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RESEARCH ARTICLE

THE INFLUENCE OF DEMOGRAPHIC FACTORS IN ACCESS TO PUBLIC HEALTH CARE IN KENYA: A CASE OF NAIROBI COUNTY, KENYA

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ABSTRACT

This study examined the influence of demographic variables on access to healthcare in Kenya, a case for Nairobi County. The objective of the study is to evaluate the influence of demographic variables on access to public healthcare, a case for Nairobi County. It focuses on age, gender, income, education and wealth. Emphasis is placed on the health status of the residents in Nairobi County and reviews the effects of selected demographic factors on access to healthcare. The study used data from a sample of 1066 households purposively selected from Nairobi County. All households were aged 15 years and above. The households were subjected to interviews that covered a wide range of topics. Descriptive and cross-sectional designs were chosen for the study. The study adopted multiple sampling methods for the study. These included purposive sampling, systematic sampling, snowball sampling, and multistage cluster sampling frame. The data was collected using various techniques or instruments which included observation, key informant interviews, questionnaires, in-depth interviews, and focus-group discussions. The data was processed using descriptive statistics. Correlation and regression analyses were used to correlate and interpret the data of the study. The findings show that access to healthcare was unequal amongst all the social classes in the County. This is despite considerable attention to the problem of health inequalities. There are substantial differences in health, and these still perpetuate. These differences have been attributed to socio-economic inequalities among the social classes. The upper and middle classes have better access to socio-economic resources, and this provides them with adequate capabilities to access healthcare resources. The lower social class are deprived of these resources and therefore have no capabilities to access healthcare. The explains the persistent inequalities in healthcare between the social groups in the County. This study argues that health inequalities should be reduced or illuminated in the County. Socio-economic inequalities limit the capabilities of the households to access healthcare. The distribution of these factors needs urgent research. There is evidence that there are biases in the allocation of these resources and policymakers should address these skewed allocations.

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INTRODUCTION

The health infrastructure in Kenya is composed of three sub-systems namely: the public sector, the private for-profit sector, and the private not-for-profit sector which includes faith-based organizations (FBOs) (MOH, 2004). A minority of the households seek healthcare from traditional healers (spiritual healers, bone setters, and herbalists). The public health facilities are expected to provide healthcare to all households in the County without discrimination. Despite advances in health care delivery to households over the last 5 decades, substantial differences in Nairobi County persist. The lower social economic groups have relatively less access to healthcare than the upper and middle classes. The lower social classes have higher mortality rates than the upper and middle-class social groups. Social inequalities cause health inequalities. Distribution of income, power and wealth. This has led to a combination of these factors shows a class-based healthcare system that undermines universal access to adequate healthcare for households (UNDP, 2001).The distribution and coverage remain uneven in parts of the County. The high and middle income areas in the selected constituencies (Karen, Lavington, Kileleshua, Kilimani, Muthaiga and Westlands, Parklands, Nairobi West, South C amongst many other upcoming areas) receive better access compared to low income areas (informal settlements like Kawangware, Majengo, Kibra, Mathare and Korogocho etc (CIDP, 2012-2018). The infrastructure in the County is poor, as the roads are characterized by congestion due to increased residential areas and poor expansion of infrastructure. The County has many informal settlements which are not planned and do not have provision for utilities like sewer lines, water, and rods. This is a serious problem that has not been addressed adequately. Most of these problems emanate from land ownership. The

