IJSDC

International Journal of Social and Development Concerns

Vol. 1, Article 10/12 | October 2017 **e-ISSN**

Chief Editor
Web: www.ijsdc.org
Email: info@ijsdc.org

Editing Oversight
Empiris Creative Communication Ltd.
Web: http://www.empiriscreative.com

Vol. 1 | Implications of Social Service Delivery on Development in Africa

Socio-Economic Determinants of Health Care Access among the Elderly in Kenya

Authors: [1]Mary Syokoli Mutisya, [2]Maurice Osala and [3]Nthoateng Cornelia Liku
[123]The Catholic University of Eastern Africa P. O. Box 62157 – 00200, Nairobi, Kenya
Corresponding Author: Email: mmutisya34@gmail.com

Abstract

Differences in access to healthcare are the main reason for existing disparities in healthcare provision among the elderly population in Kenya. Historically, the elderly population in Kenya has been somehow forgotten in the healthcare policy. Healthcare service provision in the country is delivered through the public and private (for profit and non-profit organisations) sectors. The state of a nation's development can be greatly influenced by the state of population health. This is mostly determined by the way governments take health of their citizens philosophically. Healthcare Philosophy, the most important role of government in healthcare policy is to decide what healthcare is.. The key point of contention is whether healthcare is a commodity, or a human right. Those who see it as a commodity believe the government should generally defer to the private sector so that free enterprise might develop the most profitable healthcare system and individuals might purchase healthcare according to their ability to pay. Those who see healthcare as a human right believe that government should intervene to make healthcare available to everyone, regardless of the profit margins and regardless of individuals' ability to pay. In the year 2014, President Uhuru Kenyatta launched the expanded Social Protection Plan, 2011, that sought to cover more than one million people that financial year under a multi-billion shilling program to cover an equal number of people in all constituencies. Basically, this included a monthly remuneration of Kshs. 2000 and free medical care for National Health Insurance Fund card holders in public health facilities. In spite of these efforts, healthcare access among the elderly is facing socio-economic challenges related to the following: Awareness and knowledge of available services; structural barriers; cultural belief systems and attitudes; income status; proximity to healthcare facilities; and stigma and discrimination associated with old age and elderly morbidity. A theoretical framework was identified on which the study was anchored. This study was conducted using a systematic review of social work interventions to extract socio-economic determinants of healthcare access among elderly people in Kenya. The Model of Healthcare Service Utilisation guided this study. This was a desktop analysis that utilised search engines to obtain data from various databases and e-libraries, which were guided by the purpose of the study. Thematically, fifty literature sources were reviewed to identify the extent to which these determinants influence healthcare access among the elderly population in Kenya. Social workers' role in the eradication and alleviation of these hindrances to healthcare access were discussed. Conclusions and recommendations were drawn from this study including: The respondents rated well in services affordability (82.7%) and average in services acceptability (40.1%). However there were poor results in services availability (11.0%). Although these determinants have been examined to a greater extent, the extent to which these findings have been utilised is wanting. There still exists low house hold income, and low knowledge and awareness level of available services. There exists structural barriers that hinder access to service utilisation, cultural beliefs and attitudes that are also affecting the elderly, proximity to healthcare facilities, stigma and discrimination all which are also a big problems in our Kenyan society today..

Key terms: *Socio-economic; Healthcare; Access; Elderly*

Introduction

1.1. Background of the Study

According to WHO (2002), most developed countries have accepted the chronological age of 65 years as a definition of 'elderly' or older person, but, like many Westernized concepts, this does not adapt well to the situation in Africa. While this definition is somewhat arbitrary, it is many times associated with the age at which one can begin to receive pension benefits. At the moment, there is no United Nations standard numerical criterion, but the UN agreed to a cutoff of 60+ years to refer to the older population.

Although there are commonly used definitions of old age, there is no general agreement on the age at which a person becomes old. The common use of a calendar age to mark the threshold of old age assumes equivalence with biological age yet, at the same time, it is generally accepted that these two are not necessarily synonymous.

As far back as 1875, in Britain, the Friendly Societies Act enacted the definition of old age as "any age after 50", yet pension schemes mostly used age 60 or 65 years for eligibility as the 'older generation' (Roebuck, 1979) despite the UN not adopting a standard criterion. Realistically, if a definition in Africa is to be developed, it should be either 50 or 55 years of age, but even this is somewhat arbitrary and introduces additional problems of data comparability across nations. The more traditional African definitions of an elder or 'elderly' person correlate with the chronological ages of 50 to 65 years, depending on the setting, region and country. Adding to the difficulty of establishing a definition, actual birth dates are quite often unknown because many individuals in Africa do not have an official record of their birth date. In addition, chronological or "official" definitions of ageing can differ widely from traditional or community definitions of when a person is considered older. We will follow the lead of the developed world, and use the pensionable age limit often used by governments to set a standard for the definition.

