



HEALTH INSURANCE KERALA

Karunya

Arogya

Suraksha

Padhati



സ്റ്റേറ്റ് ഹെൽത്ത് ഏജൻസി

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Health Insurance in Kerala:

Karunya Arogya Suraksha Padhati (KASP)

KERALA.HEALTH



Message



GOVERNMENT OF KERALA

Pinarayi Vijayan
CHIEF MINISTER

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MESSAGE

Kerala has always been a pioneer in advancing public health and social protection. Our State's commitment to universalism is reflected in the historic strides we have made in education, health, and social security. The establishment of the State Health Agency (SHA) in 2020, and the integration of fragmented schemes such as RSBY, CHIS, CHIS Plus, and the Karunya Benevolent Fund into the Karunya Arogya Suraksha Padhathi (KASP), represents a decisive step towards a unified and equitable health financing system.

By adopting the assurance mode, we have ensured greater transparency, accountability, and fiscal prudence, while at the same time guaranteeing that no individual is denied access to life-saving treatment due to financial constraints. KASP has emerged not merely as an insurance programme, but as a people's protection scheme, embodying the constitutional values of equity and social justice.

Since its inception in 2021, the State Health Agency has enabled the government to deliver free treatment to over 25 lakh beneficiaries, with cumulative spending exceeding Rs. 8,000 crore. Importantly, nearly 90 percent of this funding has been borne by the State Government.

As Kerala moves steadily towards the vision of Universal Health Coverage (UHC), this book offers valuable insights into our achievements, challenges, and the road ahead.

I hope that this publication will serve as a guiding document for policymakers, health professionals, and researchers, and inspire further innovations in health system strengthening.

Pinarayi Vijayan

The Additional Chief Secretary
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Message

Smt. Veena George

Minister for Health & Family Welfare and
Woman & Child Welfare Development
Government of Kerala

Kerala has consistently demonstrated that health is a fundamental right and not a privilege. In line with this vision, the Government of Kerala consolidated all existing state-supported health protection schemes and launched the Karunya Arogya Suraksha Padhathi (KASP) in 2019, implemented by the State Health Agency (SHA) established in 2020. This integration brought efficiency, reduced duplication, and extended the reach of financial risk protection to millions of families.

The transition from the insurance mode to the assurance mode has been particularly transformative, resulting in improved service delivery, significant administrative cost savings, and greater trust among beneficiaries and healthcare providers. Importantly, KASP has been an enabling platform during public health emergencies such as the COVID-19 pandemic, ensuring timely access to care and effective coordination with the wider health system.

This book documents Kerala's health insurance journey in detail, highlighting both the opportunities seized and hurdles faced. It provides evidence-based perspectives on how health insurance can be an instrument for reducing out-of-pocket expenditure, ensuring equity, and strengthening health systems.

Through the services delivered by the State Health Agency (SHA), Kerala has been able to curb out-of-pocket health expenditure (OOPE) among its population. Analysis of average household health spending from the NSS 75th and 79th rounds shows a marked decline. In rural areas, average household expenditure fell from ₹17,054 to ₹10,929 (a reduction of about 36%), while in urban areas it dropped from ₹22,123 to ₹13,140 (around 41%). These trends indicate a significant easing of the financial burden on households due to improved access to publicly supported health services.

I extend my appreciation to the State Health Agency, partner institutions, and all stakeholders who have contributed to this initiative. I am confident that this publication will add significant value to ongoing policy discussions and will help Kerala, and indeed India, move closer to achieving the Sustainable Development Goal of Universal Health Coverage.

Veena George



Foreword

It is with great satisfaction that I pen this foreword to "Health Insurance in Kerala: Road Map to UHC, Opportunities and Hurdles."

The establishment of the State Health Agency (SHA) in 2020 marked a turning point in Kerala's health financing landscape. This institution was envisioned as a single umbrella body to bring together diverse and fragmented schemes—RSBY, CHIS, CHIS Plus, and the Karunya Benevolent Fund—into the Karunya Arogya Suraksha Padhathi (KASP). The consolidation was not merely an administrative reform but a strategic step to ensure efficiency, transparency, and most importantly, equity in access to healthcare.

As someone who had the privilege to work closely in conceptualizing and nurturing the SHA, I have witnessed how the dedicated efforts of our team transformed an idea into a robust institution. The adoption of the assurance mode, the expansion of empanelled hospitals, strengthened grievance redressal systems, and the seamless integration with national initiatives like AB-PMJAY, all reflect Kerala's commitment to innovation and inclusivity in health financing.

The journey was not without hurdles. Balancing fiscal sustainability, addressing the growing burden of non-communicable diseases, and ensuring equitable access across geographies and vulnerable communities continue to be pressing challenges. Yet, it is precisely through these challenges that Kerala has evolved as a model for cooperative federalism and people-centred health protection.

The transition from private Insurance to Assurance mode was discussed at the Government level. Based on the in-principle approvals by the Government, we took it up as a challenge. Dr Rathan Kelkar and Dr Bijoy and the team has taken huge efforts and done continuous follow ups to establish the administration, structures and processes and managed KASP efficiently. It is evident from the simple fact that crores of rupees have been saved through optimal administrative costs, which would otherwise have been paid to insurance agencies.

This book covers that journey with clarity and evidence, while also providing a direction for the road ahead. I congratulate the State Health Agency, experts, and partner institutions for this valuable contribution. It is my hope that the insights contained in these pages will inspire policymakers, administrators, and researchers alike in the pursuit of Universal Health Coverage (UHC).

Dr Rajan Khobragade IAS

Additional Chief Secretary
Health & Family Welfare and
AYUSH Department
Govt of Kerala.

