN cash transfer	Reportedly ranges from 10,000-50,000TSh depending on number of people in household (US\$4.5-US\$22.9)
Zimbabwe – Goromonzi (rural)	No participants were receiving a cash transfer	No participants were receiving a cash transfer
Zimbabwe – Svishavane (urban)	Government public assistance programme cash transfer	Zim\$10-US\$25 per month (US\$50 every two months) depending on household numbers

Problems with cash transfer schemes

With the exception of the St George Welfare Association scheme in Addis Ababa and a component of the UNICEF/HelpAge scheme in Tigray, the cash transfer programmes did not specifically target older people, but rather those living in poverty. It also had limited coverage.

Older people interviewed for the study voiced concerns about the lack of transparency in the definition and application of eligibility criteria and limited coverage of the schemes that resulted, in their view, in the exclusion of many poor and vulnerable older people.

This was particularly the case in Zimbabwe, where eligibility criteria were reported as a divisive issue. Men in one focus group discussion in Goromonzi (none of whom

received cash transfers) said: “People in the community do not disclose if they receive a cash transfer” and anger was expressed in other focus group discussions in Zimbabwe about some people receiving cash transfers while others did not.

People also felt there were significant issues in the targeting of the scheme in Tanzania. Men in Umbaruku said: “It is unfair because the elderly [who do not receive the transfer] are equally vulnerable”. In Mozambique, there were multiple reports of people being registered and accepted on the programme but receiving no money, as the government was not in a financial position to extend the benefit.

The programmes in Ethiopia were time-limited. The UNICEF/HelpAge pilot in Tigray finished in 2016 and the St George Welfare Association’s cash transfer was reported to be finishing in early 2018, while the scheme in Zimbabwe was being cut back due to lack of government commitment.

These schemes also disbursed payments that often failed to cover basic needs. Men in the focus group discussion in Addis Ababa, Ethiopia, said it was only really enough to “feed us one meal per day”. In Mozambique, where the value of the transfer was lowest, there had been no adjustment in the values of the benefit for the previous two years, despite high inflation.

“It would have been better to receive a food basket, as those who receive a food basket are still getting the same amount in weight. With the money the cash transfer gives, I can only afford half what I could get with the same amount a year ago.”

Male focus group discussion participant, Manhica, Mozambique

“Beneficiaries go for long periods without receiving the amount they are entitled to, due to disturbances to the programme.”

Key informant interview, Zimbabwe

Predictability of cash transfers was also an issue, particularly in Zimbabwe, where a key informant said: “Beneficiaries go for long periods without receiving the amount they are entitled to, due to disturbances to the programme.”

The cash transfers in Ethiopia, Mozambique and Zimbabwe were unconditional, while Tanzania’s TSAF depended on the family’s participation every two months in education and health-related services, and in community sessions on health, nutrition and sanitation. The Ethiopia cash transfer programmes in Tigray and Addis Ababa provided health promotion activities at the pay points on days when the cash transfer was paid. These included activities on hygiene, sanitation, immunization and health promotion.

Despite the limitations of these cash transfer schemes, they make up a substantial proportion of recipients’ income. The majority of older people in these countries are subsistence farmers and have no predictable sources of income. Pension coverage is very limited and largely restricted to civil servants and formal sector workers.

In Mozambique, 72 per cent of survey respondents receiving the Basic Social Subsidy Programme (PSSB) said that the transfers were their most important source of household income. This reflects the findings of a survey among recipients of PSSB by HelpAge International in Mozambique in 2013, which revealed 78 per cent of the households participating in the survey depended on cash transfers for between 76 and 100 per cent of their income.¹⁴

Given the low cash value of the transfers, most recipients reported spending most of it on food. In Mozambique, for instance, 90 per cent of respondents ranked food as their number one expenditure. This was corroborated by older people in the three other countries.

In Addis Ababa, Ethiopia, men in focus group discussions said they spent the cash transfer they received on food, soap and sometimes to pay for part of their rent and medical expenses. In Bahrtseba, Ethiopia, people said it enabled them to buy only the minimum amount of food, clothing and cover some health costs.

In Tanzania, older people spoke about the cash transfer enabling them to replenish household basics, such as food, sugar, salt and soap; and meet the needs of grandchildren (especially school-related needs); and meeting some health-related costs.