Lacking an acceptable definition, in many instances, the age at which a person becomes eligible for statutory and occupational retirement pensions, has become the default definition. The ages of 60 and 65 years are often used, despite their arbitrary nature, for which the origins and surrounding debates can be followed from the end of the 1800's through the mid-1900's (Thane, 1978 & 1989; Roebuck, 1979). Adding to the difficulty of establishing a definition, actual birth dates are quite often unknown because many individuals in Africa do not have an official record of their birth date.

"The ageing process is of course a biological reality which has its own dynamic, largely beyond human control. However, it is also subject to the constructions by which each society makes sense of old age. In the developed world, chronological time plays a paramount role. The age of 60 or 65, roughly equivalent to retirement ages in most developed countries is said to be the beginning of old age. In many parts of the developing world, chronological time has little or no importance in the meaning of old age. Other socially constructed meanings of age are more significant such as the roles assigned to older people; in some cases it is the loss of roles accompanying physical decline which is significant in defining old age. Thus, in contrast to the chronological milestones which mark life stages in the developed world, old age in many developing countries is seen to begin at the point at which active contribution is no longer possible." (Gorman, 2000)

Older people in developing countries are a highly vulnerable group of the society exposed to hardship, malnutrition, poverty and age-related diseases (Fouad, 2004). Health is a major concern of elderly people since it determines their ability to care for themselves and undertake other roles in society (Charles and Sevak, 2005). Older people in developing countries find it hard to access health care when they need it (Help Age International, 2010).

Access to healthcare means having "the timely use of personal health services to achieve the best health outcomes" (IOM, 1993). Attaining good access to healthcare requires three discrete steps: - Gaining entry into the healthcare system, getting access to sites of care where patients can receive much needed services and finding providers who meet the needs of individual patients with whom patients can develop a relationship with based on mutual communication and trust.

Healthcare access is measured in several ways, including: Structural measures of the presence or absence of specific resources that facilitate healthcare, i.e. having health insurance or a usual source of care, assessments by patients of how easily they can gain access to healthcare and utilisation measures of the ultimate outcome of good access to care (i.e. the successful receipt of needed services).

Globally, the percentage of older people is projected to double from 10 percent in 2000 to 20 percent in 2050. Older people also often lack access to a steady income such as pension, or retirement benefits, or salaries from good employment. Even those who do receive pensions will find it difficult to cover their healthcare needs (Help Age International, 2013). Half of the disease burden in low and middle-income countries is now from non-communicable diseases (NCD). These diseases are turning into a global pandemic that threatens the health of a large number of people and their economies (WHO, 2009, WHO, 2011). Though NCD affect older people of all nations, those in low and middle-income countries are at a peculiarly high risk of NCD (Help Age International, 2013)

A desk research done by (Help Age International,2010) in African countries identified under-financing of health systems, over-stretched health workforces, poor Health Management Information Systems (HMIS), unreliable supply of medicines, and physical and distance- related barriers to access healthcare as the main constraints that contribute to older people's poor access to healthcare services. Studies indicate that by 2050, nearly 80 percent of the world's older population will be living in less developed countries (UN, 2010). The rise in the number of older people increases the burden of providing social and healthcare services on duty bearers in developing countries, as they may be forced to leave much of the needs of these groups of people unaddressed(Help Age International,2013).

In Kenya, the number of elderly people has grown from 385,000 in 1950 (world population prospects 2008), to about 1,396,125 (KNBS, 2009). The rise in the number of older people increases the burden of providing social services, including healthcare services (Help Age International, 2013). A study conducted in Kenya, identified that lack of finance, absence of family support, physical inaccessibility of health service providers and practicing quacks are the major factors deterring older people from seeking healthcare services (Waweru et al., 2003).

