
**THE EFFECT OF CORRUPTION IN THE DECLINING HEALTH
SERVICE PROVISION: A CASE STUDY OF KENYA**

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ABSTRACT

According to the Constitution of Kenya (2010), which recently celebrated #Katiba@15, Article 43 gives every citizen the right to the highest attainable standards of health. This includes reproductive health, which encompasses all maternal, neonatal, and child health, and all the rights that come with it. The article also includes the citizen's right to emergency medication in times of war, disaster, pandemics, accidents, and any other happenings that demand emergency treatment. However, the situation in reality is far from the desired picture painted when the constitution was being drafted. The national health sector, through the Ministry of Health, has long been highlighted in the national corruption index, closely trailed by the National Police Service in terms of scandals involving corruption, grand looting, procurement graft, and the general mismanagement of allocated public expenditure. This paper explores the correlation between the rapidly declining rate of health quality in health service provision and the financial mismanagement through grand scandals and regular corruption that has tainted the public image of some national health leaders and the devolved health units in the various counties. Specifically, the mention of a few notable scandals reported in various media outlets through whistleblowers (such as the Auditor General) will constitute a majority of the references. These include the famous COVID-19 heist, the irregularities within the recently constituted Social Health Authority, the systematic looting of the now-defunct NHIF, the KEMSA tendering scandal, and other Afya House stories. Through a quantitative approach and desk-review analysis, this paper presents a highlight of the magnitude of waste and the contribution of unpunished corruption to the dwindling health sector, and the overall citizens' health welfare that can be painted in an abstract way to understand why, as policy practitioners, stringent methods need to be part of every policy

discussion that aims to end corruption. The comparisons made as a mitigation in this paper function to highlight the expense of the opportunity cost of corruption in the health sector, showing how much greed costs to the welfare of the citizenry.

As this article also attempts to suggest mitigations for the highlighted structural relationship between corruption and declining public health service provision in Kenya, it quantifies the equivalent amount that would have been used to develop functional infrastructure. Given the loopholes in health governance, neopatrimonialism, and public finance accountability, the study draws suggestions based on the economic concept of the principal–agent theory and political settlement analysis. It employs a mixed-methods case study design. Quantitative evidence from Auditor General reports and parliamentary investigations is studied using an opportunity-cost model to estimate the developmental value of lost funds if redirected to infrastructure, workforce stabilization, and insurance expansion. The findings demonstrate that corruption in Kenya’s health sector functions as a structural determinant of health inequality, undermining maternal outcomes, workforce morale, service accessibility, and public trust.

This paper eventually concludes that the crisis in Kenya’s health system is fundamentally a crisis of governance and accountability rather than resource scarcity, and proposes institutional reforms necessary for realizing Universal Health Coverage.

KEYWORDS: Corruption, Health Service Provision, Opportunity Cost, Public Finance Management, Kenya, rent-seeking, scandal.

1. INTRODUCTION

The Constitution of Kenya (2010) in Article 43 guarantees every citizen the right to the highest attainable standard of health, including reproductive health and emergency treatment. Additionally, the Constitution bestows power to the people to surrender part of their freedom to leaders for representation on national matters, including health, in exchange for protection of their welfare (Locke, 1689). Despite this constitutional backing and the nation's commitment to the Abuja Declaration (African Union, 2001), which sets a target of allocating 15% of the national budget to health, actual service delivery remains suboptimal. The Constitution of Kenya, in section 2, admits other international laws as part of the law, which means that global health laws under the United Nations framework, including the World Health Organization

Yet more than a decade after constitutional reform, Kenya's health sector continues to experience chronic service delivery disruptions, including infrastructure deficits, workforce shortages, drug stock-outs, and repeated industrial strikes.

However, there exists a paradox of a gradually increased health-sector funding alongside declining public trust and service quality, which has characterized the health sector for a long time now. Public health expenditure in Kenya has fluctuated between 6% and 8% of total government spending over the past decade, consistently below the Abuja benchmark. Maternal mortality remains high, approximately 355 deaths per 100,000 live births, while the doctor-to-population ratio averages between 1:5,000 and 1:7,000 (KDHS, 2022), far below the WHO-recommended threshold of 1:1,000. These indicators raise fundamental questions regarding governance, efficiency, and accountability. This decline in trust and accountability is frequently attributed to 'loopholes', often used as a euphemism for the organized systematic theft of public resources through neopatrimonial and inflated procurement processes, payment for non-existent services, nepotism and unmerited hiring, and outright embezzlement of funds and health equipment.