In Zimbabwe, people said they spent the cash transfer on food, taking care of children’s wellbeing, healthcare costs, and meeting basic needs such as soap.

Benefits of cash transfers for healthcare

General experiences shared by study participants indicated that, even though cash transfers were inadequate and mostly spent on food, they nevertheless contributed to improving access to healthcare directly by enabling older people to pay out-of-pocket costs related to reaching health services and accessing treatment.

Moreover, recipients across all four countries talked about the strategies they use to make the most of cash transfers to increase the amount of money available for accessing healthcare, particularly in emergencies. These included using it as collateral to borrow money, investing it in income-generating activities and participating in savings groups.

“Because a cash transfer is given monthly, it is a very important resource and acts as a health insurance – you can borrow money and pay back every month using the regular cash transfer income. It becomes collateral or security of some sort.”

Male focus group discussion participant, Ethiopia

“The cash transfer has enabled me to borrow money from family and friends, as people know that I will receive the payment each month. It has acted as security for the loan.”

Male focus group discussion participant, Bahrtseba, Ethiopia

“Because a cash transfer is given monthly, it is a very important resource and acts as a health insurance – you can borrow money and pay back every month using the regular cash transfer income. It becomes collateral or security of some sort.”

Male focus group discussion participant, Addis Ababa, Ethiopia

“Sometimes, it is not about spending the cash transfer. When I got the money, I bought a pig and when I sold the pig, I got 85,000Tzs (US\$38) which I used to meet medical expenses and also to improve the sanitation of my home.”

Male focus group discussion participant, Mbarali, Tanzania

Evidence that cash transfers support older people’s healthy behaviours was also found, as people receiving transfers were able to buy more food, safe water and hygiene products.

In Mozambique, satisfaction with household ability to meet costs associated with healthcare and personal needs was significantly higher among respondents receiving some form of cash transfer. Over 60 per cent of respondents receiving cash transfers were satisfied with their ability to meet healthcare-related costs, compared to 47 per cent of those not receiving cash transfers.

In focus group discussions in all countries, women reported a slightly more beneficial effect of cash transfers on access to healthcare than men, possibly due to them having improved health awareness and therefore a greater likelihood of seeking healthcare when needed. In the Mozambique survey, however, no gender differences were identified in the use of the cash transfer.

In the focus group discussions and key informant interviews, several examples were given of how older people use cash transfers to access health services. In particular:

- meeting transport costs to hospitals or health facilities for them and carers;
- supplementing the cost of consultation, treatment and medication; and
- enabling older people to support grandchildren’s access to health services, including by purchasing community health insurance cards for grandchildren.

The following section discusses this evidence in more detail.

Ability to seek healthcare when necessary

Knowing when to seek health services and having the ability to use household resources to do it are major factors affecting older people’s access to health services. Older people often find it difficult to prioritise their health needs given the competing demands on, and limits to, household resources – particularly if they do not contribute directly to household income.

But older people receiving cash transfers reported feeling empowered to make decisions with their own money, including accessing healthcare. Most of them would still often prioritise the needs of others in the household, particularly children, but now felt more in control. This helps improve their self-esteem and sense of belonging.

“There is a difference between now and when I had no cash transfer – now I can buy food and school materials. When there is someone sick in the family, I use it to meet medical expenses [and] it helps to meet transport costs to the hospital. In terms of health and wellbeing, I am now able to wash and be hygienic. I now get two meals a day instead of one meal and I have managed to pay for my rent consistently.”

Older man, Mbarali, Tanzania

“They [older people] didn’t think they would be treated well at the clinic, so they didn’t want to come.”