Message



The State Health Agency (SHA) has been entrusted with the vital responsibility of ensuring equitable, accessible, and quality healthcare for all citizens in the State. This document showcases the commitment to strengthening health systems, advancing innovation, and delivering services to ensure well-being of every individual.

Through initiatives such as universal health coverage, emergency response services, and community-based programs, the SHA supports the prevention, awareness, and empowerment of the health system. This stands a testament to the dedication and sincere services of the health professionals, administrators, and partners to safeguard public health.

As we move forward, the SHA remains committed to building a healthier future with timely interventions, infrastructure, and community participation. This document will serve as a valuable resource for stakeholders, policymakers, and citizens in the journey towards a better health for all.

Dr. Arun S Nair IAS.

Executive Director

State Health Agency, Kerala

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Chapter 1

Introduction and Analytical Framework

1.1 Kerala's Policy Context and Health Achievements

Kerala has long stood out within India for its commitment to health and social welfare. The state's policy orientation has consistently prioritised education, public health, and social equity. This has translated into some of the best health indicators in the country: life expectancy of 75 years, an infant mortality rate of 4 per 1,000 live births, and maternal mortality well below the national average. These achievements are often described as the "Kerala model of development," where social investments yielded outcomes far ahead of states with comparable economic capacity.

Yet Kerala faces a paradox. Despite its strong public health infrastructure, the state's out-of-pocket expenditure (OOPE) remains the highest in India Rs.7889/- per capita in 2021-22, compared to the national average of Rs.2600/-. OOPE accounts for 59.1% of Kerala's total health expenditure, whereas government spending contributes just 32.5% (National Health Accounts, NHSRC, 2024). This reliance on household spending exposes many families to catastrophic health expenditure, pushing vulnerable groups into poverty. The challenge for Kerala is therefore not just about providing healthcare but ensuring that care is affordable, equitable, and financially sustainable.

1.2 Kerala's Health System and Financing Landscape

Kerala's health system is a mix of robust public facilities and an extensive private sector. The state runs over 1,300 public health institutions, including family health centres (FHCs), taluk hospitals, district hospitals, and medical colleges, which anchor preventive and primary care. At the same time, private hospitals provide secondary and tertiary care, accounting for more than 60% of all hospital beds.

This dual structure has advantages, such as choice for patients and a wide distribution of services, but it also complicates financing. Public hospitals are funded through government budgets, while private hospitals rely on fee for services and public and private health insurance schemes. The financing streams that sustain Kerala's health system include:

- State budget allocations (through the Department of Health & Family Welfare and social protection programmes).
- Central government contributions, particularly via National Health Mission and Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PM-JAY).
- Lottery-linked revenues, most notably the Karunya Benevolent Fund (KBF).
- Household spending

1.3 Health Insurance as a Financing Strategy

It is within this context that health insurance emerged as a key policy instrument in Kerala. Starting with Rashtriya Swasthya Bima Yojana (RSBY) in 2008, the state progressively expanded its coverage through schemes like CHIS, CHIS Plus, CHIS APL, SCHIS, and KBF. While these schemes extended financial protection, their coexistence led to fragmentation, duplication, and inefficiencies.

The breakthrough came in 2019, when Kerala launched the Karunya Arogya Suraksha Padhathi (KASP) by converging state-specific schemes with PM-JAY. Today, KASP covers over 42 lakh families (72.79 lakh individuals), nearly 40% of the state's population, making it the largest risk-pooling mechanism in Kerala's history.

The role of health insurance in Kerala's financing framework can be summarised as:

- Reducing OOPE by covering high-cost treatments such as cardiology, oncology, and nephrology.
- Pooling state and central resources, ensuring broader coverage than PM-JAY alone.
- Leveraging private sector capacity, with 630 of 834 empanelled hospitals belonging to private providers.
- Reinforcing quality and accountability through audits, accreditation, and patient safety protocols.
- Acting as a reform lever, shifting Kerala from insurance-company-led models to a trust-based purchaser system that prioritises value for money.

1.4 Analytical Framework of this Report

This book applies the Universal Health Coverage (UHC) cube as its central analytical framework. The three dimensions population coverage, service coverage, and financial protection, are used to evaluate Kerala's progress.

Population coverage: How many people are covered by insurance, who remains excluded, and how Kerala addresses the “missing middle.”

Service coverage: What health benefit packages are offered under KASP, and how they align with the disease burden and healthcare needs of Kerala’s population.

Financial protection: To what extent KASP and related schemes reduce OOPE and catastrophic expenditure, and how fiscal sustainability can be maintained.

The framework is complemented by analysis of institutional design, provider engagement, financing flows, and beneficiary experience, providing a comprehensive view of Kerala’s health financing architecture.

1.5 Thematic Areas Covered in the Book

The subsequent chapters build on this framework:

- Chapter 2: Evolution of KASP – traces Kerala’s journey from fragmented schemes like RSBY and CHIS to the integrated KASP, and examines the policy rationale behind convergence.
- Chapter 3: Implementation Mechanism – explains the shift from insurance mode to trust mode, outlines the purchaser-provider split, and describes the institutional structure of the State Health Agency (SHA).
- Chapter 4: Access and Utilisation – presents data on enrolment, empanelment, claim patterns, and hospitalisation rates, analysing how far KASP has expanded coverage and utilisation across districts.
- Chapter 5: Fiscal Space – assesses the state’s financial capacity to sustain KASP, including state-centre contributions, lottery-linked funding, and challenges posed by rising claim liabilities.
- Chapter 6: Way Forward – proposes reforms for improving population coverage, rationalising service packages, linking insurance with primary care, and ensuring financial sustainability.

