



Public Health Services in Kenya

An Exploration of Devolved Health Service Performance
in the Context of Kenya's Multilevel Public Sector



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Note: The cover image for this report was generated with the support of AI.

1. Introduction

Kenya's health sector finds itself at a critical juncture. The 2010 Constitution mandated the transfer of most primary and secondary health service delivery functions to Kenya's 47 County Governments, while the national government retains policy and regulation responsibilities, along with the provision of tertiary health services. While devolution of health functions continues to be a cornerstone of Kenya's approach, questions are being raised about the effectiveness of the country's multilevel governance arrangements, including in the health sector.

This report applies a pragmatic, data-driven approach to assess how counties are converting public health spending into tangible service outputs. Using recurrent expenditure data from the Controller of Budget and service-use data from the Kenya Health Information System (KHIS), the analysis focuses on access, efficiency, and value-for-money—specifically, the relationship between spending and the number of patient visits recorded in FY 2023/24. The purpose is not to provide exhaustive causal explanations, but to reveal major patterns and raise questions about whether devolved health services are delivering equitable, efficient, and accountable care.

The study deliberately adopts a “big-picture” lens, relying on rudimentary but powerful metrics such as the number of patient visits per 1,000 residents and the average cost per visit. These measures allow us to highlight systemic disparities across counties without being distracted by narrower programmatic details. While this approach cannot capture every causal pathway, it provides a baseline for understanding how resources are being transformed into services and where gaps in performance are most acute.

The central questions guiding the analysis are straightforward: Is Kenya's devolved system of governance resulting in better public health services for citizens? Do people have equitable access to care across counties? Are services being delivered efficiently, in a way that provides taxpayers with good value for money? And if not, what factors may explain the observed disparities? These questions frame the inquiry and point to areas where deeper investigation is required.

The report is organized into seven sections. Section 2 outlines the intergovernmental context for public health services under Kenya's devolved system. Section 3 sets out the objectives and limitations of the study. Section 4 details the methodology, including guiding principles, data sources, and computation steps. Section 5 presents the key results, highlighting recurrent-heavy spending, uneven access, disparities in utilization, and sharp differences in spending per visit. Section 6 describes key findings in greater depth, situating them within broader governance and service delivery challenges. Section 7 draws tentative conclusions, while the Appendix identifies areas for further inquiry and methodological refinement. Together, these sections provide a baseline for understanding how Kenya's counties are performing in delivering devolved health services, and where further work is needed to strengthen equity, efficiency, and accountability.

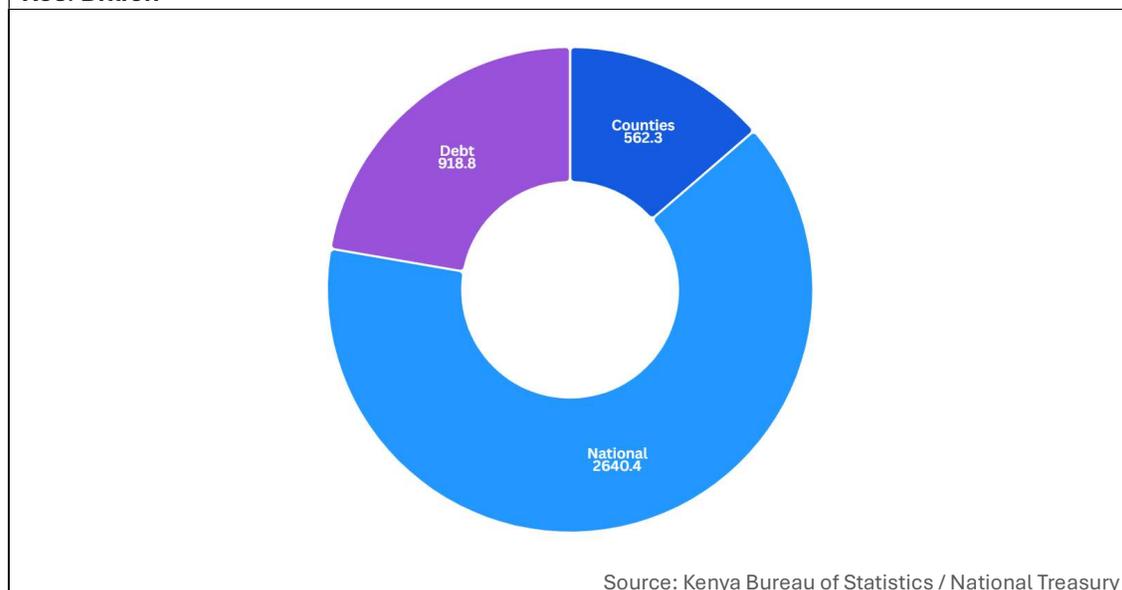
2. The intergovernmental context for public health services in Kenya

Since the introduction of the 2010 Constitution, County Governments have taken over a wide range of public sector functions. In fact, most government functions that people see and use every day fall under the constitutional purview of county governments, including public health care, county roads, access to drinking water, urban services (such as solid waste management), and ECDE Centers.

The leading role of county governments is especially true in the health sector. Under Schedule 4 of the Constitution, counties are responsible for the delivery of health services from Level 1 (community health) through Level 5 (secondary referral hospitals). The national government, by contrast, retains responsibility for Level 6 facilities (national referral hospitals) as well as policy formulation, regulation, and overall stewardship of the health system. This division of roles reflects Kenya’s devolved governance framework, where counties serve as the frontline providers of essential health services while the national government focuses on policy, standards, and specialized care.

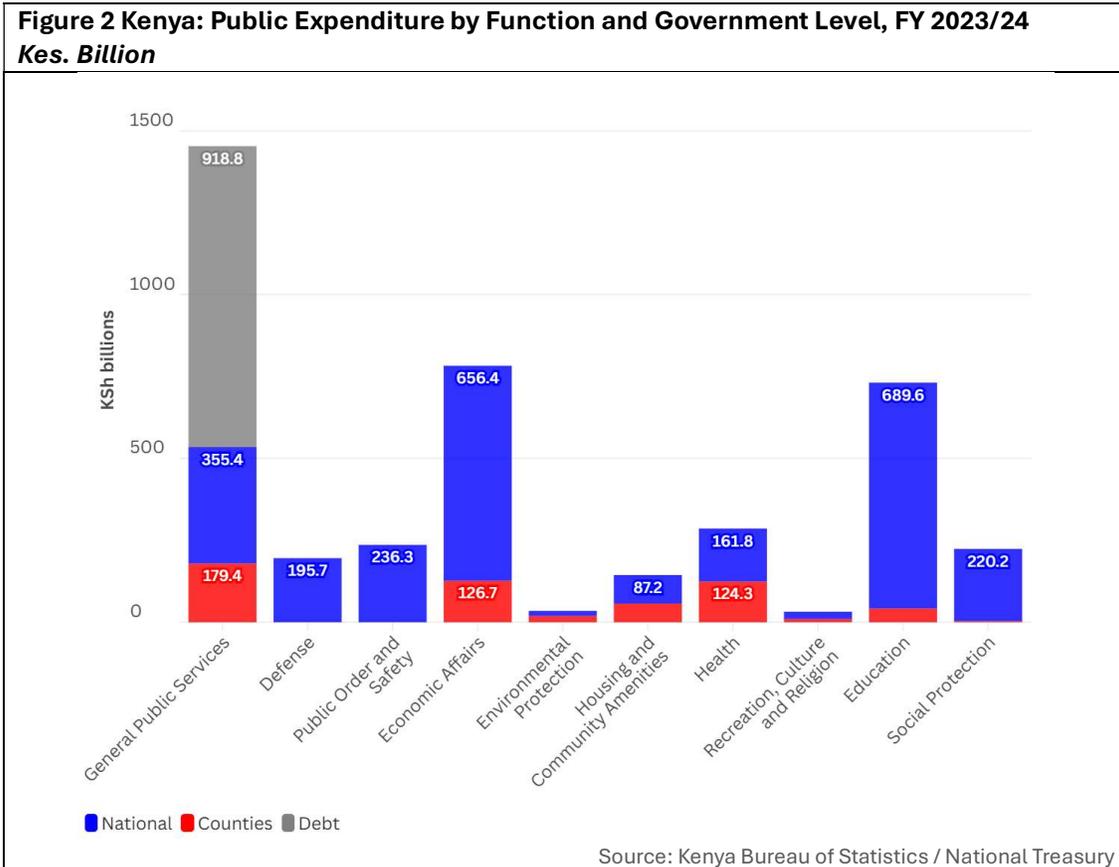
One concern that has systematically been raised is that despite the constitutional and legal devolution of functional responsibilities, the vertical allocation of public resources has not followed suit. In fact, county government expenditures amount to only 562 billion Shillings per year (Figure 1; Kenya Bureau of Statistics / National Treasury 2024). This amount reflects 13.6 percent of public expenditure in the country. Even when debt is excluded, county governments are only allocated less than one-fifth of all available public resources.