Dr Maria, Head of health clinic, Mozambique

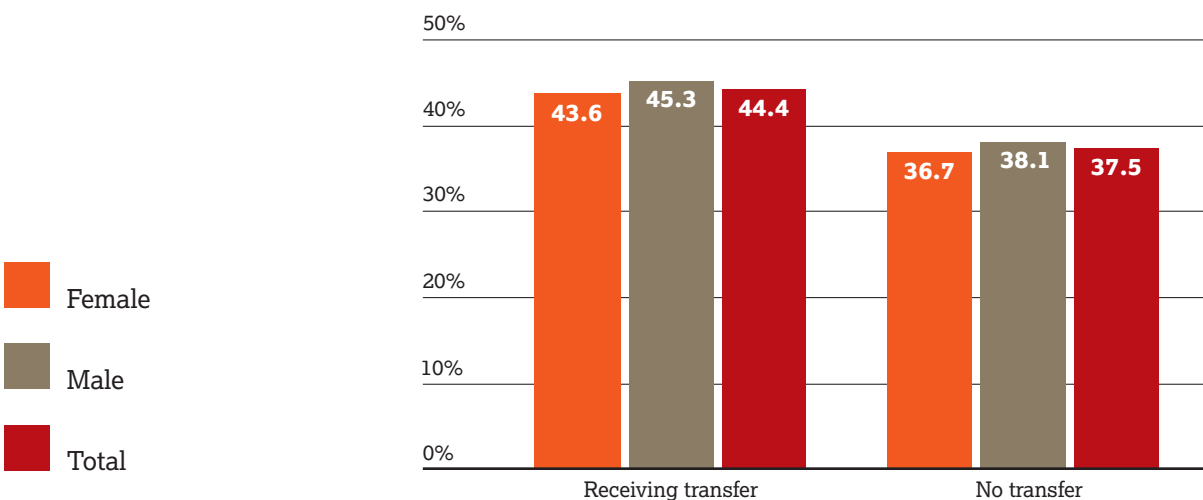
The survey in Mozambique showed that older people receiving cash transfers were more likely to prioritise healthcare expenditure, compared to those not receiving cash transfers. Costs relating to access to healthcare was a top three priority of 44 per cent of people receiving cash transfers, compared to 37.5 per cent not receiving transfers. Among respondents receiving cash transfers with at least one self-reported chronic disease, this percentage increased to 53 per cent (see Figure 2).

Cash transfers in Ethiopia and Tanzania were particularly successful at improving older people’s abilities to recognise and act on their health needs because they were linked to health awareness activities.

In Bahrtseba, Ethiopia, various health promotion activities were carried out in cash transfer pay points, encouraging recipients to use some of the money from the cash transfer on promoting healthy behaviour – including buying nutritious food, soap, and investing in improved sanitation and clothes. In Tanzania, meanwhile, health interventions were an integral part of the cash transfers, with receipt of the money conditional on participation in health sessions and attending health facilities for treatment.

Evidence showed that these interventions helped increase awareness and recognition of health problems and the need to seek treatment, and also encouraged the adoption of healthy behaviours, which can have a direct impact on health. For example, older men in Ethiopia said: “The awareness training that takes place during pay days helped us to focus on using some of the money for accessing health services.”

Figure 2: Health as a top-three expenditure in the past six months among survey respondents in Mozambique



Ability to reach health services and pay for treatment costs

Across all focus group discussions, a large number of older people receiving a cash transfer said they had used it to cover some healthcare costs. For example, about a third of survey respondents in Mozambique reported using cash transfers to meet costs associated with access to healthcare.

Meeting transport costs

Older people across all four countries identified transport costs as one of the main barriers to accessing health services. As reported above, distances to health facilities are usually large, particularly in rural areas, and mobility among older people is often restricted. Cash transfers were said to be important in meeting the cost of transport to health services for older people and their carers.

“Through the cash transfer, I have money for transport to go and seek services.”

Female focus group discussion participant, Bahrsteba, Ethiopia

“Sometimes when [the cash transfer] is there, it helps to meet transport costs to the hospital. If the cash transfer money is there I do not beg – I just use it to go to the health facility.”

Male focus group discussion participant, Mbarali, Tanzania

“At least we now have options ... we can decide to go to a facility providing better services rather than being restricted to the dispensary. Through cash transfers I have money for transport to go and seek services from a better health facility.”

Female focus group discussion participant, Mekelle, Ethiopia

In Mozambique, survey respondents receiving a cash transfer rated their household's ability to meet transport costs associated with healthcare 15 per cent higher than households not receiving the cash transfer.

The ability to use cash transfers to pay for transport costs can be a particularly important issue for people with chronic or long-term conditions who need continuous treatment. This was particularly evident for older people on antiretroviral (ARV) treatment in Ethiopia and Zimbabwe, where the cash transfer was found to be a critical source of income for supporting older people's adherence to treatment. This correlates with data collected in the survey in Mozambique where respondents with chronic conditions were more likely to use the PSSB to cover healthcare costs.