1.6 Conclusion

Kerala’s health financing journey illustrates both opportunities and hurdles. The state has demonstrated political commitment by pooling resources and integrating schemes under KASP. Its trust-based implementation model and engagement with both public and

private providers represent important institutional innovations. Yet, the fiscal burden remains heavy. Kerala spends nearly ₹3,848 per family annually under KASP, while central support is capped at ₹631 per family, leaving the state to carry the bulk of costs. This book documents Kerala's experience, offering lessons for India and beyond. By situating Kerala's health financing reforms within the UHC framework, it highlights both the achievements—coverage expansion, integration, quality monitoring and the challenges such as fiscal strain, and sustainability concerns. The analysis sets out a roadmap for the next phase: ensuring that Kerala can translate its strong health outcomes into a financially sustainable, equitable pathway to Universal Health Coverage.

Chapter 2

Evolution of the KASP Scheme

2.1 The Genesis of Health Insurance in Kerala

The journey of publicly financed health insurance in Kerala began with the nationwide rollout of the Rashtriya Swasthya Bima Yojana (RSBY) in 2008. Introduced by the Ministry of Labour and Employment, Government of India, RSBY was conceptualized to provide financial protection against catastrophic health expenditures for families working in the unorganised sector. Its narrow focus on labour welfare, however, meant that the scheme was not designed to serve as a vehicle for universal health coverage (UHC).

The scheme was jointly implemented by Departments of Labour & Rehabilitation, Health & Family Welfare, Finance and Local Self Government. The Labour Department is the Nodal department for implementation of RSBY/CHIS. A Special Purpose Vehicle viz CHIAK, "Comprehensive Health Insurance Agency Kerala" registered under the provisions of Travancore-Cochin Literary, Scientific and Charitable Societies Registration Act of 1955 was created for the implementation of the scheme.

The state adopted the Planning Commission-approved Below Poverty Line (BPL) list as the eligibility criterion, which led to the initial coverage of 11.79 lakh families. The expenditure (premium) is shared at 75:25 ration between Centre and State government.

RSBY beneficiary families are entitled to get cashless health insurance coverage up to Rs.30,000/- per annum for inpatient treatment. Coverage extends to five members of the family which includes the head of household, spouse and up to three dependents. Almost all the diseases are listed and made in to a package with fixed rates. Pre-existing conditions are covered from day one and there is no age limit. Transportation charges are also covered upto a maximum of Rs. 1,000/- per annum with Rs. 100/- per visit. The scheme benefit is available to inpatient treatment only except a few pre-notified day care cases.

State Governments select the Insurance Company/Companies for implementing the schemes through an open tender process. The technically qualified lowest bidder is selected as the Insurer for running RSBY/CHIS for the next year in the State. During the first four years of the schemes, United India Insurance Company Ltd was the Insurance

partner in the Kerala. For the fifth and sixth years, Reliance General Insurance Company had implemented RSBY-CHIS in Kerala. For a short period of one-year, ICICI was also responsible for running the programme.

2.2 Expanding Coverage: The Birth of CHIS

It soon became apparent that the BPL list in use did not reflect the full spectrum of economic vulnerability in Kerala. A significant number of poor families were left uncovered, prompting the state government to introduce the Comprehensive Health Insurance Scheme (CHIS) as a supplementary programme. CHIS widened the eligibility criteria, allowing families with an income of less than ₹600 per month, as per ration card records, to enroll. Unlike RSBY, CHIS was fully funded by the state government and marked a decisive step toward inclusive health coverage. The digitisation of the enrolment process under CHIS further facilitated efficient targeting and expansion of coverage.

Over time, both the central and state governments expanded their respective schemes to include additional beneficiary groups. The central government extended RSBY to workers under the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) with at least 15 days of recorded work, as well as Scheduled Castes, Scheduled Tribes, street vendors, and quarry workers. Simultaneously, Kerala used its labour welfare boards to cover members of unorganised sectors such as fishermen, toddy tappers, auto and taxi drivers, and construction workers.

2.3 Supplementing Basic Coverage: CHIS Plus and Other Add-Ons

While the base sum insured under RSBY and CHIS was ₹30,000 per family for up to five members, the growing burden of non-communicable and high-cost diseases necessitated enhanced financial protection. In response, Kerala introduced CHIS Plus in 2011, which provided an additional ₹70,000 of coverage specifically for critical conditions such as cardiac and renal diseases, trauma care, cancer and other high-cost treatments. This benefit was available only at selected public and cooperative hospitals, acting as a gatekeeping mechanism and ensuring that state resources were channelled effectively.

In an attempt to open health coverage to the general population beyond workforce groups, Kerala launched CHIS APL (Above Poverty Line) in 2010. This allowed any citizen to voluntarily enrol by paying a premium directly to the insurance provider. Though more

than 1.6 lakh people enrolled in its first year, the programme suffered from low renewal rates. Adverse selection, where only the sick continued participation, led to financial non-viability, causing the scheme to gradually phase out.

At the national level, the central government introduced the Senior Citizens Health Insurance Scheme (SCHIS) as an additional layer of coverage for older adults within beneficiary households, offering ₹30,000 of supplemental coverage over and above the basic entitlement.

Summary of schemes and its benefit packages

Table 2.1 : Schemes and benefits

Scheme	Beneficiary	Benefits
RSBY	BPL as per planning commission and 10 other unorganized occupational categories	Free inpatient care worth Rs. 30,000 per family for maximum 5 members annually
CHIS	57 State identified categories	
SCHIS	RSBY/CHIS beneficiaries who are 60 yrs and above age	Free inpatient care worth Rs. 30,000 for each senior citizens in a family
CHIS Plus	RSBY/CHIS card holders	Additional top up cover of Rs. 70,000 every year for ailments of Brain, Heart, Liver and Kidney, Cancer and Accident & Trauma care through selected Government Hospitals.

