LOCAL PUBLIC SECTOR ALLIANCE

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POLICY BRIEF

Devolved health services in Kenya: Access, efficiency, and the unfinished business of devolution

Over the past decade, Kenya's devolution reform has fundamentally reshaped the country's public sector by transferring responsibility for a wide range of public sector functions—including primary health services—to 47 county governments. The intent of this constitutional transformation was not merely to establish subnational political or administrative structures, but the creation of a more responsive, accountable, and citizen-centered system of governance in which public services would be better aligned with local needs and preferences. More than ten years into implementation, however, important questions remain regarding whether these institutional changes have translated into tangible improvements in health service access, efficiency, and value for money. This policy brief summarizes the principal insights from a recent analysis by the Local Public Sector Alliance (LPSA) examining how county governments in Kenya are converting public health expenditures into measurable service outputs.

The assessment applies a deliberately simple but powerful performance lens, evaluating recurrent spending per patient and the actual number of patient-visits as key performance measures in order to establish a transparent baseline of devolved health service performance across all 47 counties. The results point to a central tension at the heart of Kenya's devolution journey: while the structure of governance has changed, the underlying mindset of health service delivery continues to reflect a top-down, input-driven, and technocratic approach. Many county health systems continue to be organized around budgets, buildings, and administrative processes rather than around the goal of ensuring that patients have access to quality public health services in a way that provides taxpayers with good value-for-money.

Analytical framework and approach

The analysis of primary health services in Kenya departs from infrastructure- or input-oriented assessments and instead focuses on two core output-oriented indicators:

- ***Access to county health services***: patient visits per 1,000 residents
- ***Unit cost of service delivery***: recurrent spending per patient visit

These measures are intentionally straightforward. Their strength lies precisely in their simplicity: they focus on whether citizens are actually receiving services and at what cost. By emphasizing utilization and unit cost, the methodology allows for direct comparison across counties while avoiding overly technical or program-specific metrics that can obscure the fundamental question of public value.

This approach is grounded in the premise that a citizen-centric health system is one in which services are not only funded, but used, trusted, and accessible. The main purpose of the analysis is therefore not to provide definitive causal explanations, but to surface systemic patterns that reveal how effectively county governments are transforming financial inputs into tangible benefits for residents. In doing so, the analysis highlights not only performance outcomes, but also the institutional gaps that prevent counties from systematically measuring and improving those outcomes.

Main analytical findings

1. County health spending is predominantly recurrent

Public discourse around health sector progress frequently emphasizes visible capital investments such as new hospitals, upgraded wards, or modern equipment. The evidence, however, shows that county health budgets are overwhelmingly devoted to recurrent expenditures — salaries, medicines, utilities, and routine operational costs. In most counties, recurrent spending accounts for the large majority of total health outlays.

This pattern underscores an important reality: citizens experience health systems not through infrastructure alone, but through the reliability and quality of day-to-day operations. A facility that is well-staffed, open on time, and adequately supplied delivers far greater public value than a modern building that lacks personnel or medicines. The dominance of recurrent spending therefore reinforces the need for county health systems to be organized around service reliability and performance, rather than around construction projects or capital visibility.

Yet the analysis suggests that, despite the financial centrality of operational inputs, many counties do not consistently monitor whether these recurrent expenditures are actually resulting in higher utilization, better patient experiences, or improved outcomes. In this sense, the recurrent nature of spending highlights the importance of performance management — and simultaneously exposes the absence of systematic mechanisms to ensure that operational resources are being translated into citizen-focused results.

2. The aggregate provision of — and spending on — county health services does not reveal a clear "devolution dividend"

When data from all counties are combined, the national performance picture is modest. Counties collectively deliver fewer than one public health visit per resident per year on average, at a recurrent cost exceeding two thousand Kenyan shillings per visit. While international benchmarks vary, these figures suggest a system that is underperforming in reach while absorbing substantial public resources.

This outcome challenges the implicit expectation that decentralization alone would automatically generate a "devolution dividend" in the form of improved service access. Instead, the aggregate evidence points to a system in which financial resources and institutional responsibilities have been redistributed without a commensurate strengthening of the performance and accountability mechanisms required to convert autonomy into improved services.

The modest national averages also reflect a broader structural issue within Kenya's intergovernmental fiscal architecture. Counties — which bear primary responsibility for routine, population-wide services — control a limited share of total public expenditure relative to their mandates. This vertical imbalance constrains the operational capacity of county health systems and limits their ability to respond flexibly to local needs. The result is a paradox in which the level of government closest to citizens is often the least empowered to deliver consistently high-quality services at scale.