“I am living with HIV and I go regularly to replenish my medication. However, sometimes I feel tired and sick. One month ago, I was sick and when I went to hospital they took very good care of me and I felt well. Whenever I felt ill, I would have loved to go back but the cost of transport is high. If it were not for cash transfer, I would not go there. Last time I spent 150 Birr (US\$6.55) on transport to get ARVs which are free from the hospital.”

Female focus group discussion participant, Bahrsteba, Ethiopia

It has also been acknowledged that, by contributing to transport costs, cash transfers have in some instances expanded people's choices of health services.

“At least we now have options... we can decide to go to a facility providing better services rather than being restricted to the dispensary. Through cash transfers I have money for transport to go and seek services from a better health facility.”

Female focus group discussion participant, Mekelle, Ethiopia

Paying for fees, treatment and medicines

Older people reported struggling to meet not only travel costs but treatment-related costs – particularly for medication. In focus group discussions across all four countries, older people spoke of using cash transfers to cover some of these costs.

In Ethiopia, where health services are not free at the point of delivery, paying consultation and hospital fees was a particularly important use of cash transfers.

“Without the cash transfer we would not be able to access any health services as they are too expensive, even at the health centre.”

Male focus group discussion participant, Bahrtseba, Ethiopia

“155 Birr (US\$6.77) [value of the transfer] is ok but it is not sufficient to meet all the needs of the household. However it has contributed a fair share to helping us access health services.”

Female focus group discussion participant, Bahrtseba, Ethiopia

Even though older people are entitled to free healthcare in Mozambique, Tanzania and Zimbabwe, underfunding of the health systems often means that older people's health entitlements are not fully implemented and older people are still expected to meet some treatment costs. In Zimbabwe, which has an acute lack of resources in its public health facilities, older people spoke about using cash transfers to pay for

“We use cash transfers as transportation money to help us go to the hospital when sick. We also use it to buy drugs when we are sick – or when prescriptions are done but there is no medicine in health facilities.”

Female focus group discussion participant, Mbarali, Tanzania

private care. In Mozambique, older people reported needing to pay for some procedures.

“I had an operation and the money from the PSSB helped me pay for it.”
Male focus group discussion participant, Manhiça, Mozambique

Lack of access to medication was a particularly strong concern for older people. Across all four countries older people talked about the need to cover the costs of medicines since usually the prescribed medication is not readily available at the health centres – either because of lack of stock or most commonly because the medication needed is not included in essential drugs list and hence not provided free of charge. In this context, some older people talked about using cash transfers to buy medicine, though the majority were still unable to buy the medication needed.

In addition to using the cash transfer to meet some of their own health needs, many older people reported using transfers to support family members, particularly grandchildren, to access healthcare.

“[My friend] lives with HIV/AIDS and gets free health services, but she uses the money to pay for her children to be treated in the health centres.”

Female focus group discussion participant, Tigray, Ethiopia

In Tanzania, older people talked about how they have been using cash transfers to purchase Community Health Funds (CHF) cards for children in their care – a form of health insurance that enables vulnerable children to access healthcare.

“[W]hen we get sick, we go to hospital, but for our grandchildren, we make sure that we get CHF cards to reduce the cost of healthcare. It is challenging to get TSh10,000 (US\$4.47) to get CHF cards but we have no option, we must make sure that we acquire them for our grandchildren to access health services.”

Female focus group discussion participant, Mbarali, Tanzania

Camilla Williamson/Development Action



“The payments allow me to meet our basic needs”

Tewelde lives with his wife and children in a remote, rural village of the Tigray region of Ethiopia, called Bahrtseba. He works a small plot of land, though he says it is too small to feed his whole family. Regular droughts have compounded their problems.

Like others in his village, Tewelde received a HelpAge, UNICEF and government-sponsored cash transfer for two years. Each month he was paid 150 Birr (US\$6.77), which he collected in the village. Tewelde says the payment was vital to his and his family’s survival. Even the small amount it provides meant he was better able to meet his family’s basic needs, allowing him to buy food, fuel and shelter, and other items such as text books for his children.

Tewelde says the cash transfer has had a positive impact on his family’s health, particularly in terms of providing nutrition and warmth. It also allowed him to access primary health care and medicines. However, Tewelde says the cash transfer was not enough to cover secondary care.

Speaking about health services in general, Tewelde says there is a big mismatch between people’s health needs, their ability to pay, and what is provided. While the healthcare provided in the community has improved in the past 20 years, Tewelde says many people are still not able to access the services and medicines they need, either because they are not available, or because they cannot afford them. This means people often rely on traditional medicine, or take no action.