In RSBY, 75% of the premium is met by the Central Government and 25% by State Government while under CHIS, the State Government bears 100% premium. The beneficiary pays Rs.30/- towards registration fees/family in both cases. In case of APL, the beneficiary bears the premium amount as well as registration fees.

A summary of the coverage, premium paid and utilisation for the period October 2008 to March 2019 is given below.

Table 2.2: Year wise beneficiary enrolment, premium and claims.

Year	Total number of beneficiaries covered (in lakhs)	Premium per family (Rs.)	Total Claims	
			Count in Lakh	Amount in Cr
2008-10	11.78	506/-	1.43	45.00
2010-11	18.75	464/-	3.6	113.00
2011-12	28.01	748/-	6.98	212.00
2012-13	28.28	1100/-	7	181.00
2013-14	29.73	738/-	5.57	199.03
2014-15	31.94	738/-	5.87	228.06
2015-16	31.94	678/-	5.26	205.86
2016-17	32.53	558/-	5.86	267.42
2017-18	34.85	738/- + 182/-*	7.08	314.14
2018-19	40.96	738/- + 182/-*	8.08	367.71

* Additional premium of Rs.182/- for SCHIS families

2.4 Expansion of Health Financing Through Departmental Initiatives

The introduction of RSBY and CHIS in Kerala marked a major turning point in the landscape of publicly funded health insurance. These schemes not only extended financial protection to the unorganised sector but also catalysed broader interest in health financing across government departments. The visible impact and popularity of RSBY and CHIS encouraged several other departments—beyond the Department of Labour and

Health—to initiate their own targeted programmes, aiming to fill coverage gaps and respond to the unique health needs of specific population groups.

This wave of innovation led to the rollout of several noteworthy schemes. Among the most prominent was the **Karunya Benevolent Fund (KBF)**, launched in 2011–12 by the Department of Finance. Supported by revenue from the state-run Karunya and Karunya Plus lotteries, the fund provided up to ₹3 lakh per family for treatment of major illnesses such as cancer, cardiovascular and kidney diseases, cerebrovascular conditions, haemophilia, and palliative care. These benefits were made available through both public and select private hospitals.

Similarly, the Social Justice Department and Kerala Social Security Mission launched schemes like Sruthitharangam, which supported cochlear implant surgeries for children with hearing impairments. Other schemes include Thalolam, Sukrutham, Cancer Protection Scheme and Arogya Kiranam. Detailed benefit packages for each scheme are attached in **Annexure 1**.

While these programmes were born out of a genuine intent to improve health equity and responsiveness, the proliferation of independently administered schemes gradually gave rise to systemic challenges. In the absence of a unified regulatory framework or coordinated governance, issues such as duplication of beneficiaries, overlapping benefit packages, disconnected technology systems, and fragmented fund flows began to emerge. These inefficiencies not only strained administrative resources but also created confusion for beneficiaries and limited the potential for strategic purchasing and comprehensive care.

2.5 The Case for Integration

Kerala's commitment to equity and financial protection in healthcare prompted a reassessment of its fragmented insurance architecture. Despite notable successes in expanding coverage, the siloed approach posed structural limitations. Multiple schemes meant duplicated administrative expenses, conflicting coverage rules, and lack of continuity in care. Patients with chronic or complex conditions often fell through the cracks of disconnected schemes, and data from various systems could not be effectively integrated to drive planning or policy.

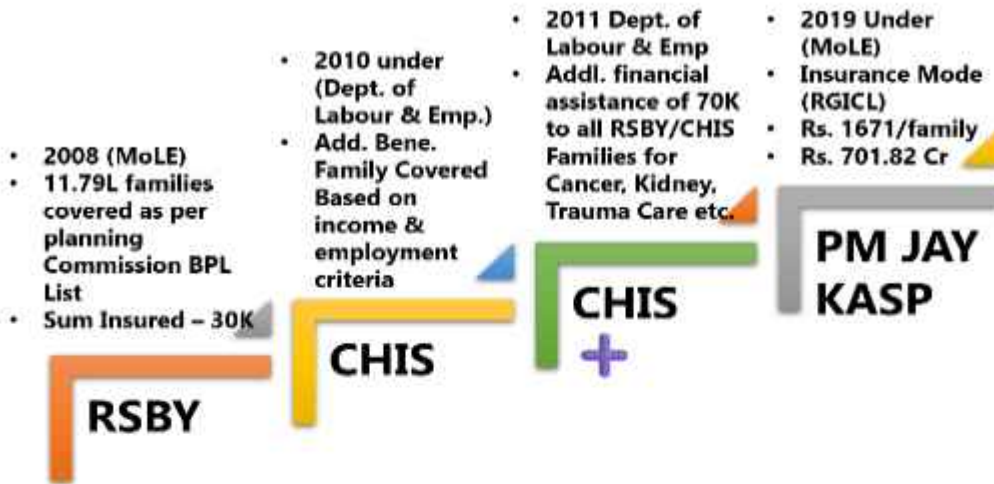
Recognizing these challenges, the Government of Kerala initiated a comprehensive convergence process. In 2018, a state-level expert committee was constituted to assess the implications of joining the centrally sponsored Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY). The committee was also tasked with exploring the integration of Kerala's multiple state-financed schemes into a unified model that could enhance efficiency, equity, and scalability. The committee proposed convergence of existing schemes into a unified programme with single implementation agency and unified benefit package.