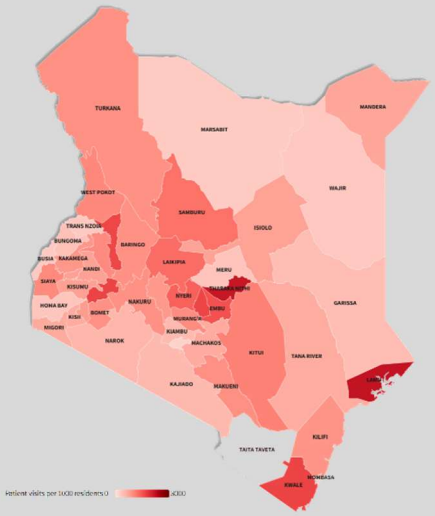
3. County performance in access to health services is highly uneven

Beyond national averages, the most striking feature of Kenya's devolved health landscape is the magnitude of territorial variation in service utilization. Patient-visit rates differ many-fold between counties, and these disparities do not follow a consistent geographic or regional pattern. High and low access levels are observed in both urban and rural contexts, as well as across diverse economic and demographic environments.

This unevenness has direct implications for citizens' lived experiences. Two residents of different counties — even when facing similar health needs — may encounter dramatically different levels of service availability and reliability. Such disparities weaken the social contract and undermine the central promise of devolution: that governance closer to the people would yield more equitable and responsive services.

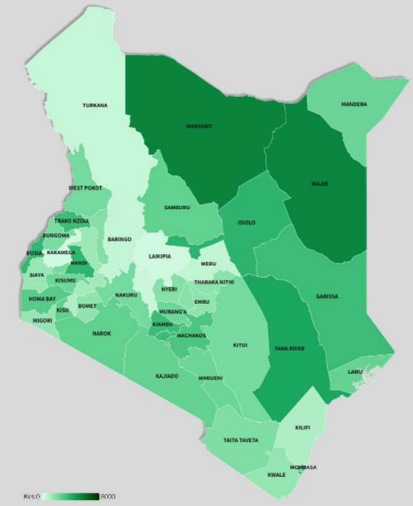
While structural factors such as geography and population density play a role, the absence of a clear spatial pattern indicates that institutional and managerial differences are equally, if not more, influential. Counties that organize services predictably, manage facilities effectively, and maintain public trust tend to achieve higher utilization. Conversely, where management is fragmented or unreliable, facilities may exist but remain underused. The uneven access revealed by the analysis therefore reflects not only differences in resources, but differences in how citizen needs are prioritized and translated into operational practice.

Figure 1
Access to county health services: the number of (in and out) patient visits at county health facilities per 1000 residents, 2023/24



Source: Prepared by authors based on data from the Kenya Health Information System and Kenya National Bureau of Statistics (KNBS).

Figure 2:
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

4. Wide variations exist in recurrent spending per patient visit

The analysis further reveals extraordinary variation in the recurrent cost per patient visit across counties, with differences exceeding an order of magnitude between the lowest- and highest-cost jurisdictions. Some variation is attributable to legitimate structural cost drivers, including sparse populations, long travel distances, and logistical challenges in arid regions.

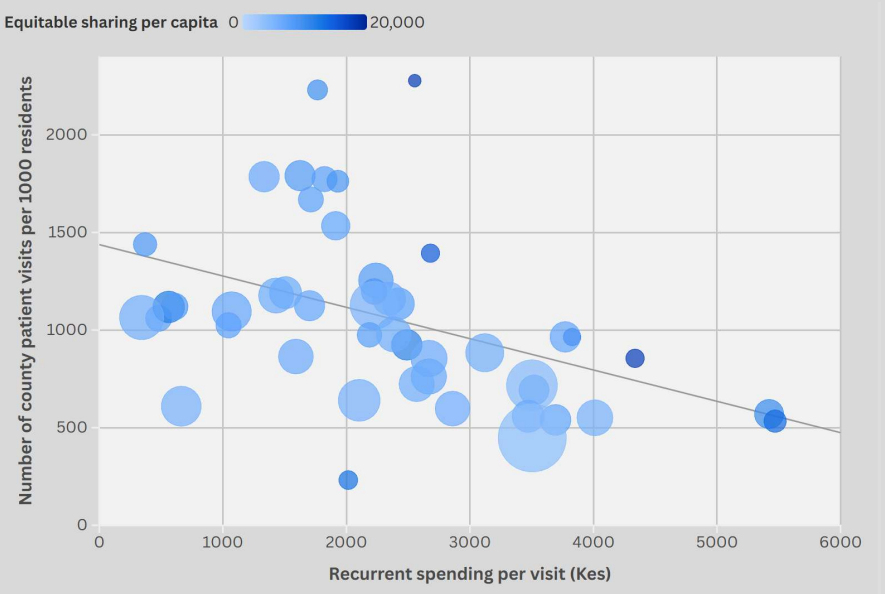
However, structural explanations alone are insufficient. Counties facing broadly similar demographic and geographic conditions often report widely divergent unit costs. This suggests that operational efficiency, facility utilization, and management practices are decisive factors. High per-visit spending frequently reflects facilities operating below efficient scale, rigid staffing structures, or unreliable service delivery that depresses utilization while fixed costs remain constant.