Figure 1 Kenya: Public Expenditure by Government Level, FY 2023/24
Kes. Billion



The vertical allocation of resources in Kenya raises the concern that public sector resources are getting stuck at the national government level (for instance, for political reasons), rather than flowing down to the county level, where public resources might be used in a more responsive and accountable manner for frontline service delivery. A breakdown of public spending by

function and level of government suggests that this is indeed a potential concern across many different functional areas, including health.



Overall public expenditure figures at different government levels (including by function) may result in some double-counting, as conditional grants provided within a sector be counted both as national government expenditures, as well as county-level expenditures. According to the Controller of Budget in FY 2023/24 the national government accounted for about 49 percent of total health sector expenditure (Kes. 103 billion), while county governments accounted for the remaining 51 percent (Kes. 113 billion) of total health spending across both levels of government.

The Controller of Budget FY 2023/24 report reveals that two specialized national programs — National Referral and Specialized Services and General Administration — together absorbed 65% of all national health spending. By contrast, the programs that support preventive, promotive, and curative services (at Level 2–5 facilities, which counties are constitutionally mandated to deliver) receive barely half of health sector spending, despite covering the running costs of hundreds of facilities across the country. This raises a critical concern: can it be justified that a handful of specialized national facilities consume such a disproportionate share of resources, while county-level facilities that serve millions of Kenyans on a regular basis operate with far less? There is a clear need for further investigation into whether national health spending is crowding out county-level service delivery, and whether fiscal allocations are aligned with constitutional responsibilities.

What is generally not revealed by available analyses is the horizontal allocation of resources at the county level in Kenya. Few, if any, analyses of health spending consider whether resources are spent equitably and efficiently across the national territory, or whether public health spending is concentrated disproportionately in one or more counties. Naturally, the territorial distribution of health resources, as well as the territorial distribution of health outputs (number of patients provided with health services) has major implications for the equity and efficiency of the health system.

Finally, looking at only one financial year (FY 2023/24) merely provides a snapshot in time of the health sector's funding situation. The pandemic years (FY 2020/21 and FY 2021/22) had disrupted service delivery, supply chains, and financing flows — so FY 2022/23 and 2023/24 were both recovery and reset years. Under the prior administration, the “Big Four Agenda” (2018-2022) placed heavy emphasis Universal Health care which promoted access to affordable, quality health services for all, and protecting households from the risk of financial hardship when seeking care. With the incoming administration of President William Ruto assuming office in late 2022, there was both a restart of strategic priorities and a revisiting of the previous government's flagship policies. However, a cursory review of preceding years suggests that FY 2023/24 was not a major outlier in terms of the vertical allocation of health sector resources.

3. Objective

The objective of this study to conduct a high-level analysis of public health service delivery performance in Kenya. The assessment aims to apply a pragmatic, data-driven approach to evaluate how Kenya’s 47 county governments are converting public health spending into tangible service outputs.

The analysis focuses on access, efficiency and value for money — specifically, the relationship between recurrent expenditure and the number of patient visits recorded in the Kenya Health Information System (KHIS) for the financial year 2023/24.

Specifically, the analysis of devolved county health services in Kenya considers:

1. The total amount of county spending on county health services in each county.
2. The total number of health services (patient visits) provided by the county government in each county; and
3. The overall “performance” of county health services in each county, by computing the level of access or utilization of county health services (total number of patients served per thousand residents) and the total (average) amount of spending on county health services per patient-visit in each county (i.e., unit-cost per health visit).

This study deliberately adopts a big-picture approach to assessing public health service delivery, relying on a small number of simple but powerful performance metrics. In particular, the primary output measure used is the total number of patients served, defined as the combined number of inpatient and outpatient visits recorded in each county.

While many health sector analyses seek to incorporate detailed distinctions—disaggregating patient-visits by service types, case severity, or clinical complexity—this study intentionally opts for a more rudimentary output measure in order to surface broad systemic patterns that are often obscured by more granular, program-specific indicators. By focusing on the most basic manifestation of service delivery — whether people are actually receiving care — the analysis provides a transparent and policy-relevant baseline for comparing performance across counties that would otherwise be obscured.

For this reason, the report does not attempt to identify the causal pathways behind observed performance differences, or to attribute county health outcomes to any single explanatory factor. Instead, the analysis presents a clear statement of objectives, a replicable methodology, and a set of initial empirical results, while explicitly recognizing the limits of what these data can establish.

Indeed, the purpose is not to offer definitive explanations, but to reveal major performance disparities, pose diagnostic questions, and identify directions for deeper, policy-relevant inquiry. In this sense, the current analysis is intended as a starting point for evidence-based discussion and reform, rather than as a comprehensive evaluation of the Kenyan health system.

4. Methodology

The methodology combines elements from two analytical frameworks developed by the Local Public Sector Alliance (LPSA). LPSA's Intergovernmental Fiscal and Expenditure Review (InFER) framework is a diagnostic tool to understand a country's entire public sector by analyzing revenue, spending, institutional structures, and fiscal patterns across all government levels to guide better decentralization and multi-level governance reforms. It offers a "big picture" view, examining how funds flow and are used, helping to identify inefficiencies and promote localization for effective service delivery. In addition, LPSA's Promoting Results-Oriented Management for Local Transformation and Efficiency (PROMOTE) framework is a tool designed to assess how well subnational governments are delivering inclusive and effective public services, focusing on their role as platforms for collective decision-making and efficient service provision for citizens. As such, it provides a conceptual and practical tool for evaluating local governance institutions to ensure they create real value and achieve sustainable, inclusive development at the local level.

4.1 Guiding principles and practices

The analysis was designed around a number of guiding principles:

- 1. Focus on the number of patient visits as the main metric of access to public health services.** The goal of the Kenya Health Policy 2014–2030 is attainment of the highest standard of health in a manner responsive to the needs of the Kenya population. In turn, the purpose of public health provision in Kenya is to ensure all citizens have access to quality, affordable essential health services, focusing on Universal Health Coverage (UHC), which means preventing disease, promoting wellness, offering curative care, and protecting people from financial hardship. Perhaps the most obvious single indicator of the public sector's performance in the provision of public health services is the number of people that seek—and are provided with—healthcare services at public health facilities. When access to, or the quality of—public health services is poor (or if the health provider does not show up), the number of patients that receive outpatient health services should be expected to be smaller. When access to—or the quality of—public health services is better (when the health provider shows up on a regular basis, and when the public sector provides medical supplies to frontline facilities in adequate quantities), the number of patients that show up for outpatient health services is generally greater. As such, the number of people that receive public healthcare services (measured as the number of public health facility patients. per thousand residents) is a pretty good indicator for the quantity and quality of public health services provided.
- 2. Focus on recurrent expenditure.** When considering county performance, considerable attention is paid in Kenya to the construction of new infrastructure or county facilities. For instance, county politicians may tout the number of county health facilities that have been constructed in the previous year. However, what matters is not the “four walls” of the health facility, but whether health services are delivered to local constituents within those four walls. As such, the focus of this analysis is largely on the day-to-day operational spending associated with inpatient and outpatient care, which focuses less on the one-off development expenditures that finance capital investments. Recurrent spending better reflects actual service delivery performance.