2.6 The Formation of Karunya Arogya Suraksha Padhathi (KASP)

A significant policy shift at the national level also accelerated this transition. In 2015–16, the central government transferred the implementation of RSBY from the Ministry of Labour to the Ministry of Health & Family Welfare, with the intent to widen the focus beyond unorganised sector workers and move towards universal health coverage. This paved the way for the launch of Ayushman Bharat PM-JAY in 2018, which offered expanded benefits (Rs.5 lakh coverage, and over 1,500 treatment packages), real-time digital claim processing, and automatic enrolment based on the Socio-Economic and Caste Census (SECC) 2011.

Kerala though hesitant initially due to low central share of expense, later joined this shift based on the recommendation of the expert committee formed for studying the convergence of publicly funded health financing programmes and signed a Memorandum of Understanding (MoU) with the National Health Authority (NHA) for the implementation of a converged model. On April 1, 2019, the state formally launched Karunya Arogya Suraksha Padhathi (KASP), bringing together the previously fragmented programmes, RSBY, CHIS, CHIS Plus, KBF, and others—under a unified umbrella scheme. CHIAK, which had experience in implementing earlier schemes, was retained as the State Health Agency to implement KASP.

Diagram 2.6.1: Evolution of health financing schemes in Kerala



KASP aligned closely with PM-JAY in terms of benefit design, hospital empanelment norms, package pricing, and technology platforms. However, Kerala continued to contribute additional funding to ensure the inclusion of vulnerable populations that were outside the SECC list, thereby maintaining its commitment to universalism. KASP became a model of cooperative federalism where both Centre and State pooled resources, shared infrastructure, and harmonized systems for better health outcomes.

KASP marked a transition not only in administrative structure but also in the underlying philosophy of health financing in Kerala. By adopting strategic purchasing practices, using pooled funds to buy services from empanelled providers based on quality and efficiency, the scheme sought to maximize value for public spending. The implementation of a robust Transaction Management System (TMS) enabled greater transparency in claims processing, audit trails, and performance monitoring.

The integration process also spurred improvements in digital infrastructure, including linkages with the Ayushman Bharat Digital Mission (ABDM), eHealth systems, and real-time analytics. These enabled better targeting, faster reimbursements, and more strategic use of health data.

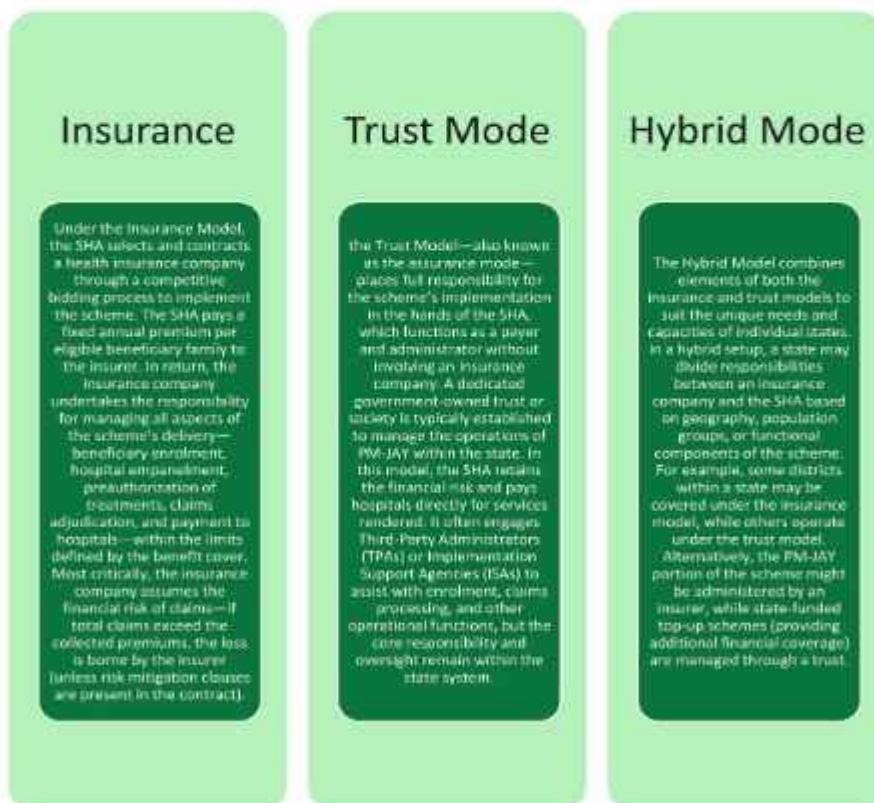
Chapter 3

Implementation Mechanism at the State

3.1 Risk Arrangement / Implementation Models under PM-JAY: Insurance, Trust, and Hybrid Approaches

The Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PM-JAY) was designed as a flexible framework that allows states to select from different implementation models based on their administrative capacities, financial management capabilities, and policy priorities. To operationalize the scheme across India’s diverse landscape, the National Health Authority (NHA) permitted three principal models: the Insurance Model, the Trust Model, and the Hybrid Model. Each model has distinct implications for financial risk-sharing, operational control, and integration with existing health systems.

Diagram 3.1.1 : Implementation models in AB PM-JAY



This **Insurance** model is attractive to states that may not yet have developed the institutional capacity or technical expertise to manage a large-scale health assurance program. By outsourcing the risk and many administrative functions to an experienced insurance provider, states can ensure rapid deployment and scalability. However, this model also limits the SHA's direct control over operational aspects and introduces the risk of under-servicing by insurers attempting to minimize claims outgo. Moreover, administrative costs tend to be higher due to insurer margins.

The **Trust** model allows states to exercise much greater control over the scheme, ensuring that processes are aligned with local public health goals and systems. It is cost-effective in the long run because it eliminates insurer profits and provides flexibility in managing claims and provider networks. However, it requires robust institutional mechanisms, skilled personnel, and sound financial forecasting and risk management capabilities. Only those states with sufficient administrative and technical capacity are well-suited to operate under this model effectively.