From a citizen-centric perspective, such variation raises fundamental questions of equity and fairness. Taxpayers across the country contribute to the public system, yet the value they receive — measured in accessible and reliable services — differs substantially. The dispersion in unit costs therefore signals not merely financial inefficiency, but the absence of a consistent performance framework that ensures resources are aligned with actual service delivery outcomes.

5. A negative relationship exists between per-visit spending and access

Perhaps the most counterintuitive finding is the observed negative association between recurrent spending per visit and service utilization. Counties that spend more on average per patient frequently serve fewer patients. This pattern challenges the conventional assumption that higher health spending automatically produces better health services.

Figure 3. Correlation between recurrent county health spending (per patient-visit) and county health access



Source: Prepared by authors based on data from the Kenya Health Information System, Controller of Budget, and Kenya National Bureau of Statistics (KNBS). Note: bubble size reflects county population.

In many instances, elevated unit costs are symptomatic of underutilized facilities rather than superior quality. When patient volumes are low, fixed operational costs — salaries, utilities, and maintenance — are spread across a small number of visits, mechanically driving up the average cost per interaction. Conversely, counties that achieve higher utilization often benefit from economies of scale that reduce average costs even when total spending is modest.

This relationship underscores a central governance lesson: budgets alone do not generate performance. What matters is how resources are organized, managed, and aligned with citizen demand. A performance-oriented and citizen-centric system focuses on reliability, accessibility, and trust — conditions that naturally attract greater utilization and improve efficiency over time. The observed negative correlation therefore reveals the extent to which many county health systems remain trapped in a low-access, high-cost equilibrium driven by weak performance management rather than by insufficient funding.

Governance and management implications

Taken together, these five findings point toward deeper systemic challenges related to results-based management, performance monitoring, and institutional accountability in post-devolution Kenya. Many county health departments appear to operate without comprehensive performance dashboards that track patient volumes, facility utilization, and unit costs in a systematic and publicly accessible manner. At the national level, there is no routine consolidated assessment that integrates financial and service-output data across all counties.

This institutional gap produces a form of operational invisibility. Underperformance becomes difficult to diagnose, successful innovations remain localized, and citizens lack the information necessary to evaluate whether services are improving. In effect, the analysis suggests that Kenya's devolved health system has not yet fully embraced the performance-oriented ethos that devolution was intended to enable.

While the structural foundations of devolution are in place, the managerial and informational systems required to realize its full promise remain only partially developed. A truly citizen-centric multilevel health system would continuously measure whether people are receiving services, whether facilities are reliable, and whether public resources are delivering value for money. In turn, county officials would actually use this data to make evidence-informed resource allocation decisions. In addition, the facility-level health performance data would be made public, so that citizens could judge the performance of their county officials.

Completing the unfinished business of devolution

The health sector in Kenya provides a particularly clear illustration of a broader governance lesson about the unfinished business of devolution in Kenya. Structural decentralization reforms alone do not automatically produce improved public services. The transformative potential of devolution lies in its capacity to foster responsive management, evidence-based decision-making, and continuous institutional learning across all levels of government. Yet, these public sector reforms are not automatically triggered by the restructuring of the multilevel government system.

The analysis demonstrates that Kenya's next phase of reform must move beyond the transfer of functions toward the strengthening of performance-oriented governance. Devolution's success ultimately depends not on the number of facilities constructed or budgets allocated, but on whether citizens experience tangible improvements in accessibility, reliability, and quality of care. By making visible how public resources are — or are not — translated into services, performance-based analysis offers a pathway for aligning multilevel governance with its original objective: a public sector that is organized around the needs, expectations, and well-being of citizens.

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