huge chunks of land are owned by the government and therefore the residents and the landlords have no legal claim of owner land (GOK, 2008-2012). This is complicated further by the fact that most of the physical developments do not follow the laid- down procedures. The County is divided into zones with each having specific requirements for development. Commercial and residential development is allowed for Parklands and Westlands. Residential areas are allowed in Spring Valley, Kilimani, Kileleswa, Woodley, Loresho, Spring Valley, Karen, Kitisuru, Muthaiga, and Lavington. These are areas of low population density. However, mixed residential areas are in Langata, Nairobi West, South C. Nairobi Dam, Ngong road, Hurlingham and Golf Course. Special scheduled areas like Kibera, Kangemi and etc are of mixed development. In most cases, these areas lack basic infrastructure. These are informal settlements with high population density. These areas do not have sewerage and water connections. They empty their waste and otherwise, directly into the rivers. The infrastructure in the informal settlements stands at 50% (GOK, 2008-2012). Public health facilities are few as there are only 9 hospitals, 32 health centers, 83 dispensaries, and 36 clinics in the County (CIDP, 2012-2022). Both the middle (20%) and lower (70%) social classes share these facilities. This poses a major challenge, especially the 70% of the households who live in informal settlements. These are households who end up suffering ailments which are environmentally related, arising from where they live, and also where they work. The County enrolment rate in the ECD centers is about 55%, primary enrolment is over 90% while the transition rate to secondary schools is only 45% (GOK, 2008-2012). Enrolment in secondary schools is low because there are few secondary schools compared to their population desiring to join secondary schools. Unemployment rates are high in the County, especially among the youth. About 50% of the population is self-employed and mainly engages in micro and small enterprises. The MSE operations are uncoordinated and access to various finances is a major challenge. This is because most of the youth do not have collaterals. The working populations work in government departments and non-governmental organizations. Unemployment among the youth has led to the emergence and formation of illegal gangs, and they participate in drug and substance abuse.

LITERATURE REVIEW

Access to Healthcare: Access to healthcare has been a difficult concept to define. Many researchers have used the concept "access" as synonymous with "utilization", implying that an individual's use of health services is a testimony that he or she can access these services. However, access refers to opportunities, while utilization is the manifestation of these opportunities. Whitehead M. et al defines access to refer to the ability to secure a specified range of services, at a specified level of quality, subject to a specified maximum (Whitehead, 1997). He goes further to make a distinction between having access (the possibility of using a service if required) and gaining access (actually using a service). A precondition for access is an adequate supply of services so that individuals have the potential to use a health service (Gulliford, 2002). According to Gulliford (2002) and Whitehead (1997), an individual faces many challenges when attempting to access healthcare. Some of these challenges include financial, organizational, social or cultural barriers that limit access to resources. Gulliford further argues that access is affected by timing and outcomes, and the receipt of services when the individual needs it. He further points out that equity needs to be considered for all social groups who are different in terms of need, socio-economic status, culture, language, and religion. According to this research, both supply and demand factors influence equal access to healthcare. On the supply side, healthcare resources have to be distributed to Counties according to population size, healthcare needs, and income (Oliver and Mossialos 2004). This requires sufficient incentives, facilities, and staff to be retained in underserved areas. However, on the demand side, the ability of individuals to pay must be considered. Mossialos and Thomson (2003) cite the use of user charges but these have also faced numerous challenges especially with regard to upper and lower social groups. The application of user charges should be consistent with the accepted principles of equity. Other factors like waiting times should not differ between social classes or income groups. Mossialos and Thomson (2003) further argue that demand is also influenced by other factors like knowledge, information, cultural beliefs, indirect financial costs (e,g travel costs)., the opportunity costs of patient's time, and their preferences. Some of these could be addressed by providing healthcare information and health promotion strategies.

Health Inequalities: The study used both group-level differences and health distribution to evaluate health inequality in the County. The study examined differences in health outcomes at the group level in order to understand social health inequalities. This was found useful to policymakers to target investments in areas that are worst hit by inequalities; this can also help create policies and programs that try to eliminate such group differences. Tracking social group differences can also help shape unfair distributions and monitor health inequalities in the County (WHO, 2005). This approach can also help understand health inequalities in a historical and cultural context; it provides some understanding of how such health differences could have arisen. For example, it helps us understand how health inequalities occurred in Nairobi during and after independence. This approach helps to guide interventions, equity issues, and understanding of health inequalities (3/5). The study also focused on health differences across individuals, for example describing the range or variance of a given measure across the entire population. This method puts all households into one distribution (8). The study used such factors as income, education, and employment to determine the wealthy individuals in given areas of the County and the poor in informal settlements (28). This method is useful because you get to understand for example how resources are so unequally distributed amongst the households and the factors that drive such differences.