The **Hybrid** approach provides flexibility for states to leverage the operational efficiency and risk absorption capacity of insurance companies in areas where state capacity is weak, while simultaneously building trust-based models in areas with stronger institutional frameworks. It also allows for experimentation and learning, enabling states to gradually transition toward trust models over time. However, the hybrid model is operationally complex, requiring clear delineation of responsibilities, rigorous data sharing protocols, and careful coordination across multiple implementing entities.

3.2 State-Level Preferences and Transitions

Over time, several states have transitioned from insurance to trust models as they built internal capacity and became more confident in managing health financing mechanisms. For instance, Kerala and Tamil Nadu, which initially experimented with insurance-based approaches, now run PM-JAY entirely through their respective state health trusts. Meanwhile, states like Gujarat and Odisha continue to operate under hybrid models, blending insurance-based and trust-based components to manage both PM-JAY and their own state-specific health protection schemes.

As of July 2025,¹ Dadra and Nagar Haveli, Daman and Diu, Jammu and Kashmir, Lakshadweep, Meghalaya and Rajasthan are running in insurance mode. Gujarat, Jharkhand, Tamil Nadu and Maharashtra are implementing in Hybrid Model. Remaining 24 States including Kerala are implementing in Trust Mode.

The implementation model chosen by each state under PM-JAY reflects a balance between operational feasibility, financial risk appetite, and the ambition to build sustainable, state-owned health assurance systems. While the insurance model provides a quick route to implementation with minimal risk to the government, the trust model offers long-term sustainability and alignment with public health systems. The hybrid model serves as a transitional or adaptive pathway, accommodating both flexibility and phased institutional strengthening. Each model carries its own trade-offs, and the choice among them must be informed by the state's capacity, governance frameworks, and commitment to achieving universal health coverage.

3.3 Institutional Structure of PM-JAY at National, State, and District Levels

The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) is one of the world's most ambitious government-funded health financing initiatives. To successfully implement a scheme of such scale, complexity, and ambition, a structured and sustainable institutional architecture has been embedded within its very design. The institutional framework of PM-JAY is built across three tiers (national, state, and district) each with specific roles, functions, and interlinkages. These institutions are supported by clearly defined systems of governance, staffing structures, and accountability mechanisms.



1. **National Level: National Health Authority (NHA):** At the national level, the scheme is led by the National Health Authority (NHA), an autonomous body restructured from the National Health Agency in 2019. Chaired by the Union

¹ <https://pmjay.gov.in/states/states-glance> retrieved on 8th July 2025

Health Minister, the NHA is managed by a CEO, Deputy CEO, and Executive Directors overseeing key functions.

The NHA provides strategic leadership, develops operational guidelines, manages core IT systems such as the Beneficiary Identification System (BIS) and Transaction Management System (TMS), and ensures data privacy and compliance. It fosters partnerships with states, insurers, and development partners and is also responsible for national-level capacity building, knowledge management, and cross-state learning. It manages fraud prevention, grievance redressal systems, and national audits.

2. **State Level: State Health Agencies (SHAs):** Each state establishes a State Health Agency (SHA) to implement PM-JAY. These may be new or adapted from existing insurance trusts. The SHA is governed by a council chaired by the Chief Secretary and led operationally by a CEO.

SHAs adapt national policies to state needs, integrate local health insurance schemes with PM-JAY, and manage hospital empanelment, beneficiary verification, claims processing, and IEC activities. They also oversee fraud control, grievance management, and capacity building. Financial management, including fund disbursement through escrow accounts, is a key function. The SHA team typically includes experts in policy, IT, finance, medical management, and training.

3. **District Level: District Implementation Units (DIUs):** At the district level, PM-JAY is implemented through District Implementation Units (DIUs), usually headed by a District Nodal Officer. DIUs ensure last-mile service delivery, liaise with empanelled hospitals, oversee beneficiary registration, handle grievances, and monitor claims and service utilization.

DIUs may include programme coordinators, IT managers, grievance officers, and medical officers. They conduct field training for Arogya Mitras placed in the hospitals and ensure regular reporting to SHAs, contributing to scheme refinement based on grassroots realities.

4. Cross-Cutting Mechanisms

- Specialized committees strengthen governance at all levels:
 - Empanelment Committees vet and approve healthcare providers.
 - Grievance Redressal Committees (GRCs) function at national, state, and district levels with defined timelines and escalation procedures.

- Capacity Building Architecture enables continuous training through national ToTs and state/district master trainers.
- Knowledge Management Units document best practices and promote peer learning.

The PM-JAY institutional structure is a decentralized, tiered system built to deliver large-scale health protection efficiently. It balances national oversight with state-level adaptation and district-level execution. This architecture ensures resilience, accountability, and responsiveness, driving India's progress toward Universal Health Coverage.

3.4 Implementation Model in Kerala and Its Evolution

The implementation of the Karunya Arogya Suraksha Padhathi (KASP), the state-specific version of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY), has undergone a significant institutional and operational transformation since its inception. The agreement between the Government of Kerala and the National Health Authority (NHA) for implementing KASP was signed on 31st October 2018. The scheme became operational across the state from 1st April 2019.

Initially, the Comprehensive Health Insurance Agency of Kerala (CHIAK)—the agency responsible for managing earlier health insurance schemes such as RSBY, CHIS, and CHIS Plus—was entrusted with implementing KASP. CHIAK continued to function as the implementing agency until the formation of a dedicated State Health Agency (SHA). As per the Government Order (Ms).3/2020/H&FWD dated 10th January 2020, the SHA was established specifically to oversee the implementation of PM-JAY and KASP. With this development, all responsibilities related to KASP and PM-JAY were formally transferred to SHA, while CHIAK continued to manage legacy schemes and issues related to RSBY, CHIS, and CHIS Plus.