Over recent years, Kenya's health sector has been marred by a series of back-to-back high-profile scandals that have resulted in substantial public resource losses. Beyond monetary implications, these losses have instituted measurable consequences for health outcomes and reversed health gains across regimes. Studies demonstrate that corruption in public health systems is associated with poor health outcomes, such as higher infant and maternal mortality and lower immunization coverage (Gupta, Davoodi, and Tiongson 2000; Treisman 2000). Drawing on the concept of structural determinants of health (Marmot 2005) and structural violence (Farmer 2004), corruption may be perceived, not necessarily as a governance failure, but as a deeply-entrenched systemic condition that promotes preventable morbidity and mortality. In Kenya, illegal diversion of maternal health funds in the Afya House scandal and procurement irregularities during the COVID-19 pandemic illustrate how institutionalized rent-seeking translates into poor service delivery and preventable health troubles.

The insatiable greed of a few people in influential positions then becomes the destruction of lives and health welfare for the majority of citizens. The immediate former President of Kenya, President Uhuru Kenyatta, was once asked what he was doing to curb the rampant corruption, where he claimed that up to KSH 2 billion was lost daily through loopholes and cartels, to which he replied '*Sasa mnataka nifanye?*' (What do you want me to do?), showing

that some of the individuals and systems engaged in corruption hold a heavier weight than the top-most leadership of the country.

This study argues that corruption in Kenya's health sector is systematized within procurement systems, insurance frameworks, and governance structures rather than existing as isolated cases. When institutional incentives normalize rent extraction, financial diversion becomes systemic (Rose-Ackerman 1999). Empirical research demonstrates that such corruption is associated with diminished health outcomes, including increased mortality and reduced service coverage (Gupta, Davoodi, and Tiongson 2000). In this sense, resource leakage constitutes a form of structural violence that translates into preventable health losses, including high rates of maternal morbidity and mortality (Farmer 2004).

2. Literature review

This paper is grounded in the principal-agent theory (Jensen and Meckling 1976; Klitgaard 1988), which posits that corruption occurs when agents (public health and non-health officials) deviate from the interests of the principals (the Kenyan citizens) to pursue private gain. In the context of Kenya's health sector, this deviation is manifested through illicit payments and appointments, procurement fraud, unmerited public service appointments, and regulatory capture, where the very institutions designed to provide care are misused for individual and nepotic wealth accumulation.

Beyond the principal-agent model, the political settlement theory (Khan 2010; Kelsall 2018) suggests that corruption persists where elite groupings may manipulate resource distribution to maintain political links and stability. Within such organized establishments, lucrative health-sector contracts may function as instruments of patronage rather than vehicles of service delivery. This paper highlights the structural context to explain the recurrence of large-scale scandals despite repeated investigative findings.

Previous studies have established that corruption in health systems lowers the overall life expectancy, child immunization rates, delays treatment, and increases child mortality. In Kenya, the Linda Mama program's financial struggles highlight how fiscal mismanagement directly affects maternal outcomes. An overview of the tagged Auditor General's reports provides the primary empirical evidence of these leakages, consistently flagging unsupported expenditures and procurement theft loopholes.

3. METHODOLOGY

The paper utilizes a mixed-methods case study design. It combines qualitative analysis of corruption reports with a quantitative ‘redirection analysis.’

Data has been sourced from, among others:

1. Public reports by the Office of the Auditor General (OAG).
2. Credible media investigative archives (e.g., ‘The Covid Billionaires’ feature).
3. The Official Ministry of Health budget estimates and collective bargaining agreements (CBAs) for staff salaries.

Through a desk-review of existing resources, the paper highlights major financial irregularities recorded over the last 6-8 years. Notably, these are just a fraction of the reported scandals, with several others going unreported in terms of actual figures lost.

1. The Afya House Scandal (2016), where the Auditor General reported that approximately KSH. 5 billion went unaccounted, allegedly diverted from the USAID-supported HIV/AIDS programs and maternal health programs to pay for unrelated goods.
2. The KEMSA ‘Covid billionaires’ Scandal of 2020, where, during the COVID-19 crisis, the government entity, Kenya Medical Supplies Authority (KEMSA), appropriated the irregular procurement of Personal Protective Equipment (PPE) to the tune of billions. The Auditor General reported a direct loss of KSH 2.3 billion due to purchasing at inflated prices, with total irregular awards amounting to over KSH 7.8 billion.
3. The NHIF fraud (2023-2024). The systemic fraud within the National Health Insurance Fund (NHIF) led to the suspension of 27 hospitals due to irregular reimbursements and cash-request records. Investigations revealed that approximately KSH 20 billion (\$126 million) was lost to manufactured claims, including instances where facilities billed for procedures on non-existent patients.
4. Linda Mama and the maternal health crisis: The celebrated free maternity program, pioneered by former First Lady, Mama Margaret Kenyatta, dubbed ‘Linda Mama’, faced imminent collapse due to funding cuts (from KSH 4 billion to KSH 2 billion) and accumulated debt, leading to facilities denying services to expectant mothers.
5. The Social Health Authority (SHA) experienced irregularities between 2024 and 2025. The transition to the SHA from the National Health Insurance Fund (established in 1968) has been marred by controversy, with the Auditor General flagging a potential loss of KSH 104.8 billion in the acquisition of the healthcare information technology system, alongside early reports of fraudulent claims mimicking the old NHIF patterns.