Social Groups: The study identified and defined social groups based on age, gender, ethnicity, and place of residence, occupation/employment, income, education, SES, social capital, and other resources that helped define social groups (5). Access to healthcare means that the households are not restricted by barriers such as geography, cost, language, lack of facilities, poor infrastructure and other institutional deficits (Brawley, 2000). Socio-economic status (education, income, and occupation) creates divisions among households. They are skewed in favor of the upper and middle-class groups. The upper and middle class have adequate socioeconomic resources which provide information and skills necessary for accessing healthcare. They have adequate capabilities that access them better healthcare than the lower social groups. On the hand, the lower social classes, deprived of all these socio-economic resources, remain poor and vulnerable to diseases.

Lack of these resources deprives them the capabilities to raise resources to access healthcare. This is compounded by poor living conditions, congested housing, lack of water and proper sanitation. The unhygienic environment acts as a major deterrent to accessing healthcare. This leads to falling of life expectancy, infant mortality rates, and this increases any gains made. Poverty creates misery and missed opportunities. Due to poverty deprivations, they cannot afford access to healthcare. Healthcare, therefore, remains unequal between the social classes and this inequality is perpetuated. The study was designed to investigate the influence of institutional factors on access to public healthcare. The focus was households who provided information for the study. Specifically, the study set out to evaluate the influence of institutional factors in access to public health care.

Multivariate Analysis: Multivariate analysis was performed to study how variables (demographic, socio-cultural and institutional factors) were related to access to healthcare. The analysis used as its framework Capability Approach of health access as proposed by Sen Amartya (Sen, 1990). This approach, which seeks to explain variations in access to healthcare, divides determinants of health care into commodities, human functioning/capability, and utility. In this analysis, Sen emphasizes that economic growth and expansion of goods and services are necessary for human development. Economic growth has a bearing o human development. This is because growth provides economic opportunities, incomes, and jobs. Income provides the capability to access the basic necessities of life such as food, shelter, and health. It also provides a purchasing power for participation in the economy. In his analysis in judging the quality of life, it is important to consider what people are able to achieve. He observes that different people and societies differ in their capacity to convert income and commodities into valuable achievements. In comparing the well-being of different people, it is imperative to consider how people are able to function with the goods and services at their disposal (Sen, 1985). Functioning is an achievement of a person: what she or he manages to do or able. It reflects a part of the "state" of that person. Achieving functioning depends on a range of personal and social factors: age, gender, and health, access to medical services, knowledge, education, employment, and environmental conditions. A functioning, therefore, refers to the use a person makes of the commodities at his or her command. A capability reflects a person's ability to achieve a given functioning (Saith, 2001). In this analysis, resources and their overall distribution are important in society. These resources include demographic factors (social economic factors like income, education, and employment), socio-cultural factors (social capital) and institutional factors (policies, leadership and governance, health infrastructure, health workers, health finances and insurance covers). The distribution of these factors (income and wealth) to the population determines their level of access to healthcare (ILO, 1972). Multivariate models were constructed using the ordinary squares method. The results indicate the independent effects of Demographic factors: age, gender, marital status, households' size, income, education, employment and wealth:

MATERIALS AND METHODS

Research Design: Descriptive and cross-sectional research designs were chosen for the study. The descriptive research design was chosen because it involves large samples and can help define sets of variables. The descriptive research design also uses field studies and survey to collect data, which essentially is numerical. Specifically, cross-sectional design was used to determine what extent variables were related, and to examine categories like gender, different age groups, income groups, social class, and ethnic groups. The use of the two designs enabled the study to collect both qualitative and quantitative data. It was felt that using a combination of both improved evaluation of the study as it ensured that the limitation of one type of data was balanced by the strength of the other. This combination also ensured that the understanding is improved by integrating different ways.

Sample Selection: The study purposively selected Nairobi County, from the 47 Counties of Kenya, following the adoption of the 2010 constitution in which Kenya was divided into 47 Counties. The County has 17 constituencies, sub-divided further into wards that constitute county assemblies. The constituencies purposively selected were: Starehe, Dagoretti North, Langata, Westlands and Mathare.