3.5 Transition from Insurance to Trust Mode in Kerala

In its initial phase, the implementation of KASP followed an insurance model. A private insurance company was selected through an open tendering process and assigned the task of administering the scheme, including claims settlement and beneficiary management. After running the mass government health financing scheme in insurance mode for more than 10 years, the State Government made a conscious decision to move

from insurance mode to assurance mode. The outcome of this action has positively benefited the beneficiaries in terms of increased accessibility, and the government in terms of maximum return on investment. 3.6 Improvements Under Assurance Mode

The result of transitioning from insurance to trust mode are as follows

1. **Expansion of Empanelled Hospitals:** Following the transition, the State Health Agency (SHA) conducted a comprehensive analysis of hospital availability across different geographies. Gaps were identified and addressed by proactively engaging potential providers. As a result of these transparent and targeted efforts, the number of private hospitals empanelled under the scheme increased by 151%, growing from 216 during the insurance period to 544 in the assurance period.
2. **Awareness and Community Engagement:** SHA implemented extensive Information, Education, and Communication (IEC) initiatives. These included:
 - Collaborations with community-based organizations
 - Partnerships with other government departments
 - Targeted campaigns to inform the public about scheme benefits and entitlements

These efforts contributed to **greater public awareness** and utilization of services.

3. **Strengthened Grievance Redressal:** SHA enhanced the grievance redressal mechanisms to reduce friction between beneficiaries, hospitals, and the payer. This improvement led to:
 - Higher satisfaction among stakeholders
 - Better quality of services delivered
4. **Increased Beneficiary Footfall:** The assurance mode empowered beneficiaries with improved freedom of choice and accessibility. This resulted in a significant increase in utilization, with footfall rising from 4,72,399 individuals in FY 2019–20 to 5,41,233 individuals in FY 2021–22. Contributing factors included:
 - Rational package rates
 - Reduced friction at the facility level
 - Increased availability of empanelled hospitals
5. **Financial Flexibility and System Resilience:** In insurance mode, advance premium payments were required. Delays in payment led to suspension of

services by insurance companies. In trust mode, payments are made post-service delivery, improving cash flow management for the government.

SHA maintained provider confidence and avoided service disruption even during intermittent payment delays.

6. **Stronger Public-Private Trust:** The trust established between SHA and private providers was a major enabling factor for program stability and flexibility under the assurance model.
7. **Leveraging Trust Mode During COVID-19:** The trust model enabled full integration of KASP into the state's COVID-19 management strategy, including:
 - Real-time monitoring of bed and oxygen availability
 - Coordination with COVID control rooms
 - Support for patient triaging and referrals

Vaccination Drive: SHA leveraged its network of empanelled hospitals (over 550 private hospitals) to implement a wide-reaching COVID-19 vaccination campaign, further highlighting the strategic value of trust-mode implementation

3.6 Financial Benefits of Transition to Trust Mode: Reduction in Administrative

Costs One of the significant advantages of transitioning from the insurance mode to the trust mode under the Karunya Arogya Suraksha Padhathi (KASP) has been the substantial reduction in administrative expenses. Under the insurance model, administrative costs typically range between 8% and 12% of the total claims. In contrast, the State Health Agency (SHA) operating under the trust model has maintained an annual administrative budget of less than ₹5 crore consistently.

The table below compares the total claims raised each year with the estimated administrative cost at a conservative rate of 8%, the lower end of the insurance model's range:

Table 3.6.1: Administrative cost savings in Trust mode

Financial Year	Total Claim Raised (in Cr)	Administrative Cost @8% (in Cr)	Actual SHA expenditure per Annum in Crores	Approximate Savings in Cr.
2020-21	646.05	51.68	2.35	49.33
2021-22	1563.55	125.08	4.7	120.38
2022-23	1695	135.6	5.26	130.34
2023-24	1724.98	138	5.03	132.97
2024-25	1592.13	127.37	5.27	122.1
Total	7221.71	577.74	22.6	555.14

This conservative estimate shows that Kerala has saved over Rs.400 crore in administrative costs over four years by moving away from the insurance mode. The trust model, by enabling in-house claim management and reducing dependency on insurance intermediaries, has proven to be a financially prudent strategy.

Chapter 4

KASP Scheme Assessment in the Context of Access and Utilization of Healthcare Services

4.1 Introduction

This chapter presents an analytical overview of Kerala's progressive efforts towards achieving Universal Health Coverage (UHC), using the UHC Cube as a guiding framework. It examines key dimensions—population coverage, service coverage, and financial protection—to assess how the state is advancing access, equity, and affordability in healthcare. Drawing on data from financial years 2020 to 2025, the chapter evaluates services, trends in service utilization, provider distribution (public and private), and beneficiary reach under state insurance schemes KASP and other supportive programs. Through this lens, the chapter highlights Kerala's strategic approach in expanding the depth and breadth of healthcare access and its alignment with the core principles of UHC.4.1 Introduction: Advancing Universal Health Coverage in India and Kerala.

All UN Member States have signed up to the Sustainable Development Goals (SDGs) including target 3.8: “achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all (United Nations, SDG, , 2015). In the context of India, achieving Universal Health Coverage (UHC) is particularly challenging yet critically important, given the country's vast and socio-economically diverse population of over 1.4 billion people (WorldBank, 2023). India is making significant strides toward achieving the Sustainable Development Goal (SDG) targets, particularly universal health coverage (UHC), through large-scale health financing reforms, the expansion of social protection schemes including PM-JAY, and sustained efforts to improve equitable access to quality healthcare across its diverse and socio-economically varied population.