3. **Use of actual expenditure (not approved or revised estimated).** Actual spending data from the Controller of Budget (CoB) provides a truer measure of utilization than exchequer releases or budget estimates, which may not translate into real spending.
4. **Reliance on administrative data from KHIS.** Only *active facilities* (those submitting data during FY 2023/24) were included to minimize bias from dormant or under-reporting facilities.
5. **Population normalization.** County performance measures are standardized or normalized to account for population differences between counties. For instance, access to county health services is expressed as the number of patients served *per 1,000 residents* using 2023 population projections based on the 2019 Census to ensure comparability across counties. Similarly, spending efficiency of cost-per-unit is expressed as total (recurrent) expenditures *per patient served*.

4.2 Data sources

Three primary data streams underpin the analysis:

Dataset / Indicator	Source	Purpose
Total and recurrent health expenditure by county (FY 2023/24)	Controller of Budget (CoB)	Quantify actual resource utilization.
Outpatient and inpatient visits (Form 717 dataset)	Kenya Health Information System (KHIS)	Capture service-use outputs from all active public, private, and FBO facilities.
County population projections (Economic Survey 2023)	Kenya National Bureau of Statistics (KNBS)	Provide denominator for per-capita measures.

Where available, cross-validation was done using county budget documents and the *Health Sector Working Group Report 2023/24* to ensure consistency.

4.3 Computation steps

The methodology operationalizes a simple but replicable model for measuring the provision of (or access to) public health services, as well as the per-patient cost of health care provision by county governments in Kenya:

1. **Data extraction from KHIS** – Facility-level data were extracted from KHIS and aggregated to county level after cleaning missing or duplicate entries. Based on the KHIS data set, total patient visits for each county were computed as the sum of outpatient visits and inpatient visits for all county health facilities in each county.
2. **Data extraction from other sources.**
 - Total and recurrent health expenditures were extracted by county from the Controller of Budget report for 2023/24.
 - *Population* = County population (2023 projection).
3. **Compute county health services provided** (per 1,000 Residents)

$$\text{Access to County Health Services} = \frac{\text{Number of Patient Visits}}{\text{Population}} * 1000$$

4. **Calculate average cost per visit** (or cost-per-unit / value for money):

$$\text{Cost per Visit (Kes.)} = \frac{\text{Recurrent Expenditure}}{\text{Total Patient Visits}}$$

5. **Validation and Visualization.** Results were summarized in a master Excel sheet for all 47 counties, visualized through scatterplots and heat maps to identify outliers and regional disparities.

4.4 Limitations and possible refinements

The analysis, while in some ways groundbreaking—acknowledges data and methodological constraints that should be taken into account in interpreting the results and findings:

- **Inconsistent or incomplete reporting** in KHIS. To the extent that public health facilities are inconsistent or incomplete in reporting their performance, this should be seen as a major breakdown in the system of public sector performance and accountability.
- **Non-standardized financial data**, with potential differences in the coverage of reported county-level health spending and treatment of Facility Improvement Funds (FIF).
- **Limited disaggregation county level** — whereas KHIS can be disaggregated to the facility level, spending generally cannot be broken down by ward or facility level.
- **External disruptions**, such as possible health-worker strikes, procurement delays, or late disbursements, may have distorted county expenditures and patient visit counts.

Despite these limitations, the study establishes a baseline that can be expanded in future to strengthen the analytical robustness.

For instance, whereas the current analysis considers every patient-visit equally, a more refined approach could make distinctions between in-patient treatment and out-patient treatment, either by analyzing them separately, or by transforming different types of outputs (in-patient bed days, births, or ART visits into “outpatient equivalent visits” (IHME 2014).

Other obvious possible future refinements of the methodology or analysis include interpreting the performance of county health services by considering variations in the underlying burden of disease, adjusting for outlier services (or the presence of tertiary hospitals), isolating the cost and impact of community health services, or extending the time frame of analysis.

5. Presentation of key results

The results of the analysis are presented in Table 1 (next pages), as well as in map form as Figures 3, 4, and 5. Figure 3 (below) presents the ratio of county recurrent health spending to county total health spending, indicating that county health spending in Kenya is overwhelmingly recurrent-heavy, with nearly 90% of budgets devoted to salaries, allowances, medicines, and day-to-day operations rather than development investments.

Figure 3
Recurrent county health expenditure, as share of total county health expenditure, 2023/24