Target Population: The target population was 1066 households purposively selected from Nairobi County. Chardha's formula was used to estimate the sample size (Chardha, 2006). Other key informants included 20 officials from the County Government and 100 workers. Questionnaires were sent to these target and key informant groups for purposes of carrying out all the interviews.

Sampling Techniques: The study adopted multiple sampling methods to formulate procedures for selecting the subjects or cases to be included in the sample. These were purposive, systematic, snowball and multistage cluster sampling techniques.

Data Collections Techniques: Two types of data were collected: primary and secondary data. Primary data refers to information collected from the field. Secondary data refers to information collected from research articles, books, and interviews. The data collected was both qualitative (words, phrases) and quantitative (numerical). The techniques used included; observation, key informant interviews, questionnaires, face-to-face interviews, in-depth interviews and focus group discussions.

Data Analysis: Data analysis is the process of systematically examining data with the purpose of spotlighting useful inferential. This was designed to determine the impact of the research process. The data collected in this study involved qualitative and quantitative data. Descriptive statistical methods, which summarize data from a sample using indexes such as the mean or standard deviation; and inferential statistics which draw conclusions from data that are subject to random validation were used to analyze quantitative data. The study used inferential analysis to determine if there is a relationship between interventions and outcomes as well as the strength of the relationships. The inferential analysis was used to find out whether the evidence supported or rejected the hypotheses which had been formulated at the early stages of the study. Qualitative analysis is the process of examining qualitative data to derive an explanation for the research problem (phenomenon). Qualitative analysis gives an understanding of the research objectives by measuring patterns and themes of the data. The qualitative data were analyzed

using content analysis and presented along with the quantitative data.

RESULTS

Age factor: The age bracket of 15-29 years is productive and contributes significantly to National development. This is about 50% of the current population in the County. It also contributes to 5% of the labor force. The findings show that this age group faces many challenges including education, employment and health problems, risky behaviors like drugs, substance abuse, irresponsible sexual behavior that lead to HIV/AIDs or STDs (CIDP, 2018-2022). These are major challenges. Due to these, this segment of the population lack capabilities to access good access to healthcare. They lack resources including insurance cover to purchase private healthcare. These challenges, therefore, affect access to healthcare. They end up accessing unequal access to healthcare. These findings show that youth of this age bracket (15-29 years) have fewer opportunities to access resources that can enable them to purchase access to healthcare. Lack of knowledge and skills necessary for access to healthcare services put them at high risks. They become vulnerable as they lack the capacity to purchase healthcare. These limitations deny them access to healthcare services. From the inferential statistics, age group was found to have a significant influence on access to healthcare services. The age bracket 15-49 years comprises females who give births at very early ages. These early childbearing age females distort many social developments in the County (CIDP, 2018-2022). These family concerns are a major problem. Most of the areas they live lack trained family health attendants and therefore end up giving births at home. This is risky and it endangers the lives of many females of this age bracket. These age brackets lack adequate capabilities to access healthcare, compared to other age groups. Age factor, therefore, has an influence in access to healthcare. The variable explains inequality in access along with age brackets. At 50-64, the households are very central to economic growth and they form the bulk of the labor force. They are found that they are energetic and they are found in most productive sectors of the economy. But the findings show that 40% of the respondents found in this group are neglected and are given no incentives to invest and contribute to the growth of the County. This is a critical age and left without resources undermine their capabilities to procure easy access to healthcare. These households have no resources and this affects their capabilities to access healthcare. Above 65 years and above, this group was found to have an insignificant input to the economy (GOK, 2008-2012). Most of them are retired public servants, and some have gone back to the upcountry while others are still in the County. This is 15% of the respondents and they had no resources to support themselves. This denied them the capacity to procure the knowledge and resources necessary to access healthcare. This dependency undermines their well-being.