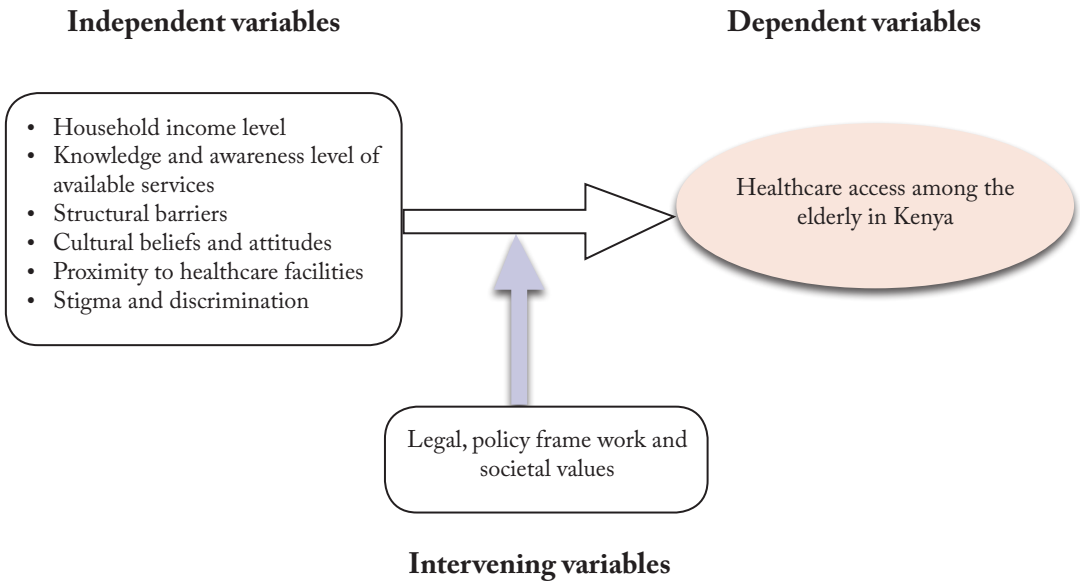
The *Kenya Health Sector Strategic and Investment Plan,* 2012-2017 adopts a broader approach that entails moving from the emphasis on disease burden to the promotion of healthy lifestyles of individuals, with attention to the various stages in the human life cycle. The elderly is cohort five (60+) years. Each cohort needs different interventions that respond to its specific needs. The promotive and preventive services needed for this cohort are annual screening and medical examinations, exercise, the promotion of general hygiene and social/emotional/community support. The curative services they need include access to drugs for degenerative illnesses. (*Kenya Health Sector Strategic and Investment Plan,* 2012-2017). The health services received by the elderly in Kenya today are part of the standard services provided for the all life cohort, without strategic attention to geriatric health requirements including physical, social, and emotional needs. A study done among the elderly in Nairobi indicated that social ties had an impact on both men and women accessing healthcare services. Survey data in this context showed that the proportion of older people seeking health services was relatively higher for older people who lived with at least one other adult, compared to those who lived alone (Mudege & Ezeh, 2009).

1.2 Statement of the Problem

The elderly population is increasing rapidly in Kenya. This age comes with health problems like hypertension, diabetes, and cancers among others. These diseases can be delayed if good healthcare is accessed. There have not been adequate studies as to whether the healthcare system is prepared enough to take care of the elderly, especially in Kenya. Sixty three percent of older people find it hard to access healthcare when they need it (Help Age international, 2001)

Kenya adopted the *Madrid International Plan of Action on Ageing,* 2017, after the Second World Assembly on Ageing. The Plan focuses on three priority areas: older persons and development; advancing health and well-being into old age; and ensuring enabling and supportive environments (World Population Ageing 2009). Although the previous *National Health Sector Strategic Plan 2* (2005-2012) and the *Draft Kenya Health Strategic and Investment Plan* (2013-2017) have included the elderly as one of their cohorts, there is still need to do a desktop review to check on the extent to which determinants of health influence the health of the elderly. Most Kenyans in the rural areas are extremely poor and lack access to basic services, including health. The elderly in Kenya therefore face serious challenges in accessing and managing personal health. Studies conducted in Kenya, South Africa, and Pakistan identified that lack of finance, absence of family support, physical inaccessibility of health service providers, and practicing quacks as the major factors that deter older people seeking healthcare services (Ladha et al., 2009; Paxton 2008; Waweru et al., 2003,). However, the studies have not identified stigma, social cultural factors, and availability of services as factors deterring older people from seeking healthcare services. This study reviewed literature on socio-economic determinants of healthcare access among the elderly in Kenya.

1.3 Conceptual Framework



Source: Researcher, 2017

The above conceptual framework demonstrates the interaction of both independent and dependent variables as conceptualised by the researcher. Income levels, knowledge and awareness levels, structural barriers, cultural beliefs and attitudes, proximity to healthcare facilities, and stigma and discrimination are believed to influence healthcare access among the elderly in Kenya. Legal policy framework and societal values are believed to influence the independent variables under examination.

Theoretical and Literature Reviews

2.1 Theoretical review

Andersen's Behavioural Model of Healthcare Utilisation

The Andersen's Behavioural Model of Healthcare Utilisation, initially developed in the late 1960', suggests that people's use of health services is a function of their predisposition to use services - factors which enable or impede use, and their need for care - thus providing a way to conceptualise these variations in utilisation rates and consumption of medical resources (Padgett and Brodsky, 1992). In this model, use of services is defined as a function of three main elements: need, enabling, and predisposing. Factors to do with one's need, which have been shown to account for the majority of the explained variability in physician use, include the individual's perceived healthcare needs, and other health indicators. Factors such as self-reported number of symptoms, self-perceived health, number of bed days, restricted activity, and activities of daily living, are part of the patient's perceived need of healthcare. Enabling factors include items such as the individual's income, health insurance status, and access to a source of regular care. Finally, predisposing factors include demographic variables, socioeconomic status, attitudes, and beliefs (Murimi and Harpel, 2010). Even though this model could either explain or predict use of services, predisposing factors might be exogenous, and enabling resources are necessary but not sufficient. In this regard, assuming the presence of predisposing and enabling conditions, the subject must perceive illness as a need for the utilisation of health services. Perceived health may include different dimensions such as overall quality of life, perceived health, activities of daily living (ADL), depression, psychosocial distress, and other psychological variables as the strongest predictors of hospitalisations and physician visits (La Vecchia , Negri, Pagano, Decarli,1987).