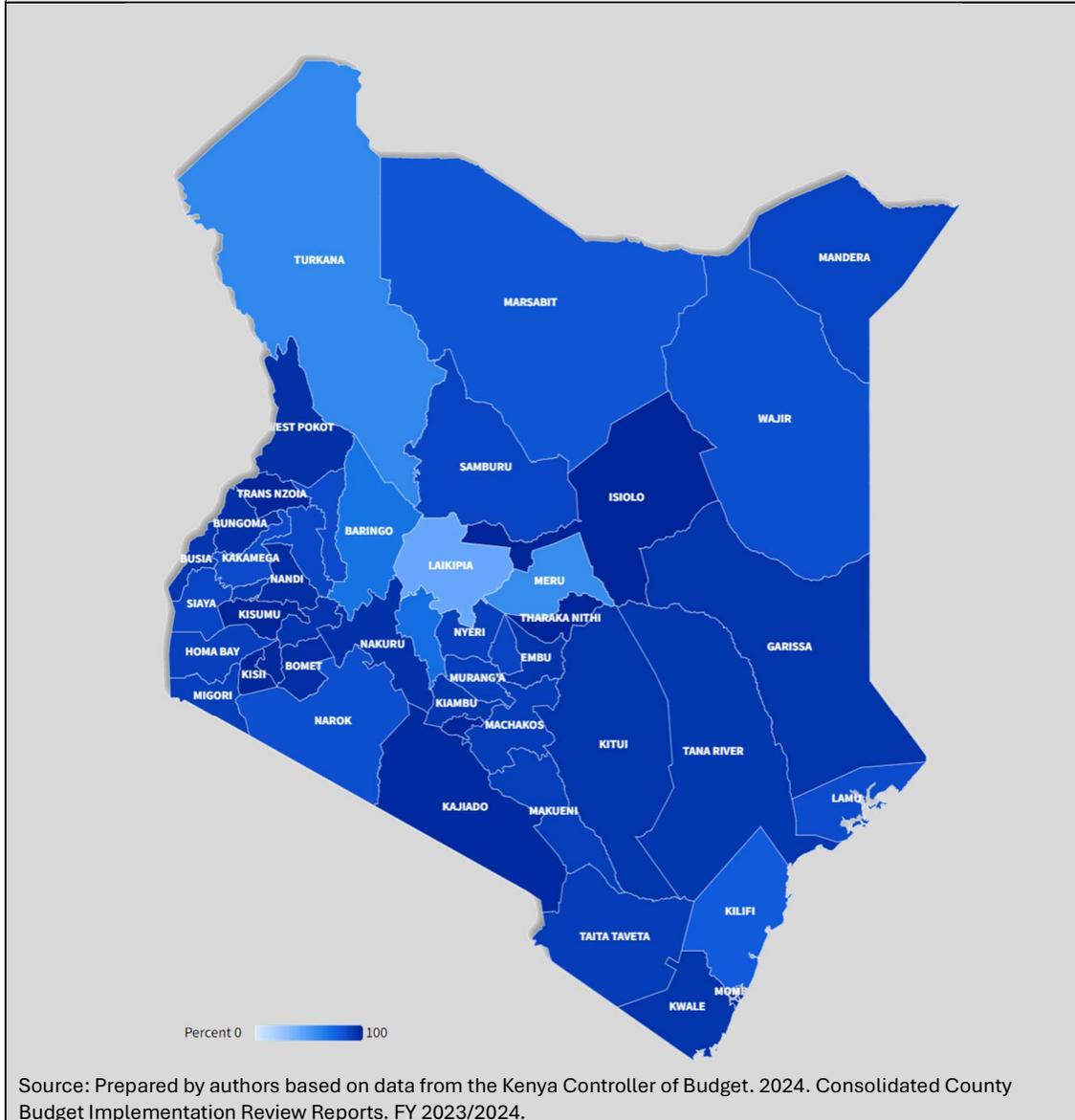


Table 1. Kenya county health performance indicators, 2023/24

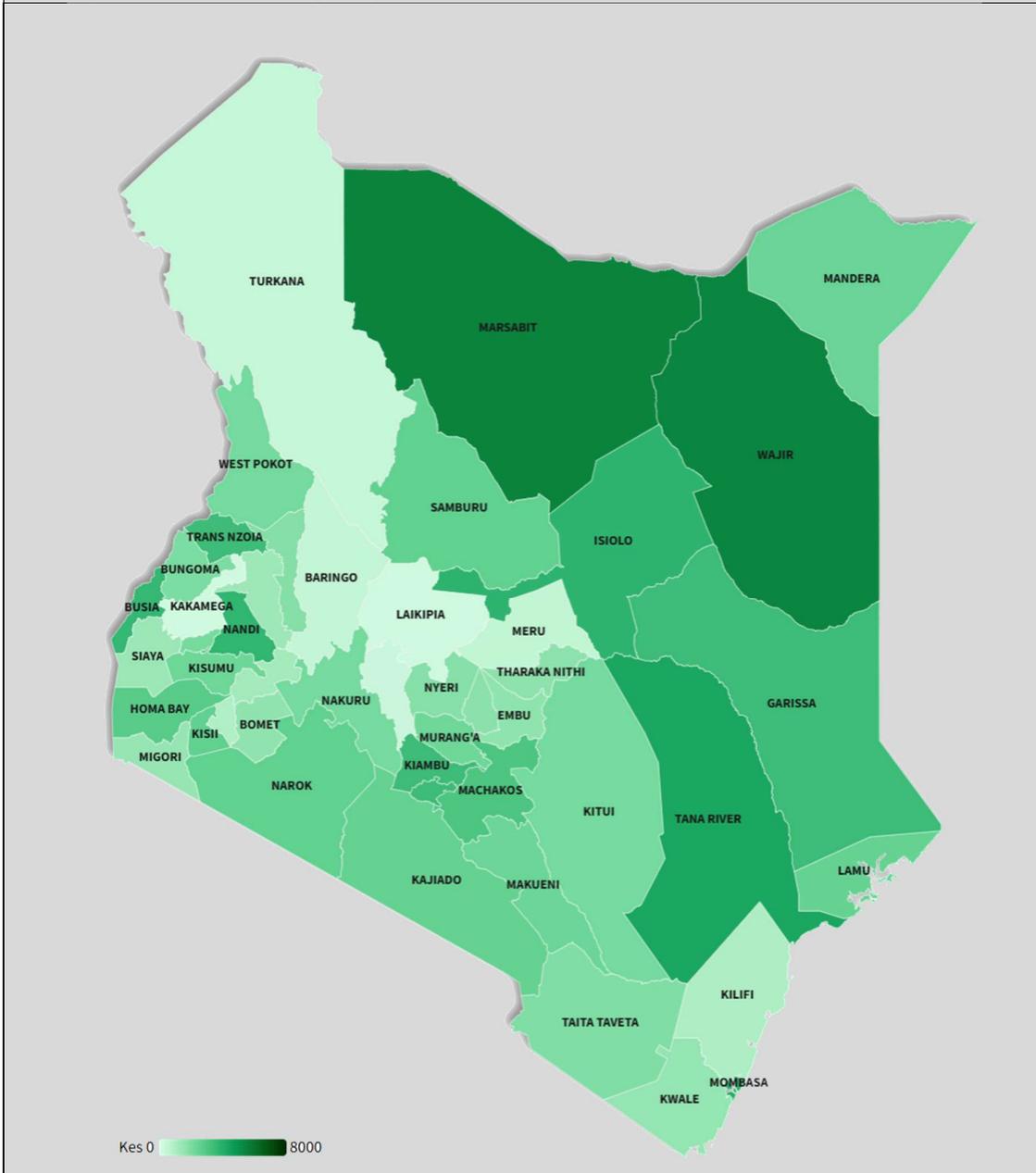
County	Population 2023	County health visits (OPD and inpatient)	Number of county patient visits per 1000 residents	Total county health spending (Kes million)	Recurrent county health spending (Kes million)	Recurrent share of county health spending	Recurrent spending per visit (Kes)
Mombasa	1,311,860	722,047	550.4	2,981.7	2,896.5	97.1	4,011.5
Kwale	944,464	1,691,329	1,790.8	2,921.4	2,747.7	94.1	1,624.6
Kilifi	1,577,335	1,727,303	1,095.1	2,321.6	1,850.2	79.7	1,071.2
Tana River	352,549	301,405	854.9	1,405.0	1,307.0	93.0	4,336.4
Lamu	167,332	381,073	2,277.3	1,139.2	973.0	85.4	2,553.2
Taita Taveta	363,990	84,154	231.2	186.0	169.6	91.2	2,015.2
Garissa	927,031	641,909	692.4	2,403.4	2,258.7	94.0	3,518.7
Wajir	870,636	495,997	569.7	3,178.9	2,689.0	84.6	5,421.3
Mandera	959,236	886,314	924.0	2,499.2	2,206.1	88.3	2,489.1
Marsabit	515,292	274,777	533.2	1,841.4	1,503.0	81.6	5,470.0
Isiolo	315,937	304,614	964.2	1,180.4	1,165.7	98.8	3,826.8
Meru	1,625,982	991,128	609.6	1,071.4	657.2	61.3	663.1
Tharaka Nithi	416,383	928,478	2,229.9	1,658.9	1,639.8	98.8	1,766.1
Embu	648,425	1,082,028	1,668.7	1,973.3	1,853.0	93.9	1,712.5
Kitui	1,229,790	1,542,873	1,254.6	3,674.9	3,454.5	94.0	2,239.0
Machakos	1,487,758	1,314,458	883.5	4,505.1	4,101.2	91.0	3,120.0
Makueni	1,042,300	1,182,086	1,134.1	3,158.5	2,862.0	90.6	2,421.2
Nyandarua	695,531	737,085	1,059.7	483.1	353.6	73.2	479.8
Nyeri	835,408	1,281,506	1,534.0	2,732.5	2,452.2	89.7	1,913.5
Kirinyaga	653,112	1,157,974	1,773.0	2,389.6	2,110.7	88.3	1,822.8
Murang'a	1,112,288	1,291,378	1,161.0	3,344.5	3,028.3	90.5	2,345.0
Kiambu	2,652,880	1,901,289	716.7	7,161.2	6,657.9	93.0	3,501.8
Turkana	1,022,773	1,143,597	1,118.1	1,016.2	642.4	63.2	561.7
West Pokot	676,326	809,758	1,197.3	1,893.0	1,801.0	95.1	2,224.1
Samburu	348,298	485,360	1,393.5	1,477.6	1,300.9	88.0	2,680.3
Trans Nzoia	1,069,039	596,597	558.1	2,106.3	2,071.2	98.3	3,471.7