Tewelde, 68, Ethiopia

The impact of cash transfers on older people's health and wellbeing

Evidence emerged on the significant impact of cash transfers enabling older people to better meet their basic needs, particularly in buying an increased amount and diversity of food, and hygiene products – focus group discussion participants in all countries reported that a large share of their cash transfers was spent on food and soap. In Mozambique, cash transfers were also spent on accessing clean water.

“Everyone says that all the money from the cash transfer is used to help them meet their basic needs for food, salt and sugar.”

Key informant interview, Tanzania

“Drought is a consistent challenge in our region leading to food insecurity. The cash transfer assisted us a great deal in meeting basic needs – especially food.”

Male focus group discussion participant, Addis Ababa

“I can say that because of the cash transfer there has been an improvement. My home is much cleaner than when I did not have it. All of us at home can buy what we need to make sure our bodies and clothes and environment are clean. And in fact, there is less sickness at home because of our better hygiene.”

Female focus group discussion participant, Mozambique

Improvements in nutrition and hygiene have reportedly reduced illness among older people and other household members. Improved hygiene also has important implications for self-esteem and social inclusion as older people reported feeling more confident to attend community gatherings or welcome people to their homes if they were clean.

“[Cash transfers] also improve nutrition, food security, hygiene and sanitation, and therefore reduces the number of elderly falling sick and going to the health facilities.”

In-depth interview, female, Ethiopia

“We used to have one or two meals but now we have three meals. We are also able to buy vegetables and onions, and buy meat twice a month to vary the diet. We can also buy soap to wash our clothes and utensils and wash clothes for our children and grandchildren. I feel stronger and more energetic than before... I am sure I even look more beautiful.”

Female focus group discussion participant, Ethiopia

“I can say that because of the cash transfer there has been an improvement. My home is much cleaner than when I did not have it. All of us at home can buy what we need to make sure our bodies and clothes and environment are clean. And in fact, there is less sickness at home because of our better hygiene.”

Female focus group discussion participant, Mozambique

“We have seen a reduction in diseases – children used to get sick about twice a month, but now a month can go by without them falling sick.”

Male focus group discussion participant, Mbarali, Tanzania

Evidence was also found of the positive effect of cash transfers on older people's mental health and wellbeing. Older people talked about how cash transfers gave them some level of security and made them feel more empowered and in control.

“Cash transfers also improve the psychology and self-esteem of the family and the elderly people in particular – the more they secure their livelihoods, the more they are socially included.”

Key informant interview, civil society organisation, Ethiopia

Cash transfers also led to increased social engagement. In Tanzania, older people said that participation in social activities and village savings and loans associations as a result of cash transfers helped to strengthen trust, reciprocity and respect between them and others in society. Older men in Bahrtseba, Ethiopia, spoke about how receiving the money from the cash transfer had impacted upon their engagement in social networks, enabling them to participate in community life. One man described having felt ostracised as he was unable to afford to buy anything to take to social gatherings, so he would not go. Now that he was receiving the cash transfer, he could attend as he could afford to take something small. Apart from the social interaction, he said that these gatherings also offered him access to other forms of community support, such as direct help from friends and neighbours.

Conclusion

This study documents how older people use cash transfers to access health services in situations where healthcare is limited and resources are scarce. Older people across eight research areas in Ethiopia, Mozambique, Tanzania and Zimbabwe talked about using cash transfers to pay for transport to get to health facilities, paying consultation fees and treatment costs, buying insurance cards, as well as buying prescribed medication.

Evidence also suggests that cash transfers can have a positive effect on older people's wellbeing, through improved access to food and better sanitation, and greater confidence and self-esteem. Access to health promotion linked to cash transfers was also identified as important in supporting older people to seek healthcare when needed.

However, older people across all four countries reported that the monetary value of the cash transfers was not enough to remove their concerns about seeking healthcare when needed (because of costs) or to be able to prioritise their healthcare above other needs. Coverage of the cash transfer schemes in the research countries was very limited and the benefit was invariably too low even to cover recipients' basic needs.

Older people also talked about the significant challenges presented by low staffing levels, and the lack of health facilities and equipment. Even when cash transfers helped older people to attend health facilities, poor quality services often meant older people were still unable to access the services they needed.