Data Analysis: The redirection model

The core analysis will use a comparative cost model. Confirmed stolen/lost amounts (L) will be divided by the unit cost (C) of specific health inputs to determine the Opportunity Cost (OC):

$$OC = L/C$$

1. Inputs to be modeled:
2. Infrastructure: Construction and equipping of Level 4 hospitals (given the estimated unit cost as KSH 200 million based on recent county tenders).
3. Human Resources: Annual salary of medical interns (Estimated unit cost: KSH 2.5 million/year based on KSH 206,000/month gross).
4. Insurance Coverage: Annual SHA premiums for indigent households (Est. Unit Cost: KSH 6,000/year).

4. FINDINGS AND DISCUSSION

The analysis reveals that funds lost to corruption in the past 6-8 years could have been adequate to build and equip several health facilities across the nation while also meeting the payment demands of existing Collective Bargaining Agreements for medical professionals.

4.1 The Afya House Scandal, 2016:

The KSH 5 billion confirmed lost in the Afya House scandal was diverted from HIV/AIDS programs and maternal health budgets.

Given a unit cost of KSH. 200 million for the construction of a level 4 hospital in Kenya, this amount would have enabled the construction of 25 new hospitals.

The construction of 25 Level 4 hospitals would have significantly decongested the Kenyatta National Hospital (KNH) and Moi Teaching and Referral Hospital (MTRH), reducing patient waiting times and mortality rates in counties with marginal health access.

Additionally, measured against the estimates of the scarce dialysis machines costed at about KSH. 1.5 million, the amount would have purchased 3000 machines to meet the demand for kidney dialysis patients in the country.

4.2 The KEMSA Covid-19 Scandal, 2020.

While medical interns strike annually over posting delays and salary arrears, the KEMSA scandal saw KSH 2.3 billion lost directly to irregular pricing by inflation of procurement (buying PPEs at KSH 9,000 vs the market rate of KSH 4,500).

The lost funds could have fully paid nearly 930 medical interns for a year at the rate of KSH. 206,000 per month and KSH. 2.472 million annually or 3000 nurses at an average annual

salary of KSH. 720,000, thus averting the industrial strike that brought the health sector to its knees in 2024. Instead, the money enriched a handful of ‘Covid billionaires’ while actual frontline workers lacked PPEs that were depended on to prevent deaths and further infection by the pandemic.

4.3 The NHIF Fraud of 2023/24.

The KSH 20 billion lost to the NHIF fraud through manufactured claims represents perhaps the most significant blow to the country’s ambitious plans orchestrated for the achievement of Universal Health Coverage (UHC).

Assuming an average premium of KSH. 6,000, this loss represents insurance cover for approximately 3.3 million Kenyans. The government’s struggle to finance UHC is not due to a lack of funds, but the hemorrhaging of premiums into the pockets of corrupt cartels running false cash claims.

4.4 SHA system leak and Linda Mama scandals

The ongoing controversy regarding the KSH 104 billion SHA system suggests that the trend is worsening while the Linda Mama program faced a budget cut of KSH 2 billion, threatening the lives of thousands of mothers. In comparative analysis, the cost of the leakage in system procurement alone could fund the Linda Mama program for over 50 years.

5. CONCLUSION

This study concludes that the crisis in Kenya’s health sector is not solely a crisis of underfunding, but a crisis of leakage. The ‘Redirection Model’ demonstrates that the monies stolen in just three major scandals could have:

1. Built 25 new Level 4 hospitals or purchased 3000 dialysis machines
2. Paid 3,000 nurses or 930 medical interns for a year.
3. Provided health insurance for 3.3 million poor households.

Grand corruption leading to the wastage of resources meant to benefit the national health sector has a strong causation link to severe issues such as a dwindling life expectancy (~55 years), high rates of maternal mortality, distrust of government systems, and the widening socioeconomic gap between the social classes.

Worse still, it is evident that all these monies are lost at the expense of an underpaid and understaffed medical workforce, from interns to nurses to doctors and other support staff, frequent drug and health commodities stockouts, lack of or uncompleted and under-equipped

medical facilities across the country, and the disregard for existing health policy that cushions citizens' health welfare.

These are just a few of the many unearthed scandals, with others including the EduAfya students' health scheme, which was flagged for inflated health payment claims that were mismatched with the actual services provided, among others.

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