Table 1. Kenya county health performance indicators, 2023/24 (Continued)

County	Population 2023	County health visits (OPD and inpatient)	Number of county patient visits per 1000 residents	Total county health spending (Kes million)	Recurrent county health spending (Kes million)	Recurrent share of county health spending	Recurrent spending per visit (Kes)
Uasin Gishu	1,257,330	1,479,211	1,176.5	2,440.0	2,116.8	86.8	1,431.0
Elgeyo Marakwet	495,239	872,601	1,762.0	1,964.8	1,684.8	85.7	1,930.7
Nandi	951,460	917,828	964.7	3,600.9	3,461.1	96.1	3,771.0
Baringo	733,333	821,515	1,120.2	704.2	501.0	71.1	609.8
Laikipia	561,223	807,474	1,438.8	639.3	299.1	46.8	370.4
Nakuru	2,347,849	2,644,060	1,126.2	6,220.5	5,880.8	94.5	2,224.1
Narok	1,284,204	978,491	761.9	3,103.4	2,609.6	84.1	2,667.0
Kajiado	1,268,261	917,602	723.5	2,427.4	2,357.4	97.1	2,569.1
Kericho	954,896	1,704,705	1,785.2	2,423.5	2,273.8	93.8	1,333.8
Bomet	939,761	1,056,617	1,124.3	1,874.0	1,798.1	96.0	1,701.8
Kakamega	2,002,435	2,130,625	1,064.0	849.5	730.2	86.0	342.7
Vihiga	625,765	610,302	975.3	1,459.9	1,334.7	91.4	2,186.9
Bungoma	1,786,973	1,143,330	639.8	2,530.8	2,405.0	95.0	2,103.5
Busia	968,763	522,610	539.5	2,069.2	1,930.0	93.3	3,692.9
Siaya	1,059,458	1,262,062	1,191.2	2,168.9	1,901.7	87.7	1,506.8
Kisumu	1,248,474	1,220,200	977.4	2,951.4	2,908.6	98.6	2,383.7
Homa Bay	1,231,659	735,874	597.5	2,361.2	2,104.2	89.1	2,859.5
Migori	1,234,082	1,066,408	864.1	1,885.3	1,696.8	90.0	1,591.1
Kisii	1,344,907	1,148,975	854.3	3,133.6	3,066.6	97.9	2,669.0
Nyamira	657,502	673,291	1,024.0	721.9	704.1	97.5	1,045.8
Nairobi	4,750,056	2,126,311	447.6	7,611.1	7,451.1	97.9	3,504.2
Total	51,525,585	48,796,611	947.0	113,844.6	103,967.6	91.3	2,130.6

Finally, Figure 5 explores the performance of county health services in terms of unit cost: how much does each county spend, on average, on providing county health services. Here, we should be careful not to reflexively consider that higher public spending is automatically better. In fact, from a value-for-money viewpoint, it is desirable to have a low per-unit cost: if a county is able to provide public health services of acceptable quality (as reflected by higher levels of access or reliance on public health services, as shown in Figure 4), then being able to provide those services at low cost is a good thing. At the same time, it is likely that when public health services are underutilized (either due to misallocation or poor quality), the per-unit cost of public health services actually increases.

Figure 5:
County recurrent spending per patient visit, FY 2023/24



Source: Prepared by authors based on data from the Kenya Health Information System and Controller of Budget.

6. Discussion and tentative findings

One of the features of the current state of devolution in Kenya is the lack of effective intergovernmental coordination and collaboration. This is true in the health sector as it is in other sectors. For instance, no regular, annual national assessment is performed that takes stock of the delivery of health services across different levels of government in Kenya.

As a result, the health system's overall performance is largely invisible, as assessing the performance of county health services requires data from all 47 counties to be aggregated and examined together. Individual county budgets, facility statistics, sectoral surveys and administrative reports provide only fragmented snapshots of activity in the sector, without systematically revealing how much the country is spending in total on frontline health services, how many patients are actually being served by county governments across the nation, or what this implies for average spending per patient. When these pieces are assembled—as is done here—a sobering picture emerges.

Finding 1: County health spending in Kenya is predominantly recurrent

Public debate and political messaging around development progress and public sector effectiveness in Kenya health—including health sector performance—tends to be dominated by visible investments in infrastructure: new hospitals, additional wards, modern buildings, and upgraded equipment. County leaders routinely highlight the number of facilities constructed or rehabilitated as evidence of progress in delivering better health services. While such investments are important, this infrastructure-centric narrative is deeply misleading, as buildings do not treat patients. What ultimately determines whether citizens receive timely, reliable, and quality care is not the number of walls or beds, but whether health facilities are staffed, stocked, supplied, and operational on a day-to-day basis. In practice, the real binding constraint on service delivery in Kenya's devolved health system is recurrent spending—the financing of health workers, medicines, utilities, maintenance, and routine operations that make service provision actually happen.

In this context, our first finding—despite the political attention of health infrastructure—is that health spending across Kenya's counties is actually overwhelmingly recurrent-heavy (Figure 3).

On average, counties spend approximately 89% of their health budgets on recurrent items. In 42 out of 47 counties recurrent expenditure accounts for 80% or more of total county health spending in FY 2023/24. This means that most county health resources are absorbed by ongoing operational costs—primarily salaries, allowances, medicines, supplies, utilities, and day-to-day facility expenses, rather than by capital investments that expand or modernize service delivery capacity.

Only five counties fall below this threshold. Among them, Laikipia County is a clear outlier, allocating 47% of its health budget to recurrent spending and 53% to development expenditure.¹ The other five: Meru, Turkana, Baringo, Nyandarua, and Kilifi have relatively higher shares of development spending than the national pattern, though recurrent expenditure remains dominant in each case.²

¹ This pattern reflects Laikipia's priorities, with planned investment in a Level 6 Hospital (Medical Tourism Centre).

² Section 107(2)(b) of the Kenya Public Finance Management Act (PFMA), 2012, mandates that over the medium term, a minimum of 30% of a county government's budget must be allocated to development

Our focus on recurrent expenditure is deliberate. Recurrent spending has a direct and immediate relationship to service utilization because it finances the core inputs that make health service delivery possible in practice: health workers, essential medicines and supplies, utilities, maintenance, and day-to-day facility operations. These are the factors that determine whether facilities open on time, staff show up, medicines are available, and patients are actually seen. By contrast, development expenditure primarily expands or upgrades future service capacity and often does not translate into observable changes in patient visits or access within the same financial year. For the purposes of assessing short-run service delivery performance, recurrent expenditure is therefore the more relevant and policy-salient measure.

Finding 2: The aggregate provision of—and spending on—county health services does not show a ‘devolution dividend’

As noted above, it is impossible to make any meaningful judgment about the performance of devolved county health service without combining spending and utilization data across all county governments. When the necessary data is combined across counties, and subjected to basic analysis, it is revealed that Kes 113 billion is spent on devolved health services in Kenya, of which 104 billion is spent on recurrent outlays. In total, these expenditures “buy” 48,796,611 patient-visits in 2022 for the people of Kenya. For comparison, Kenya currently has estimated population of 51,525,585 residents.

This means that the national average number of county-level outpatient and inpatient visits per 1,000 residents is 947 — less than one public health visit per person per year. The national average spending (or cost) per patient visit is 2,131 Shillings per patient-visit. While there is no widely accepted international benchmark against which to judge this figure, it is difficult to imagine that Kenyan policymakers would consider either of these results satisfactory. Taken together, low average utilization and relatively high per-visit costs point to a devolved health system that is underdelivering in reach while absorbing substantial public resources, raising serious concerns about access, efficiency, and value for money.