Gender Disparities: The survey findings show that 52% (554) of the respondents were females, 48% (512) were males. However, the findings show that the majority of females, 60% of the respondents had fewer or unequal opportunities than men in the ownership or access to productive resources. The findings show that women face unequal earning prospects than men (30%); they have limited education largely due to discrimination (40%), and their lives were in danger of being cut short (45%). The policy bias by the government has worked to exacerbate these differences. The result has been limited access to healthcare services because of their vulnerabilities. This has translated into limited capabilities to effectively participate in productive activities. The life expectancy for males was higher (55%) than that of females (45%). Males lived longer than females due to their higher adult rates (60%) compared to females' (40%). The surveys also show that male had better incomes (70%) than females (30%). Using measures of the Gini coefficient and the Theil index, results show that inequality in health increases with age. This is true for both men and women. However, the level of inequality is generally higher among females. Gender disparity is a significant factor that influenced access to healthcare. Their male counterparts enjoyed better opportunities and therefore had better access to healthcare. Opportunities increased their capabilities to purchase healthcare, and the inverse denied females to the opportunities to access healthcare services.

Socio-Economic Status: The most fundamental causes of health inequalities are socioeconomic inequalities (Link *et al.,* 1995). Socio-economic status has been defined by education, income, and occupation. Each provides different resources, relationships to various health outcomes, and requires different policies. The findings show that there are disparities in income opportunities between social classes. The distribution of income, employment/occupation in the County are heavily skewed in favor of the upper class. Thirty percent of the top and middle classes get more than 70% of total income, while the lowest 70% get only 30% of the total income (UNDP, 2001). This shows that the difference in the basic life and general well-being between the upper/middle and the lower social classes is very big. The findings show that there is a serious disproportion of the incomes between the various classes, as the majority (70%) lack these capabilities and can therefore not access healthcare. The findings show that inequality in income has to do with the unequal access to productive resources. The upper and middle classes have more capabilities to access resources that critical for accessing healthcare. On the other hand, the lower social class has fewer capabilities and therefore cannot access health care. The socio-economic status (independent variable) influences access (dependent variable) to healthcare.

Education: The adult literacy levels in the selected constituencies show that number of literacy classes are 45. The total enrolment by sex shows that females are 888 and the male is 554. The literacy levels are generally high. Those with the ability to read are 96.6% and those unable are 3.4%. Those with the ability to write are 96.6% and those who cannot write is 3.4%. However, those with the ability to read and write are 97.4% and that who cannot is 2.4%. The findings show that 20% (213) had not attended school, 42% (448) attended primary education, 24% (256) attended secondary education, and finally, 14% (149) attended university education. The results show considerable variations in education achievements. 14% of those with university education had more knowledge and skills that allowed them to gain more ready access to information and resources to promote health (Ross *et al.,* 1995). The findings also show that most of these respondents lived in high-income estates, like Karen, Westlands, Kileleshwa, Lavington, and Runda amongst others. The findings also show that they were more likely to be employed or have high incomes, and could, therefore, afford

healthcare insurance. Education increased their social commodities (resources) and they could, therefore, live well. They had better capabilities that could enable them to access healthcare. The findings also show that 24% with secondary education had medium healthcare. These were households of middle incomes and lived in middle-income estates like Parklands, Nairobi South, Nairobi Central, Ngara and Eastleigh amongst others. These estates were medium income and could, therefore, live use their level of education knowledge, skills to acquire access to information and resources to promote their health. Their medium incomes coupled with a medium estate status gave them some opportunities to access fairly good healthcare. In that respect, education added them capabilities to access healthcare.

However, 42% with only primary education had fairly limited opportunities; they had little knowledge and skills and therefore could not access the requisite information and resources to promote their health. Most of these respondents lived in lower income estates which included Mathare, Huruma, Mlango Kubwa, Korogocho, and Ngei. Primary education limited their access to knowledge and skills, and therefore they could only access minimal information and resources to promote their health. The findings show that 20% had no education and therefore virtually limited from having socio-economic bundles that were imperative to good functioning. They had limited or no options at all given that they lacked knowledge and skill that could gain them access to information and resources to promote their health. These respondents lived in low-income estates like informal settlements found in all estates (upper, middle and lower). These households were found to have low incomes and they resided in areas like Kibera, Kawangware and Kangemi amongst others. These informal settlements have high population densities, with some of the migrants fleeing the city center from the rapidly rising costs of living (CIDP, 2018-2022). These estates are overcrowded and social services like health care and education are virtually scarce. The opportunities to access education or employment are very scarce, given their poor distribution. Lack of incomes or source of livelihoodlimits functioning and capabilities to lead a good life (Sen, 1985). Education, therefore, is an important variable that has a significant influence on access to healthcare.