In the context of increasing national and international awareness and commitment to strengthening universal health coverage, and the need for addressing ageing and health issues in all countries, cash transfers can be seen to play an important role in removing some of the barriers to access to health for older people, particularly those related to out-of-pocket expenditures. But in order to fulfil this potential, cash transfers need to be adequate and reliable.

Policy recommendations

1. Improve coverage and adequacy of cash transfers

This study provides evidence of the positive impact of cash transfers on access to health services, but this impact is limited by the fact that many vulnerable older people are excluded, and benefit levels are low.

Expand older people's access to cash transfers, preferably through the introduction of adequate social pensions.

- **Ethiopia:** Prioritise scaling up cash transfers to older people via the direct support component of the Productive Safety Net Programme (PSNP) while working towards implementation of a non-contributory pension, in line with the Social Protection Strategy for Ethiopia published in 2016.
- **Mozambique:** Increase coverage of the PSSB to 62 per cent of eligible older people by 2024, in line with the strategy ambitions of ENSSB II
- **Tanzania:** Building on from the successful experience of the scheme in Zanzibar,¹⁵ introduce a universal social pension for all older people aged 70 years and over within one year, and work towards reducing the eligibility age to 60 years within the next five years.
- **Zimbabwe:** Commit government funding for an adequate cash transfer programme for all vulnerable older people.

Improve the adequacy of cash transfers to a level that allows recipients to meet their basic needs, and supports access to healthcare services. The levels should be reviewed regularly and adjusted to reflect price inflation and inter-generational transfers that could affect how money in a household is spent.

2. Ensure health entitlements and service delivery include older people

Cash transfers cannot compensate for major weaknesses in health systems that are often the main barriers for the full realisation of older people's entitlements to access quality and affordable health service delivery. Specific recommendations for improvements are:

Ensure entitlements to free healthcare are implemented (where they exist). This can be supported by awareness raising programmes (for older people and health professionals) and by monitoring and holding service providers to account for those policy provisions.

- **Mozambique:** Ensure annual plans at the Ministry of Health include older people's entitlements to free healthcare – especially medication and adequate consultation services.
- **Tanzania:** Establish a legal framework that guarantees sustainable provision of free health services to older people by enacting the National Ageing Policy 2013 and ensuring the Health Service Act and the National Universal Health Coverage Strategy (currently at draft stage) include health and care entitlements for older people, including free health insurance for all older people.
- **Zimbabwe:** Revive older people's health service entitlements, including access to free health services through the Assistance Medical Treatment Order programme.

Introduce entitlements to free healthcare where they do not exist:

- **Ethiopia:** Introduce specific entitlements for older people's access to health services alongside the development of those that exist for poorer people, in line with the National Action Plan of the Elderly and the National Action Plan of Persons with Disabilities.¹⁶

Integrate the health needs of older people more comprehensively into health strategies and programmes, including:

- Ensuring outreach and prevention services address older people's needs specifically.
- Ensuring availability of relevant treatment (including medicine) for age-related conditions, especially NCDs.
- Incorporating older people's health needs into training of existing and new health staff.
- Mainstream ageing issues into health service policy.
- **Mozambique:** Positive developments in the training of healthcare professionals in older people's health and care needs should continue and an ambitious target for delivery and expansion established.
- **Tanzania:** Government to set aside six per cent of the total budget to buy medicines that treat diseases that affect older people; a special window for older persons should be open in all public health facilities; and there should be better integration and provision of health and social care.
- **Tanzania:** Need to review and update the user guide for geriatric care and to consolidate efforts to integrate geriatric care training in the continuous medical education and the curriculum of all health workers' training institutions. Efforts to strengthen geriatric healthcare training should also be extended to universities and other higher learning institutions.
- **Zimbabwe:** All stakeholders should work together to support the revival of the healthcare system in Zimbabwe. There were clear indications during this study that although services are free, the healthcare system faces immense challenges, affecting access to and uptake of health services by older persons and other population groups

3. Promote links between cash transfer programmes and other social protection and health promotion initiatives

Cash transfer programmes were found to be effective in encouraging the adoption of healthy behaviour and increased use of health services in some cases when accompanied by health promotion activities.

Strengthen awareness of cash transfer programmes as a means of supporting healthy behaviours in conjunction with health promotion activities

Coordinate cash transfer with other social protection programmes to optimise capacity and generate synergies.