Andersen and Newman's model of healthcare utilisation has been mainly used for explaining healthcare utilisation patterns by the general population (Chobanian, Bakris, Black, Cushman, Green, 2003). Multiple studies have evaluated these

determinants, describing both prior physician utilisation as a strong predictor of subsequent physician use, and items such as low-income status, and a lack of motivation regarding prevention to healthcare procrastination. Additionally, differences in healthcare utilisation exist amongst various social classes. These findings do not only hold true for developed countries, but also for developing countries. (American Academy of Family Physicians, 2005)

Under this theoretical framework, we decided to use blood pressure measurement over the last year as an indirect marker for clinical preventive service utilisation. The rationale of this proxy is that blood pressure assessment is an integral part of clinical practice and the benefits of screening for hypertension in adults older than 18 years old are well established. Although evidence is lacking on the recommended optimal interval for screening adults for hypertension, most groups recommend measuring blood pressure yearly in normotensives, while also encouraging a check on every physician visit. According to this premise, most individuals who make use of health services should have their blood pressure checked at some time in the process. In fact, 97.5% of the population in Buenos Aires has had their blood pressure measured at least once previously. (Silva, Hernandez-Hernandez, Vinueza, Velasco, Boissonnet, 2010)

2.2 Literature Review and Findings

Limited access to healthcare poses a significant barrier to long-term social and economic development around the world. Currently, one-third of the world's population does not have access to essential medicines. In addition, with the global population projected to reach 9 billion by 2050, and with most of this growth in developing countries, ensuring broad access to medicine and healthcare is a critical issue. A lack of basic health education, limited investment in healthcare infrastructure, insufficient numbers of trained personnel, and long distances from communities to hospitals or treatment centers are other significant barriers to healthcare services. Effectively addressing this multi-faceted issue requires the collaboration and combined efforts of governments, healthcare professionals, healthcare companies, and non-governmental organisations (NGOs), with governments having the primary responsibility for improving public health and for fulfilling the right to the highest attainable standards of physical and mental health, which is a core human right. This paper critically reviewed literature on the six thematic areas designed for this study.

Income levels and access to healthcare among the elderly

Affordability is only one of the many hurdles to access to healthcare and especially by the elderly. Poverty, lack of access, and poor health are inextricably linked, and poor elderly patients are often faced with an inability to pay for medicines, sometimes even for the cheapest medicines and other medical services. In her unpublished MSc thesis in healthcare management from Kenyatta University, Wairiuko (2014), on determinants of access to healthcare among the elderly in Kibera informal settlement, Nairobi County, Kenya, confirmed that there was no significant association between one's occupation and access to healthcare among the elderly. She compared different occupations including those who had none: farmers, casual workers, and professionals. She further confirmed that access higher among professionals (15) 48.4% than among the non-employed respondents (66) 36.9%.

Marmot, (2002) on *The Influence of Income on Health – the Views of an Epidemiologist* observed that income is related to health in three ways: through the gross national product of countries, the income of individuals, and the income inequalities among rich nations and among geographic areas. From his statement, a focus for analysis would be the degree to which these factors reflect a causal association. If the association according to Marmot is significant, then, redistribution of income in any society would improve quality of health of the population.

Richard Wilkinson drew attention to the apparent contradiction, set out above, that when comparing rich countries, there is little relationship between average income and life expectancy, yet within these countries there is a close relationship between an individual's incomes and their life expectancy and mortality (Wilkinson, 1996). His resolution of this puzzle was that within a society, income was a measure of status and relative position. This is what was related to mortality. When comparing whole societies, however, relative status has little meaning. Hence, the lack of relationship between mean income and a country's life expectancy was because a country's mean income did not convey the same meaning as the relative income level of people within a country (Wilkinson, 2000).