Income: The findings show that income was an important variable and determinant to access to healthcare services. The statistics show that income in the County is mainly in agriculture 8%, self-employment 50%, wage employment 24% and others 18%. The study findings show that income was linked to rates of mortalities (Wilkinson, 1996). Income provides the capability to access the basic necessities in life. The findings show that income provides a means of purchasing healthcare, nutrition, housing, schooling, and recreation. It provides purchasing power for participation in the economy, and therefore it is a very important variable in evaluating the capacity to access healthcare. Lower per capita income erodes the capacity of the individual or household to access basic social services and goods for a decent life. The findings show that employment, incomes, and equality, show an extremely high degree of income inequality in the County (ILO, 1972). The report indicates that the richest 20% of the population received nearly 70% of the total income (ibid). The data based on the Integrated Labour Survey 1998/99 show the persistence of inequality. The data shows that incomes in the County are heavily skewed in favor of the upper quintiles. The bottom 20% gets 2.5% of the total income. The figures show the difference between the rich and the poor is heavily unequal access to the basics of life and general well-being (ibid).The findings show that 20% (213) of the respondents had high incomes, 305 (320) had medium incomes and the majority 50% (533) had low incomes. The 20% lived in Karen, Westlands, Kileleshwa, Lavington, Runda, and Muthaiga amongst some other upper market places. These households were able to function because incomes increased their abilities to access education and high employment status. Education increased their information and skills to access healthcare resources that promote healthcare. Such incomes also enabled to purchases healthcare insurance that mitigated out-of-pocket expenditures to meet their health needs. Incomes increase their capabilities to function well, given that they don't have many challenges in access to healthcare. Therefore, income is an important predictor in access to healthcare. The findings show that the 30% respondents are of medium incomes, and lived in medium income areas which included Parklands, Nairobi West, Nairobi south and Eastleigh among other middle-income estates. These respondents are of middle incomes and had the opportunity to afford some middle-level education that increased their skills and access to information that was important for access to healthcare. The medium level of incomes enabled them to purchase healthcare, given that they could additional resources from employment opportunities due to the fact that they were educated. This finding, therefore, suggests that income has a significant influence to access to health.

The final findings on this variable, show that 50% of the respondents have low incomes, and live in informal settlements which include Kibera, Kawangware, Kangemi, Mathare, Huruma, Mulango Kubwa and many more others that are on the rise (CIDP, 2018-2013). These settlements are uncontrolled, spontaneous with increasing settlements created by low-income migrants escaping the ever-rising costs of living in the City (ibid). Further, these estates are overcrowded with poor housing, water supply, and sanitation. The scarcity of basic infrastructure makes life in these settlements unbearable (ibid). Due to this, the respondents are not able to access healthcare services easily. They cannot obtain a good education nor can they get good employment and these are crucial for increasing or obtaining incomes. They, therefore, have no information and skills necessary to make access to healthcare services accessible for themselves. This undermines their health given that they can neither function well nor have the capability to sustain good health. Income therefore in an important (independent variable) that has an important influence on access (dependent variable) to healthcare.

Occupation/Employment: Occupational status was found to be an important variable in the survey findings. The employed have health than the unemployed have (Ross *et al.,* 1995). Employment in the County shows that employment in the agriculture sector is 48,857, self-employment 305, 358, wage employment 146,572 and others 48,857. The total number of unemployed at the time was 61,068. The findings show that being unemployed and the length of unemployment affect health status. The study findings show that 48% (512) of the respondents were in lower occupations (manual workers), 25% (267) were in middle occupations (non-manual), and 15% (160) were in highest occupations. Twelve percent (127) were unemployed. The 48% of these respondents lived in informal estates/settlements with low incomes. While slightly better