4. Ensure age-disaggregated data and evidence on older age, social protection and health at all ages is available

The study helped to highlight that the evidence base on older age, and specifically social protection and health status and health needs, is very limited. Some specific suggestions to improve this include:

Improve national statistical systems to build a clearer picture of the situation of older people, and their health needs, including:

- Expanding Demographic and Health Surveys to include questions relating to people above the age of 49 – the current cut-off point in most countries
- Presenting age-disaggregated data in regular national surveys (such as household surveys and Labour Force Surveys).

Integrate the collection of age-disaggregated data into the implementation of cash transfer programmes.

Endnotes

1. World Health Organization Regional Office for Africa, *Multisectoral Action for a Life Course Approach to Healthy Implementation Framework for the African Region*, Regional Committee for Africa, Sixty-sixth Session Addis Ababa, Federal Democratic Republic of Ethiopia, 19-23 August 2016, AFR/RC66/8.
2. Lloyd-Sherlock P, Agrawal S, Pensions and the Health of Older People in South Africa: Is there an Effect?, *The Journal of Development Studies*, 50:11, 1570-1586, 2014; OPM, 2016; Evaluation of the Uganda Social Assistance Grants for Empowerment (SAGE) Programme
3. Stefanoni S, Lloyd-Sherlock P, Bukuluki P, Williamson C, Wandiembe S, Van Eys T, *Social Protection and Access to Health Services for Older People*, unpublished, 2017
4. HelpAge Ethiopia, *The State of Health and Ageing in Ethiopia: A Survey of Health Needs and Challenges of Service Provisions*, 2013, p. 4.; World Health Organization, *Ethiopia: WHO Statistical Profile*, 2015, p. 1; World Health Organization, *Mozambique Statistical Factsheet*, 2016; World Health Organization Africa, *Comprehensive Analytical Profile: Tanzania*, 2016; World Health Organization, Country statistics and global health estimates by WHO and UN partners, 2015
5. Ministério de Género, Criança e Ação Social, *Estratégia Nacional de Segurança Social Básica II 2016-2024*, Maputo, Mozambique, 2016; World Health Organization, Country statistics and global health estimates by WHO and UN partners, 2015
6. Stefanoni S, Lloyd-Sherlock P, Bukuluki P, Williamson C, Wandiembe S, Van Eys T, *Social Protection and Access to Health Services for Older People*, unpublished, 2017
7. World Health Organization, 2010, *Constraints to scaling up the health Millennium Development Goals: costing and financial gap analysis*, www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Results_Evidence/HAE_results_lessons/Working%20Group%201%20Technical%20Background%20Report%20%28World%20Health%20Organization%29.pdf (Last accessed: April 2017)
8. In April 2001, the African Union countries met in Abuja and pledged to set a target of allocating at least 15 per cent of their annual budget to improve the health sector.
9. World Health Organization Regional Office for Africa, *WHO Country Cooperation Strategy 2016-2020*, Tanzania, 2016, p.12
10. World Health Organization, *Country Profile Ethiopia*, 2016
11. Mato, C and Beran D, Non-communicable diseases in Mozambique: risk factors, burden, response and outcomes to date, *Global Health*. 2012; 8: 37, 2012
12. Private health expenditure includes direct household (out-of-pocket) spending, private insurance, charitable donations, and direct service payments by private corporations. Out-of-pocket expenditure on health comprises cost-sharing, self-medication and other expenditure paid directly by private households, irrespective of whether the contact with the healthcare system was established on referral or on the patient's own initiative.
13. HelpAge International, *Better Health Mid-Term Evaluation*, unpublished, 2014
14. HelpAge International, 2014
15. In April 2016, Zanzibar became the first country in East Africa to introduce a social pension for all people over the age of 70.
16. Government of Ethiopia, 2016



Israel Seone González/Age International

Find out more:

www.helpage.org

www.ageinternational.org.uk

HelpAge International
PO Box 70156
London
WC1A 9GB
United Kingdom
Tel +44 (0)20 7278 7778
info@helpage.org
www.helpage.org

 @HelpAge  HelpAge International

Age International
Tavis House, 1-6 Tavistock Square
London
WC1H 9NA
United Kingdom
Tel +44 (0)800 032 0699
contact@ageinternational.org.uk
www.ageinternational.org.uk

 @Age_Int  Age International