Wilkinson then went on to show that the spread of income — income inequality — was related to a country's life expectancy. This finding has generated a great deal of debate. One particular criticism was that the relation was artefactual. For a given level of average income, the higher the income inequality of a society, the higher will be the proportion of people in poverty. If, as discussed above, the relation of absolute mortality rates to income is curvilinear, then although the rich will gain from income inequality and the poor will lose, the health advantage for the rich will be less than the health disadvantage for the poor. This could be one way that redistribution of income in a more egalitarian way could improve the life expectancy of the whole society (Gravelle, 1998)

The *Senior Citizens Care and Protection Bill of Kenya,* 2014 highlights the care of the elderly to receive reasonable care, assistance, and protection from their family and the State. Article 57 of the *Constitution of Kenya* 2010 says that, the National and County Governments shall, to the extent of their constitutional mandate, promote the care, maintenance and protection of senior citizens in Kenya. Regarding intervention, the government through the National Health Insurance Fund (NHIF) is currently providing free medical care to the elderly as long as they have the NHIF card. The Government has also provided a monthly stipend of 2000 Kshs for upkeep of the elderly. This has improved the quality of life for the elderly by enhancing access to the available services within their localities. The National Social Security fund (NSSF) has also enabled access of healthcare services among the previously employed elder people in Kenya.

Knowledge and awareness level on healthcare access among the elderly

Knowledge and awareness of the available healthcare services by the elderly is a great determinant of service utilisation. Knowledge and awareness are related to service utilisation through information on the available services, healthcare facilities, where to specifically get relevant healthcare services, and identification of individual problems facing the elderly, among others. According to WHO (2015) on promoting health and reducing health inequities by addressing the social determinants of health, it is essential to have a reliable and clear picture of how health is distributed in a given population, and what factors (indicators) contribute to or reduce opportunities to be healthy. In Kenya, most elderly people are not aware of the effort the government is making to enhance their healthcare. They are not aware of the NHIF Programme that enables the elderly to access free medical care from service providers especially in the rural areas. Another major challenge for the elderly in Kenya is related to lack of knowledge on where to get healthcare that meets their needs. Language barrier can also affect elderly healthcare access especially in places where the healthcare worker is not conversant with the local language or vice versa.

In Kenya, there has been a significant lack of focus on health of the elderly over recent years. The elderly are highly vulnerable to poverty, and frequently have limited access to reproductive health services. Elderly people, particularly older women, are sometimes victims of sexual and gender-based violence and discrimination. Health problems among elderly persons often relate to the higher incidence of chronic illnesses, such as cancer and degenerative diseases, as well as complications of menopause in women. Many reproductive health problems of women past childbearing age are related directly to their early lifestyles and habits, as well as their reproductive experiences. These challenges are related to awareness and knowledge levels in healthcare systems and policies.

Cultural beliefs and attitudes

According to the Cambridge dictionary, culture can broadly be defined as "the way of life, especially the general customs and beliefs, of a particular group of people at a particular time." Culture in the context of health behaviour has been defined as "unique shared values, beliefs, and practices that are directly associated with a health-related behaviour, indirectly associated with a behaviour, or influence acceptance and adoption of a health education message. The aspect of cultural beliefs and attitudes in healthcare access can be attributed to cultural belonging or practice. Egede (2006) ascertains that, in spite of significant advances in the diagnosis and treatment of most chronic diseases, there is evidence that racial and ethnic minorities tend to receive lower quality care compared to non-minorities and patients of minority ethnicity experience greater morbidity and mortality from various chronic diseases than non-minorities. From the cultural practices perspective, some cultural aspects like language barriers, unfamiliarity with preventive care, confidentiality concerns, mistrust, and stigma concerning Western medicine, and a preference for natural remedies, can all hinder healthcare access among the elderly (Allen, 2013).

WHO (2004), ascertains that gender is a greater determinant of healthcare access among the elderly. From its study, older women more than older men seek healthcare and this proved true in countries such as Jamaica and Australia. Yet, older women's "female" concerns were often trivialized while some older men said they see doctors only when their symptoms can no longer be ignored.

Kenya is a multi-ethnic country. These different ethnic groups call for different cultures that affect the day-to-day health access among the elderly in these communities. Some communities prefer to seek treatment from traditional healers or African traditional religious specialists due to the high cost of conventional medicine. This has been confirmed by Help Age International with the support from WHO and the International Network for the Prevention of Elder Abuse (2001) in a study of elder abuse in the healthcare services in Kenya. Furthermore, this study confirms that people first seek traditional healers, and when they do not get better, they then choose to go to the hospital.

With the changing structure of society, the elder persons have lost their traditional roles and respect. The extreme economic conditions have made economic considerations ever more important than the health of the elderly. Elder persons are thus increasingly marginalized within communities as they are viewed as a waste of already scarce resources. In healthcare service delivery, negative attitudes towards the elderly are manifested in different ways. The above study by Help Age International confirmed that the societal attitude that elder persons were an added liability that one could avoid is common in many hospitals in Kenya. S Some healthcare workers believe that treating the elderly is a waste of resources that could be used on younger people.