than the unemployed 12%, the study clustered them together for purposes of analysis. Their low-income estates include Kibera, Kawangware, Kangemi, Mathare and Korogocho. These estates are uncontrolled, spontaneous, mushrooming with squatter settlements. They are estates of low incomes and basically, lack essential services like health and educational facilities. They have no incomes or resources to purchase commodities that are essential for their healthcare. For example, the findings show that many had no insurance covers and so relied on public health facilities, which were poorly equipped. Occupation/employment increased resources or incomes to purchase access to healthcare, and therefore lack of the same put hurdles on the way for the residents. As suggested, employment creates resources which enable households to access education which provides knowledge and skills which provide information and resources for promoting healthcare. Accessing healthcare is dependent on many factors, and occupation was one such factor increases the functioning of the households.

The findings show that 25% had a middle (non-manual) employment. These were respondents who resided in middle-income estates like Parklands, Eastleigh, Nairobi West, South C, Nairobi central and Pangani among others. Most of them owned their own houses. The findings show that these respondents can access education facilities which increase knowledge and skills. These, in turn, promote access to information and resources to promote healthcare. They manage to achieve some middle level of access to healthcare; they are fairly healthy, given the bundle of commodities (employment) at their disposal. In this respect, therefore, employment is an important variable that can influence access to healthcare. The residents use this occupation to achieve good health (Smith, 2001). The findings also show that the 15%respondents lived in high-income estates, like Karen, Westlands, Kileleshwa, Lavington, Muthaiga, and Runda among other up-market places. These are high-income estates characterized by low population density. These residents have the ability to access high incomes which in turn can make them acquire a good education. Good education increases access to information and skills necessary to access more information and resources that can promote access to healthcare. Education also leads to high employment opportunities and this translates to high incomes. The findings show that these commodities/resources increase the functionings and capabilities of households to live good lives. They had been deprived of the necessary commodities that were vital for good functioning and requisite capabilities. The occupation was a reliable indicator of social economic status. It was a source of empowerment, and to a large extent put individuals to control incomes. The results showed that occupations played a key role in the determination of access to healthcare services in the household. Occupation had a significant influence on access to healthcare services. The results of the study show that access to healthcare depends on many factors related to socio-economic factors (income, education, occupation and wealth). These factors have to be adequate in order for all households to have sufficient capabilities to procure access to healthcare. The study shows that these socioeconomic resources are not equally distributed to households. The distributions are lopsided in favor of the upper and middle classes. These classes end up with better capabilities to confront health challenges. But the lower social classes, including the vulnerable groups like children, women, street children, PWDs have less and therefore lack adequate capabilities to access healthcare. This explains why health inequalities persist despite various interventions. Access was defined as the ability to secure a specified range of services, at a specified quality, subject to a specified maximum level of personal inconvenience and cost, whilst in possession of a specified level of information (Whitehead, 1997). A distinction was also made between having the access-the possibility of using a service if required, and gaining access–using a service. A precondition for access is an adequate supply of services so that individuals have the potential to use a health service (Gulliford, 2002). The ability, cost, and adequate services are crucial determinants of accessing healthcare. This, therefore, means that there must be an adequate supply of services and these services should be evenly distributed to the population. Socio-economic factors like income, education, occupation and wealth should be adequately distributed to all households.