This aggregate performance picture is fully consistent, however, with the concerns raised earlier about Kenya’s vertical allocation of public resources. As shown in Section 2, counties — which are constitutionally responsible for the delivery of most frontline health services — control less than one-fifth of total public expenditure and only about half of total health sector spending. A substantial share of national health resources remains concentrated in specialized national programs and referral facilities, which serve relatively few patients. When viewed through the lens of service outputs, this fiscal architecture appears misaligned with constitutional responsibilities. The result is a system in which the level of government tasked with delivering routine, population-wide health services is systematically under-resourced relative to the scale of its mandate.

From this perspective, an average of fewer than one public health visit per person per year is not merely a technical performance statistic; it is a structural outcome of how resources are distributed across levels of government and how insufficient attention is paid—at all levels—to the public sector converting taxpayer resources into public services. Counties cannot deliver

expenditure. This fiscal responsibility principle ensures that county resources are focused on infrastructure and development rather than exclusively on recurrent costs. This rule applies at the aggregate budget level rather than sectorally. Interpreting it at the sector level would be unrealistic for recurrent-heavy areas like health and education/early childhood development.

high-access, high-quality services at scale if they lack adequate recurrent financing for staff, medicines, and operations. The fact that counties collectively “purchase” only 48.8 million visits for a population of over 51.5 million residents strongly suggests that fiscal constraints — rather than weak demand alone — are a binding constraint on service utilization. In other words, the low national utilization rate is not simply a reflection of individual county failures, but the direct result of a vertically imbalanced intergovernmental system.

The national average cost of Kes 2,131 per patient visit further reinforces this interpretation. On the one hand, this figure is high enough to raise concerns about value for money and operational efficiency. On the other hand, when combined with the low level of aggregate utilization, it suggests a system caught in a low-access, high-cost equilibrium, with many county governments potentially operating health services that are both underutilized and relatively expensive on a per-visit basis.

Finding 3: County performance in terms of provision of (or access to) health services is incredibly uneven

The aggregate picture is already underwhelming, but the aggregate figures cited above represent *national averages*: while some counties perform better, other county governments perform even worse. The disparities across counties are stark. At the bottom of the list, Taita Taveta records only 231 visits per 1,000 residents, less than a quarter of the national average. This compares to Lamu and Tharaka Nithi, where county residents are able to access county health services at a rate that is ten times greater: 2,277 and 2,230 patient visits per thousand residents, respectively.

A range of legitimate factors naturally contribute to differences in how often people seek care and how easily public health facilities can be reached across Kenya. Variations in access are partly shaped by exogenous conditions, including differences in epidemiological profiles and disease burdens, as well as population density and settlement patterns, which — all else equal — determine how far people must travel to reach a health facility. Utilization is also influenced by differences in health-seeking behavior that reflect socio-economic conditions and cultural preferences. In higher-income urban counties such as Nairobi and Mombasa, for example, public-sector utilization is unusually low despite dense populations and extensive facility networks, a pattern that likely reflects substantial reliance on private providers rather than weak physical access to care.

At the same time, variations in health care utilization across counties are also shaped by factors that are within the control of county leaders and county health officials, including the number and geographic location of health facilities, the presence and availability of health staff, the availability of drugs, and differences in health-seeking behavior that result from the quality and attractiveness of country health services being offered.

While determining the exact drivers of county health utilization falls beyond the scope of the current study, what is perhaps most striking in Figure 3 is the absence of strong or persistent spatial patterns in access to county health services of the kind one might reasonably expect to observe. There is no clear evidence that urban counties systematically achieve better access than rural ones, nor that certain regions of the country consistently outperform others. High and low utilization rates appear scattered across geographic, economic, and settlement contexts, cutting across arid and semi-arid regions, across high-potential agricultural zones, and major urban centers alike. This lack of an obvious regional or structural patterns suggests that access to health services is not being driven primarily by immutable geographic or regional

characteristics. Instead, it points toward differences in how county health systems are organized, managed, and operated in practice.

In fact, some of the most important insights are likely to come not from empirical or quantitative analysis or comparing radically different counties, but from comparing counties that face broadly similar structural conditions. Within-region comparisons are therefore especially revealing. For example, Turkana, Marsabit, and Wajir all operate in arid, sparsely populated, and logistically challenging environments, yet they exhibit markedly different levels of access to public health services. Such contrasts are difficult to reconcile with geography or poverty alone and strongly suggest that county-specific policy choices, management practices, and service delivery models play a decisive role in shaping utilization. Beyond some indicative observations on possible drivers of county health access and utilization (Box 1), further in-depth analyses and comparison of county-specific performance and experiences is left for future efforts.

Box 1. Indicative observations on possible drivers of county health access and utilization

Untangling the relative contributions of different exogenous and endogenous factors would require more granular data than is available for this baseline assessment. Some preliminary and purely indicative observations on possible drivers of variation are offered, not as causal claims, but as a starting point for deeper, policy-relevant inquiry in subsequent work:

Beyond Taita Taveta County (which records only 231 visits per 1,000 residents), the bottom five counties in terms of county health access (per thousand residents) include Nairobi (448 visits per 1,000 residents), Marsabit (533), Busia (539), and Mombasa (550). These figures are troubling because they represent both urban centres with dense populations and peripheral counties with significant health needs.

In Nairobi and Mombasa, despite their concentration of facilities, show utilization far below the national average, most likely, due to a larger share of residents being able to afford private healthcare services. In counties like Marsabit and Busia, the low figures may reflect geographic barriers, resource constraints, or weak management of service delivery. Together, these counties illustrate how underutilization is not confined to one type of setting, but cuts across both urban and rural contexts.

At the other end of the spectrum, the top five counties — Lamu (2,277 visits per 1,000 residents), Tharaka Nithi (2,230), Kwale (1,791), Kericho (1,785), and Kirinyaga (1,773) — report utilization well above the national average. These figures suggest stronger engagement with public health services, but they may also reflect higher disease burdens. High utilization can be a positive sign of access, yet without evidence of quality or efficiency, it is difficult to conclude that citizens are receiving value-for-money care.

Several counties emerge as outliers when compared to the expected range of utilization. Lamu, Tharaka Nithi, and Elgeyo Marakwet stand out on the higher end, suggesting potential structural advantages such as stronger facility coverage, more compact settlement patterns, or more effective service delivery models. On the opposite side, Taita Taveta and Marsabit record exceptionally low numbers that may be influenced by vast geography, low population density, or other access-related barriers.

The current analysis points to a set of important meta-lessons about where—both territorially and institutionally—greater attention should be focused to improve the effectiveness of Kenya’s devolved health system.

One clear implication is that performance failures are not only a matter of geography or financing (as further explored below) but is primarily the result of weak results-based management. A core responsibility of the national government, as steward of the health system and overseer of county governance, is to ensure that county officials and citizens alike have access to the information needed to judge how well county governments and county health departments are performing in fulfilling their constitutional mandates. Such a national performance-monitoring system does not currently exist in any meaningful form.

Similarly, counties should “measure what they treasure”: while counties may inform their constituents about the progress in new health facilities being constructed, few—if any—regularly inform their constituents about the number of patient-visits and level of health services provided. Although there are some notable exceptions, few counties routinely monitor or publicly report on even the most basic health indicators, such as patient volumes per facility, patients per provider, compliance with opening hours, medicine stock-outs, or cost per visit. Even fewer counties use such data to make public health service delivery decisions about where to allocate additional resources. In effect, large parts of the devolved health system are operating without a functioning performance dashboard that ensures the efficient and accountable use of available public health resources.

Without such routine performance data, county health departments are structurally unable to ask — let alone answer — the most basic diagnostic questions: Which facilities are underperforming? Why are patient volumes low in some locations but not others? Where exactly are staffing, procurement, or management failures binding? In the absence of systematic county- and facility-level performance monitoring based on regular administrative and expenditure data, poor performance becomes invisible to decision-makers and therefore endemic.