A study done among the elderly in Nairobi indicated that social ties had an impact on both men and women accessing health services. Survey data in this context showed that the proportion of older people seeking health services was relatively higher for older people who lived with at least one other adult, compared to those who lived alone (Mudege and Ezeh, 2009).

In certain traditional African households, women are only allowed to visit health facilities with the consent of their spouse or head of the household (Razzaque et al., 2010). In these settings, women disproportionately bear the burden of health inequalities and are presented with significant barriers to accessing medical care. Apart from cultural beliefs, medical services are often inaccessible to the poor, and poverty intensifies the use of traditional healers who offer services at a cheaper rate (de-Graft Aikins et al., 2010). Socio-cultural barriers including stigma and lack of knowledge about health conditions and services prevent many older people from accessing healthcare (Maharaj, 2012). Waweru et al., 2003 confirms that patients began with self-medication and sought outside help only when there was no improvement after this first step.

Healthcare facilities and structural barriers

Lack of appropriate services for the elderly is a significant barrier to healthcare access. Uneven access to buildings;(hospitals, health centres), inaccessible medical equipment, poor signage, narrow doorways, internal climbing stairs, inadequate bathroom facilities, and inaccessible parking areas all create barriers to healthcare facilities.

Socio-economic factors, urban-rural residence, gender, education, marital status and social networks have been identified as shaping the health status of people over time (Chapman, 2010). At the individual level, the elderly face numerous barriers in accessing healthcare. Some of the barriers which have been identified include interpersonal relations and communication problems between health providers and elderly patients and lack of knowledge about services and treatment. A study on health-seeking behaviour in Kenya found that negative attitudes of healthcare workers were associated with older people delaying seeking healthcare (Waweru et al., 2003). In Tanzania, 40% of older people reported that the tone of voice used by medical staff was disrespectful and mocking, while over a third reporting having to wait between 4 and 6 hours in order to see a doctor (Help Age International, 2008). In South Africa, older people expressed dissatisfaction with the quality of healthcare at the primary level, including inefficient appointment systems, long waiting times, and apparent lack of interest of staff regarding the health problems of the elderly (Joubert and Bradshaw, 2006).

Older people in urban and rural areas revealed that the quality of public healthcare services they received had major concerns including; shortage and unavailability of assistive devices, and perceived lack of respect and sharing of information by health personnel who attended to them (Joubert and Bradshaw, 2006). In Kenya, 62% of older people reported buying over the counter drugs (Waweru et al., 2003). This high level of older people accessing over the counter drugs is indicative of the inefficiency of health services in meeting the needs of the elderly in developing countries. These constraints in health service provisions are exacerbated by the shortage of staff trained in the care and treatment of older people.

In Africa, the proportion of health workers who have specialist training in management of chronic illnesses among health workers in general is poor (De-Graft Aikins et al., 2010) A study on the perceptions and attitudes of medical students towards older patients in Tanzania found that 45% of respondents regarded older people as dependent, unpleasant, unhealthy, dull, and ugly (Kowal and Suzman, 2003). It was noted that only 2% of these respondents had attended courses related to ageing, all of which were outside the country. This study concluded that a lack of geriatric teaching and exposure to geriatric medicine contributes to negative perceptions around the elderly and reduces the quality of services delivered.

Economic barriers to accessing services and treatment are often experienced by older people who lack financial and social support. In Africa, the economic situation of the elderly is closely tied with the overall situation of extended family (Maharaj, 2012). In Kenya, 73% of older people reported lack of money as hindering their access to healthcare (Waweru et al., 2003).

In a qualitative study entitled *Conditions Affecting the Elderly Primary Health Care,* urban healthcare centers in Iran, it was noted that distance to health centres is a barrier to the utilising of healthcare centers by the elderly (Firoozeh et al., 2009). Alone as a barrier, however, distance does not fully explain accessibility (Bostock, 2001).

Stigma and Discrimination

The *Kenyan Constitution,* 2010 Article 27 (1) clarifies that every person is equal before the law and has the right to equal protection and equal benefit before the law. Part (4) of the same Article states that: "The State shall not discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth" (GoK, 2010). This makes it clear that protection of all citizens against discrimination and stigma is a fundamental human right.

Many studies have confirmed the role of stigma and discrimination in preventing elderly people from accessing healthcare services. In this context, stigma can be described as a perception or fear of being treated poorly in the healthcare settings by the healthcare recipient. Removing the financial barriers to care may not guarantee greater access or better health outcomes for all people, however. Despite the medical advancements and increases in public health coverage in the United States, wide disparities in healthcare access and outcomes persist. Researchers have long documented non-financial barriers to health, and models of access to care have shifted from a focus on affordability to a framework that accounts for the dynamic ways that individuals interact with providers and the healthcare system (Ricketts and Goldsmith, 2005). Thomas and Penchansky, for instance, proposed the concept of acceptability as an additional dimension of access, which captures the relationship between the preferences of both patients and providers. According to this model, a provider's refusal to accept a form of insurance is an acceptability barrier, but these are the patients' and providers' perceptions of each other in regard to race, class, age, or other sociodemographic characteristics (Thomas and Penchansky 1981).

