

**EFFECT OF HEALTH SECTOR EXPENDITURES ON POVERTY RATES IN
KENYA**

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DECLARATION AND RECOMMENDATION


Declaration


This thesis is my original work and has not been submitted for an award of diploma or conferment of degree in any other University.

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Recommendation

This thesis has been examined, passed and submitted with our approval as University supervisors.

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DEDICATION

I dedicate this work to my parents; Patrick Ngeno and Regina Ngeno, my siblings, classmates and friends for continuous support and encouragement throughout the course. God bless you abundantly.

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ABSTRACT

Governments aim to provide sufficient health coverage to maintain a healthy population, which is vital for economic productivity. Kenya government's financial commitment remains significantly low, averaging only 4.3% of Gross Domestic Product, well below the 15% target set by the Abuja Declaration. Adding to this challenge, external health aid, a key component of Kenya's health financing, has steadily declined since 1993. With rising population growth pressure, the low-income population suffers from high medication costs, out-of-pocket health expenses, and risks sliding or remaining in poverty due to increased healthcare costs and noncommunicable diseases. Data shows that about 36% of Kenyans live below the poverty line, with rural areas being more affected. Moreover, around one million Kenyans fall into poverty each year because of healthcare costs, worsened by the high prevalence of diseases such as cancer, HIV/AIDS, malaria, and tuberculosis. Empirical studies on Kenya have not substantially covered the link between persistent poverty rates and sectoral health expenditure. Additionally, most of the existing studies concentrate on out-of-pocket spending on healthcare. It is against this backdrop that this study sought to determine the impact of domestic, external, and private health expenditures on poverty rates in Kenya. The study was guided by the Keynesian theory of poverty and Grossman's theory of human capital. The study employed a causal research design and time series data from the World Bank, Kenya National Bureau of Statistics, and the Kenya Ministry of Health's Annual Health Reports from 1990 to 2024. Autoregressive Distributed Lag Model was employed in the research to account for both short term dynamics in the economy and the long run impacts of the health sector expenditures on poverty. Error correction model and bound test was used to measure the speed of readjustment to normal in case of economic shocks hence ensure smooth the study the dynamic relationship between various health sector expenditures and poverty rates in Kenya. Cointegration was confirmed using the Bounds Test, leading to the reparameterization of the ARDL model into an Error Correction Model (ECM). The ECM captures both the short-run dynamics and the speed of adjustment toward the long-run equilibrium. According to the findings, government health expenditure demonstrated a statistically significant negative effect both in the long run and the short run. Private health expenditure had a statistically significant negative relationship with poverty rates, in the long run, while in the short run, it had a positive and significant effect. Conversely, external health expenditure showed a significant negative coefficient in the long run. The consistently strong and negative long-run coefficients for government health expenditure, external health expenditure, and private health expenditure unequivocally demonstrate that each component plays a significant role in reducing poverty rates. The research significantly provides insightful knowledge on the interplay of the health sub sectors in Kenya towards poverty alleviation. Both private sector, and government finds this research as a bedrock for reevaluation of health expenditures and need for preventive measure for both communicable and non-communicable diseases which has caused catastrophic spending that push individuals to poverty. Based on the findings, the main recommendation for Kenyan policymakers is to sustain and strategically increase public health expenditure, promote private firms, faith based organization and good partnership with international donors. This helps to reduce out of pocket spending. As well there is a need for true education on the principles of healthful living which is key input for productivity and efficiency in the economy.