This institutionalized blindness reinforces the conclusion that a large share of the observed variation in access is not an unavoidable by-product of geography or poverty, but the predictable result of weak results-based management and limited accountability within county health systems.

Finding 4: Wide variations exist in (per-patient) recurrent health spending

Beyond differences in access and utilization, Kenya’s devolved health system is characterized by extraordinarily wide variation in recurrent spending per patient visit. This indicator captures how much counties spend, on average, each time a patient interacts with the public health system and provides a simple proxy for operational efficiency and value for money.

It was already noted that the national average recurrent cost per patient visit—at Kes 2,131 per patient-visit—already raises questions about the overall efficiency of Kenya’s devolved health care system. What is far more striking—and policy-relevant—is not the national average, but the extreme variation in health care spending per patient-visit across different counties.

At the upper end of the distribution, counties such as Marsabit (Kes 5,470), Wajir (Kes 5,421), Tana River (Kes 4,336), Mombasa (Kes 4,012), and Isiolo (Kes 3,827) spend between two and three times the national average per visit. At the lower end, counties such as Kakamega (Kes 343), Laikipia (Kes 370), Nyandarua (Kes 480), Turkana (Kes 562), and Baringo (Kes 610) report per-visit costs that are less than one-third of the national mean. The resulting gap between the most expensive and least expensive counties is more than fifteen-fold. Such a degree of dispersion cannot plausibly be explained by differences in epidemiological burden, geography,

or service mix alone; it points to deep structural differences in how county health systems are being operated and their performance.

Some portion of this variation is undoubtedly driven by legitimate structural cost factors. Counties in arid and semi-arid lands face higher unit costs due to sparse populations, long travel distances, small facilities operating below efficient scale, and higher logistics and staffing costs. These contextual factors matter and should temper any simplistic interpretation of high per-visit costs as pure inefficiency. From this perspective, for instance, it is not surprising that counties such as Marsabit, Wajir, Tana River, and Isiolo appear among the higher-cost counties on a per-visit basis.

An additional explanatory variable that should be considered is resource availability: in per-capita terms, the equitable sharing formula allocates much greater resources to some counties than to others. Given that health tends to be counties' main functional responsibility, this means that some counties have greater resources available than others.³

Yet these structural explanations are clearly insufficient in explaining county variations in health care spending. The presence of counties such as Turkana and Baringo among the lowest-cost jurisdictions is particularly revealing, especially in light of the fact that they perform reasonably well in terms of providing access to county health services. Both are arid, sparsely populated, and logistically challenging, and yet they report per-visit costs nearly *ten times* lower than those of Marsabit or Wajir. This stark contrast suggests that geography alone does not determine unit costs.

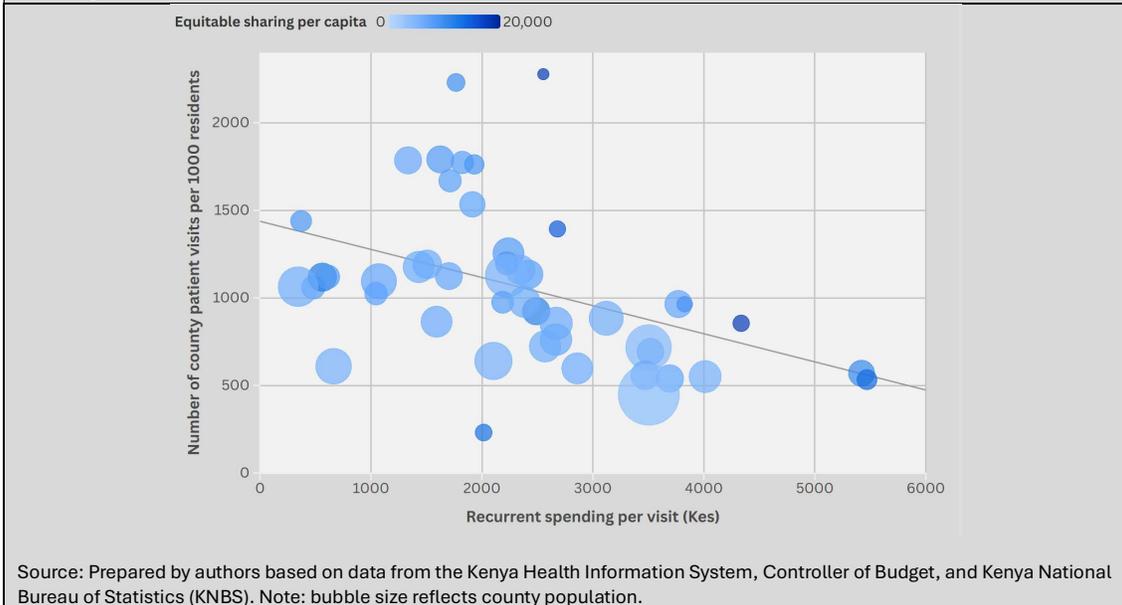
Finding 5: A negative relationship exists between recurrent county health spending (per patient-visit) and county health access

Conventional wisdom in health policy holds that higher public spending should lead to better health services, greater utilization, and improved access to care. The underlying assumption is straightforward: more resources allow governments to hire more staff, stock more medicines, operate more facilities, and expand service coverage, which in turn should result in more patients being served. From this perspective, counties that spend more on health services — especially on a per-patient basis — would be expected to exhibit higher levels of access and utilization. This logic underpins much of the policy debate around financing gaps and motivates repeated calls for increased health sector spending. The empirical evidence from Kenya's devolved health system, however, points in the opposite direction.

Figure 6 reveals a counterintuitive and troubling pattern: counties with higher recurrent spending per patient visit tend, on average, to exhibit lower levels of access to county health services. In other words, higher per-visit spending is associated not with greater utilization, but with *fewer* patient visits per capita instead. This negative relationship directly challenges one of the most entrenched assumptions in health financing and suggests that Kenya's health sector is not constrained primarily by the level of spending, but by how effectively existing resources are translated into services.

³ Likewise, counties vary in their ability to generate own source revenue from property taxes and other own revenue sources. However, own revenue sources only account for 15 percent or less of county resources.

Figure 6. Correlation between recurrent county health spending (per patient-visit) and county health access



This pattern reflects that in many high-cost counties, facilities appear to be operating at very low patient volumes while maintaining rigid staffing and operating cost structures. When utilization is low, fixed recurrent costs — salaries, utilities, maintenance, and basic supplies — are spread over a small number of visits, mechanically driving up the average cost per patient. In such contexts, high per-visit spending is not a sign of superior quality, but a symptom of inefficiency, weak demand, unreliable facility operations, or poor service organization.

Conversely, in many lower-cost counties, higher patient volumes and leaner operating models appear to be driving average costs down. When facilities are predictably open, adequately staffed, reasonably stocked, and trusted by communities, utilization rises and economies of scale emerge. Greater throughput allows fixed costs to be spread more widely, reducing unit costs even when total spending remains modest. In this sense, access and efficiency reinforce each other: better service delivery attracts more patients, and more patients lower average costs.

The implication for county health services is clear: Kenya’s devolved health system is trapped, in many counties, in a suboptimal equilibrium characterized by low utilization and high unit costs. Simply increasing budgets and “doing more of the same” in such a position is unlikely to deliver meaningful gains in access or quality. The pathway to improved performance runs instead through changing the approach to health care management—away from the top-down, one-size-fits-all philosophy of the previous centralized approach of health management towards responsive, patient-centric and results-oriented management of county health systems. Counties that succeed in organizing reliable frontline services will naturally attract more patients and reduce unit costs over time. Those that do not will remain stuck in a high-cost, low-access equilibrium regardless of how much additional funding they receive. Reversing this persistent pattern of weak county health services therefore requires shifting the policy focus from budgets and infrastructure toward facility-level performance, service organization, and accountability for results.