In a study carried out by Help International in Kenya entitled *Elder abuse in the Healthcare Services in Kenya* 2001, in all hospitals visited, ALL hospital staff concurred that 50-70% of the conditions of older persons was brought on or aggravated by malnutrition due to inadequate food. This is because in the face of scarcity, our increasingly ageist society ranks the elderly last. This societal attitude that older persons were an added liability that one could avoid is reflected in healthcare workers' attitudes towards older persons. These attitudes can easily attract stigmatisation of the elderly and consequently lead to their inaccessibility to healthcare services. In Nanyuki Hospital, the nurses in the FGD observed that whenever an older person was admitted, they would warn each other that,…

"There is trouble on bed x".

In the same study, the elders were turned away by healthcare workers implicating that they are not sick but just "age". In other instances, the elderly were injected with placebos instead of the real drugs. Further, in Kenyatta National Hospital, the nurses in the FGD observed they preferred working with younger people because older people were 'difficult'. In the same study, in ALL hospitals, the management staff recommended specialist geriatric facilities not in the spirit of desiring for better care for older persons, but so as to get the elder persons away. In a confidential interview with the head of one of the hospitals, he confided that

"Older people are a big headache and a waste of scarce resources, the biggest favour you could do to me as an Older People's Organisation is to get themout of my hospital".

Conclusion

After desktop review on the existing literature in relation to determinants of healthcare access among the elderly in Kenya, it was concluded that: Many factors combine to affect the access of healthcare services among individuals and communities. Whether people have access to healthcare services or not, is determined by their circumstances and environment. In this study, several circumstantial and environmental factors were examined as determinants of healthcare access among the elderly in Kenya. Among these factors were: Awareness and knowledge of available services; structural barriers; cultural belief system and attitudes; income status; proximity to healthcare facilities; and stigma and discrimination associated with old age and elderly morbidity. According to Wairiuko (2014), three factors; service availability; affordability, and acceptability were each considered in cumulative rates concerning access to healthcare among the elderly. The respondents rated well in services affordability (82.7%) and average in services acceptability (40.1%). However there were poor results in service availability (11.0%). Although these determinants have been examined to a greater extent, the extent to which these findings have been utilised is wanting. There still exists low household income, and low knowledge and awareness level of available services. There exist structural barriers that hinder access to service utilisation, cultural beliefs and attitudes that also affect the elderly, proximity to healthcare facilities, stigma and discrimination all which are big problems in our Kenyan society today.

Recommendations

The following recommendations are important for all stakeholders to help the elderly population access healthcare services:-

To the family: The family ought to be more dedicated to the elderly and re-consider their engagement with their needs today. Meeting the social needs of the elderly is important in alleviating the healthcare problems they face today.

Healthcare institutions: The *Constitution of Kenya,* 2010 is clear on the Government's commitment to a healthy population and a society that respects the rights of all. Healthcare institutions should be places where the elderly find health and social solutions not places where they find disappointment. Friendly services for the elderly are crucial in attracting them to access these healthcare services. Structurs in these institutions should offer a priority to the elderly considering their challenges.

The community: The family and the community are important figures in the care of the elderly population. The community ought to be alert on the needs of the elderly considering that some elderly people have no one to take care of them. Some family members might also abuse their elderly members. It is the responsibility of the community to prevent this from happening.

Other organisations: Religious groups and non-governmental organisations, are where the elderly people find care today. It is important that these organisations note the specific needs of the elderly people and act accordingly. Elderly peoples' needs are different. These organisations need to be re-designed to meet the needs of the elderly so that efforts by other stake holders are not duplicated, or some needs left out.

References

Bostock L: Pathways of disadvantage? Walking as a mode of transport among low-income mothers. Health & Social Care in the Community 2001, 9:11-18.

Chapman, A. R. (2010). The social determinants of health, health equity, and human rights: Human and Human rights,12 (2), 17-30.

De-Graft Aikins, A., Unwin, N., Agyemang, C., Allotey,P., Campbell C., and& Arhinful, D.(2010). Tackling Africa's chronic disease burden; from the local to the global:. Globalisation and Health, 6, 5.

Institute of Medicine, Committee on Monitoring Access to Personal Healthcare Services (1993). Access to healthcare in America. Washington, DC: National Academy Press.

Roebuck, J. (1979). When does old age begin? The evolution of the English definition. Journal of Social History

Gorman, M. (1999). Development and the rights of older people. In: Randel J, et al., Eds. The ageing and development report: poverty, independence and the world's older people. London: Earthscan Publications Ltd.