DISCUSSION

Socio-economic factors include income, education, occupation and wealth. The County is characterized by inequalities in growth. This conceptualized as the disparity in the distribution of such attributes or resources. In economic terms, the disparity could be in terms of ownership or resources, in the distribution of wealth and in incomes and in access to economic and social goods and services. These factors shape the distribution of opportunities and define livelihoods. Inequality influences economic and social outcomes which in turn have implications in growth, recent researches have shown a negative relationship between inequality and growth (Deineger *et al.,* 1996).The more unequal distribution of assets such as land or other income-earning assets, the lower the rates in growth. These inequalities in income and income-earning opportunities take the form of disparities between the urban areas and the informal settlements, different geographical areas, men and women, and different social economic groups in society. The growth provides economic opportunities, incomes, and jobs. Income provides the capability to access the basic necessities of life such as food, shelter, and health. It provides the purchasing power for participating in the economy. In Nairobi County, certain sections of the population have benefitted very little, and this has perpetuated inequalities. In the County, there are skewed distributions of income and wealth among the households in the County. For example, the study shows that the richest 20% of the households in the County receive nearly 70% of the total income (CIDP, 2012-20122). This pattern is persistent and retrenched in the County (CBS, 1998/99). The income and wealth are heavily skewed in favor of the upper and middle classes. These attributes explain the facts that define access to health care. The youth between 15-19 and 20-24 years encountered many challenges including lack of income, education, and employment. Due to lack of such socio-economic resources, these age groups engage in drugs, unwanted pregnancies, and high risks associated with HIV/AIDs. Lack of such resources and opportunities deny them the capabilities critical for accessing healthcare. They become vulnerable to various diseases and end up with high mortality rates and low life expectancies. Age factor, therefore, is an important factor in influencing access to healthcare. The study also shows that households at the age of 65 years and above have formally retired from active service; others have gone back to up country, this age group are inactive and rely on their relatives for upkeep. They do not have enough savings either. The age group lacks addition socio-economic resources

and opportunities to sustain their health demands at old age. Lack of these commodities limits their capabilities to access healthcare. Age factor here is, therefore, a significant factor in access to healthcare. Gender is an important factor in access to healthcare. The study shows that females have limited access to socio-economic commodities compared to men. They had less access to income, education, occupation and wealth partly because of cultural factors or pure discrimination on the basis of gender. Lack of training of health attendants, expose women to maternal and infant mortality rates. These inadequacies of material resources based on gender affect their access to healthcare. They limit their capabilities to access healthcare at equal measure as men. This perpetuates inequalities in healthcare. Gender was, therefore, an important variable that influenced access to healthcare. Socio-economic factors defined by income, education, occupation and wealth empower upper households to purchase healthcare. The high incomes, education, occupations and wealth provide more opportunities and choices to access healthcare services, both in the private wing of government facilities and in the private sector. These resources are skewed in their favor, hence increasing their capabilities. However, the lower social groups lack these resources because they are deprived of. In the study, these groups live mainly in informal settlements like Majengo, Mathare, Kawagware, Korogocho, and Kibera amongst many other upcoming informal settlements mushrooming in the outskirts of the city center. These informal settlements lack social services of all kinds, including having poor roads, poor education coupled with low incomes, and no wealth at all. The situation is compounded by poor access to water and sanitation management, with huge heaps of garbage. They live in extreme poverty, and this denies them the necessary capabilities to procure access to healthcare. These vulnerabilities expose them to serious diseases, leading to mortalities with reduced life expectancies. Socio-economic factors were, therefore, an important influence on access to healthcare

Conclusion

The study demonstrates that access to healthcare is unequal among the social classes in the County. The lower social economic groups, which include the poor, vulnerable groups like children, street children, PWDs, migrants, youth and women. These groups are disadvantaged as they are deprived of socio-economic resources, income, education, occupation and wealth. These limit their capabilities to access healthcare. On the other, the upper and middle-class groups have better access to these resources, and therefore have better capabilities in accessing healthcare. The distribution of these resources is lopsided in favor of the upper and social classes. This allows them to have better capabilities to access better healthcare, given the vast opportunities endowed upon them. This duality increases inequalities in access to healthcare. These health inequalities have been attributed to unequal distribution of socio-economic, cultural and institutional factors. These factors are varied incomes, education, occupation, wealth, social capital, poor articulated policies, poor leadership and governance, poor infrastructure and lack of medicine, drugs), inadequate health personnel, low health financing and poorly managed insurance policies and programs. This analysis suggests that there are several areas for further research: how socio-economic groups can access healthcare in equal terms; how poverty and other health determinants can be reduced or eliminated; and how capabilities can be spread across all social groups in the County. This study argues that these factors should be equitably spread across all the households in the County. All the factors discussed need to be increased or improved so that they can effectively provide access to healthcare for all. All social groups including the low social classes should be involved in addressing the challenges facing the sector.

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