7. Conclusions and next steps

This exploration of devolved health service performance should be understood within the broader trajectory of Kenya's devolution reform and the challenges that have confronted multilevel governance across sectors since the adoption of the 2010 Constitution. Devolution fundamentally transformed the formal structure of the public sector by transferring major service delivery responsibilities to county governments. Yet, in practice, neither the national government nor most county governments have fully embraced this institutional transformation as an opportunity to rethink the social contract, redesign intergovernmental relationships, or modernize the way public services are governed and delivered. In many sectors — including health — the architecture of government has changed, but the underlying vertical systems of management, accountability, and performance orientation have remained largely intact.

The original promise of devolution in Kenya was not simply administrative decentralization, but the creation of a more responsive, inclusive, and accountable multilevel governance system in which each level of government would contribute, in a coordinated manner, to improved service delivery and citizen outcomes. In such a system, national government ought to play a strong stewardship and enabling role, while counties would operate as platforms for local problem-solving and service innovation, with performance information guiding policy, financing, and accountability across both levels. More than a decade into the implementation of devolution, this promise remains only partially realized. Across sectors, devolution has too often been treated as a transfer of functions and budgets, rather than as a catalyst for transforming how the public sector works.

The findings of this report reflect this broader governance failure. Kenya's devolved health system is not primarily constrained by a lack of infrastructure or even by insufficient aggregate spending, but by weak results-based management, limited performance monitoring, and the absence of systematic accountability for service delivery outcomes. Too often, health sector debates focus on inputs — facilities, budgets, and staffing numbers — without examining whether these resources are actually being converted into accessible, efficient, and equitable services for citizens. By linking spending directly to patient visits across all 47 counties, this analysis makes visible what is usually hidden: the effectiveness — or ineffectiveness — of the public sector in fulfilling its service delivery mandate.

Three broad conclusions emerge. First, despite the political emphasis on infrastructure, county health spending is overwhelmingly recurrent, confirming that frontline service delivery depends primarily on staffing, medicines, and operational inputs rather than on capital infrastructure or “development” spending. Second, when viewed in aggregate, devolved health services are underperforming: fewer than one public health visit per person per year is being delivered at a relatively high average cost per visit. This outcome is consistent with the vertically imbalanced fiscal architecture of Kenya's public sector, in which the level of government responsible for routine, population-wide services remains systematically under-resourced relative to its constitutional mandate. Third, performance varies enormously across counties in ways that cannot be explained by exogenous factors such as geography, poverty, or epidemiology alone. Differences in access and unit costs are driven to a large extent by how county health systems are organized, managed, and operated in practice.

Perhaps the most consequential result of these patterns is the negative relationship between per-visit spending and access. Counties that spend more per patient tend, on average, to serve fewer patients. This finding directly contradicts conventional policy assumptions and

underscores a central lesson of Kenya’s devolution experience: spending more, in the absence of institutional reform, does not produce better services. Instead, the health system has settled into a set of suboptimal equilibria — in some counties, underutilized and expensive facilities; in others, overstretched and potentially under-resourced ones. Both patterns reflect governance failures rather than absolute structural constraints.

These results highlight a missed opportunity in Kenya’s devolution reform. While the structure of government changed, the public sector largely failed to use devolution as a platform to redesign incentives, modernize management, and embed performance and accountability at the core of service delivery. At the national level, the absence of a regular, public, and systematic assessment of county service delivery performance represents a major gap in stewardship. As steward of the health system and overseer of county governance, the national government has not yet established a credible performance framework that allows policymakers, counties, and citizens to judge whether devolution is delivering on its promise.

At the county level, the challenge is even more fundamental. Many counties appear to be operating their health systems without a functioning performance management architecture. Few systematically track patient volumes, facility utilization, unit costs, staffing productivity, or service reliability, and even fewer do so in a transparent and public manner. Without such information, county health departments cannot diagnose underperformance, identify binding constraints, or design corrective interventions. Poor performance therefore becomes invisible to decision-makers and, over time, normalized.

Different instruments exist within the global community of practice to assist Kenya, and countries facing similar challenges, refocus their devolution efforts on a citizen-central and results-oriented multilevel public sector. For instance, a set of assessments frameworks developed by the Local Public Sector Alliance offer a practical roadmap for reversing this pattern and for realigning devolution with its original reform objectives.⁴ Annual performance reviews should move beyond budget execution to examine service outputs, access patterns, unit costs, and facility-level performance. County executives should receive regular performance dashboards; health departments should publish annual service delivery reports disaggregated by facility and ward; county assemblies should conduct structured performance hearings; and citizen-facing tools should enable communities to assess whether services are improving. When implemented seriously, these mechanisms transform devolution from a fiscal transfer system into a learning system for continuous improvement.

Peer learning across counties represents a further, largely untapped opportunity. The analysis shows that some counties achieve relatively high access at low cost, while others struggle despite far higher spending. These contrasts provide a powerful basis for reform. Systematic comparison of service delivery models, facility networks, outreach strategies, and management practices can generate practical lessons that are directly transferable across counties. Such learning, grounded in comparable data and facilitated through national platforms, offers one of the most promising pathways to system-wide improvement.

Looking ahead, several priorities for further work and analysis emerge. Future analysis could disaggregate performance to the facility level, examine trends over time, distinguish between inpatient and outpatient services, and adjust for disease burden and service mix. Attention should further be paid to the interaction between national referral facilities and county systems,

⁴ The frameworks include LPSA’s Intergovernmental Fiscal and Expenditure Review (InFER) and LPSA’s PROMOTE framework (Promoting Results-Oriented Management For Local Transformation And Efficiency).

the role of private providers in shaping utilization, and the incentives embedded in intergovernmental transfers. These extensions will be essential for moving from diagnosis to reform.

Ultimately, the central message of this report extends beyond the health sector. Kenya does not primarily need to decentralize more, build more facilities, or spend more money. It needs to complete the unfinished business of devolution: to use multilevel governance as a platform for transforming the social contract, modernizing public sector management, and building an inclusive, evidence-based system in which all levels of government work together to deliver better services for citizens. Health offers a powerful starting point. By shifting the policy focus from inputs and infrastructure toward performance, accountability, and learning, Kenya can still realize the promise of devolution as a driver of equity, efficiency, and trust in government.

References

- Controller of Budget. 2024. *Consolidated County Budget Implementation Review Report, FY 2023/24*. Nairobi: Office of the Controller of Budget.
- Health Sector Working Group. 2024. *Health Sector Working Group Report, FY 2023/24*. Kenya National Treasury and Ministry of Health.
- Institute for Health Metrics and Evaluation (IHME). 2014. *Health Service Utilization and Outpatient Equivalent Methodology*. Seattle: IHME.
- Kenya National Bureau of Statistics (KNBS). 2023. *Economic Survey 2023*. Nairobi: KNBS.
- Kenya National Bureau of Statistics (KNBS) and National Treasury. 2024. *Public Expenditure by Government Level and Function, FY 2023/24*. Nairobi: KNBS / National Treasury.
- Local Public Sector Alliance (LPSA). 2023. *Intergovernmental Fiscal and Expenditure Review (InFER) Framework*. Washington, DC: LPSA.
- Local Public Sector Alliance (LPSA). 2024. *PROMOTE: Promoting Results-Oriented Management for Local Transformation and Efficiency*. Washington, DC: LPSA.
- Ministry of Health. 2014. *Kenya Health Policy 2014–2030*. Nairobi: Ministry of Health.
- Ministry of Health. 2024. *Kenya Health Information System (KHIS), Form 717 Dataset, FY 2023/24*. Nairobi: Ministry of Health (administrative data).
- Republic of Kenya. 2010. *The Constitution of Kenya, 2010*. Nairobi: Government Printer.
- Republic of Kenya. 2018. *The Big Four Agenda: Universal Health Coverage Pillar*. Nairobi: Government of Kenya.