Penchansky R., & Thomas JW. The concept of access: definition and relationship to consumer satisfaction. Med Care. 1981; 19(2): 127–140.

GoK (2014). The Senior Citizens Care and Protection Bill, 2014. Government Printer, Nairobi, Kenya.

Razzaque, A., Nahar,L., Khanam, M,A. and& streatfield, P. K. (2010). Socio-demographic differentials of adult health indicators in Matlab, Bangladesh; self-rated health, health state, quality of life and disability level: Global Health Action, 2, 70-77.

Ricketts T. C., & Goldsmith L. J. Access in health services research: the battle of the frameworks. Nurs Outlook. 2005; 53(6):274–280. Retrieved from: www.http://dx.doi.org/10.1016/j.outlook.2005.06.007

Thane, P. (1978). The muddled history of retiring at 60 and 65: New Society.

Thane, P. (1989). History and the sociology of ageing: Social History of Medicine.

WHO. (2002). Proposed working definition of an older person in Africa for the MDS Project. Geneva

Wairiuko, J. (2014). Determinants of access to healthcare among the elderly: The case of Kibera informal settlement, Nairobi County, Kenya. Unpublished MSc thesis in Healthcare management, Kenyatta University

Joubert, J., and& Bradshaw, D. (2006). Population ageing and health challenges in South Africa. Chapter 15, Pp. 204-219.

Kowal, P., and& Suzman, R. (2003). Directory of research on ageing in Africa 1995-2003. Retrieved from www.http//dc236.4shared.com/doc/np3te2fv/preview.html

Marmot, M. (2002). The Influence of Income on Health: Views of an Epidemiologist. International Centre for Health and Society: at University College London. UK

Maharaj, P. (2012). Aging and health in Africa. ISBN 978-1-4419-8356-5 Springer: New York

Mudege, N. N., & Ezeh, A.C. (2009). Gender, ageing, poverty and health: survival strategies of older men and women in Nairobi slums. Journal of Ageing studies, 23(4), 245-257

Waweru, L. M., Kabiru, E.W., Mbithi, J.N., & Some E.S. (2003). Health status and health seeking behaviour of the elderly persons in Dagoretti Division, Nairobi. East African Medical Journal, 80(2), 63-67

WHO (2004). Active ageing: Towards age-friendly primary health care. World Health Organization Non-Communicable Diseases, and Mental Health Chronic Diseases, and Health Promotion Ageing and Life Course 20 Avenue Appia, CH 1211 Geneva 27:Switzerland.

WHO (2015). Promoting health and reducing health inequities by addressing the social determinants of health:, World Health Organization Regional Office for Europe Scherfigsvej 8 DK-2100 Copenhagen Denmark

Allen, J., D., et al., (2013). Health beliefs, attitudes and service utilization among Haitians, Journal ofPubmedJHealthCare Poor Underserved. 2013 Feb; 24(1):106-19. Retrieved from www.https://www.ncbi.nlm.nih.gov/pubmed/23377722

Help Age International (2001). Elder abuse in the health care services in Kenya: Help age international

Wilkinson, G. (1996). Unhealthy Societies: The Afflictions of Inequality, London: Routledge Publishers.

Wilkinson, G. (2000). Mind the Gap: Hierarchies, Health, and Human Evolution (London: Weidenfeld and Nicolson.

H. Gravelle, H. (1998). "How Much of the Relation between Population Mortality and Unequal Distribution of Income Is a Statistical Artefact?" British Medical Journal (31 January 1998): 382–385.

Padgett, K., & Brodsky, B. (1992). Psychosocial factors influencing non-urgent use of the emergency room: aA review of the literature and recommendations for research and improved service delivery. Soc Sci Med 35: 1189–1197.

Murimi, W., & Harpel, T. (2010). Practicing preventive health: The underlying culture among low-income rural populations. Rural Health 26: 273–282

La Vecchia, C., Negri E., Pagano R., & Decarli, A. (1987). Education, prevalence of disease, and frequency of health care utilisation. The 1983 Italian National Health Survey.J Epidemiol Community Health 41: 161–165.

Chobanian, V., Bakris, L., Black, R., Cushman, C., & Green, A, et al., (2003). Seventh report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of HighBlood Pressure. Hypertension 42: 1206–1252.

American Academy of Family Physicians (2005). Summary of Recommendations for Clinical Preventive Services. Retrieved from www.http://www.aafp.org/online/etc/medialib/aafp_org/documents/clinical/CPS/rcps08-2005.Par.0001.File.tmp/June2012CPS.pdf Accessed 2012 20 April.

Silva H, Hernandez-Hernandez R, Vinueza R, Velasco M, Boissonnet (2010) Cardiovascular risk awareness, treatment, and control in urban Latin America. Am Ther 17: 159–166.