A significant barrier to UHC in India has been inadequate health financing, with out-of-pocket expenditure accounting for a substantial portion of total health spending, often pushing vulnerable households into poverty (National Health Accounts, 2023). Considering India's deep social, regional, and economic disparities, such inclusive health financing strategies are essential to ensure equitable access to health services and reduce

the financial burden on low-income groups. Strengthening health financing, expanding social safety nets, and effectively implementing schemes like PM-JAY are pivotal for India to move closer to achieving SDG target 3.8 and ensuring no one is left behind in its UHC journey.

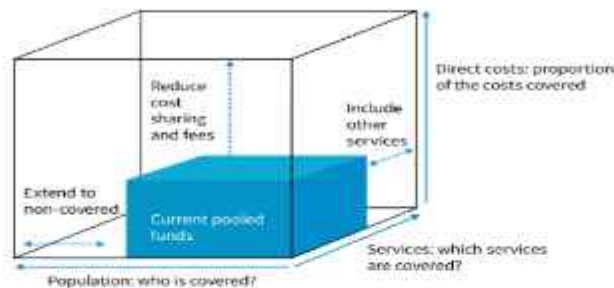
Kerala, with a population of over 35 million (Census of India, 2011) has been a frontrunner in progressing toward Universal Health Coverage (UHC) by leveraging its robust public health infrastructure and prioritizing inclusive social protection strategies. The state's population is marked by significant socio-economic and demographic diversity, including Scheduled Castes (SC), Scheduled Tribes (ST), Socially and Educationally Backward Classes (SEBC), coastal communities, and migrant populations, all of whom face unique health access challenges (Centre for Development Studies Kerala 2021). To bridge these gaps, Kerala has effectively implemented the Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PMJAY) in convergence with the Karunya Arogya Suraksha Padhathi (KASP), thereby expanding coverage and deepening financial risk protection over 42 Lakhs poor and vulnerable families (approximately 64 lakhs beneficiaries) that form the bottom 40% of the Kerala population (State Health Agency Kerala, n.d.).

The State of Kerala has converged all the Government sponsored health care schemes namely RSBY (Central and State Government combined scheme, where the premium is shared in the ratio 60:40), Comprehensive Health Insurance Scheme-CHIS (Kerala government fully sponsored scheme i.e. full premium paid by the State), Senior Citizen Health Insurance Scheme-SCHIS (all the senior beneficiaries aged 60 years and above in the RSBY/CHIS families were provided additional coverage of Rs 30,000 per beneficiary) and Karunya Benevolent Fund-KBF (Trust model implemented through Lottery department) along with Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PMJAY) and formulated Karunya Arogya Suraksha Padhathi (KASP) (State Health Agency Kerala, n.d.). The scheme is efficiently administered by the State Health Agency (SHA), Kerala, which has institutionalized transparent empanelment of both public and private hospitals, streamlined preauthorization processes, and strengthened grievance redressal mechanisms to ensure timely, cashless, and equitable service delivery (State Health Agency Kerala-Annual report, 2023-2024). By integrating national and state-level social protection frameworks and focusing on last-mile delivery, Kerala has positioned itself as

a model for health equity, demonstrating a strong commitment to achieving Sustainable Development Goal (SDG) target 3.8 and ensuring that even its most vulnerable populations are not left behind in the journey toward UHC.

4.2 Kerala's Strategy Towards UHC: Addressing the Dimensions of the UHC Cube

Figure 4.2.1 The UHC Cube



Universal Health Coverage (UHC) has been defined by the World Health Organisation (WHO) as ensuring that “all people obtain the health services they need without suffering financial hardship when paying for them. The three dimensions of UHC (population coverage, package of services provided, and level of financial protection) are often represented through the UHC cube .(Figure 4.2.1). (WHO Principles of Health Benefit Packages, 2021).

The assessment of Kerala's approach towards achieving Universal Health Coverage (UHC) is understood using the widely accepted UHC Cube framework, which emphasizes three critical dimensions: population coverage, service coverage, and financial protection (WHO, 2010). This framework provides a comprehensive lens to systematically analyze how Kerala's health financing model, particularly through the implementation of the Karunya Arogya Suraksha Padhathi (KASP) under the PM-JAY umbrella, is addressing these key dimensions. By aligning Kerala's performance with the UHC Cube, this assessment seeks to understand the extent to which the state has succeeded in ensuring equitable access to essential health services while offering adequate financial risk protection for its diverse population.

4.3 The Population Coverage: Assessing the reach of Insurance Protection

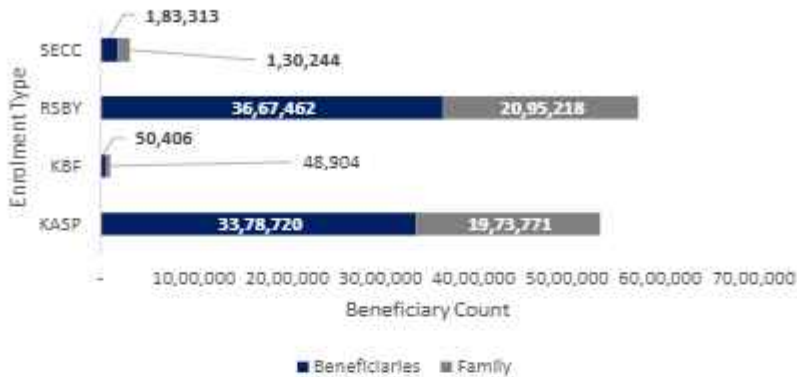
This section provides an overview of overall enrolment, year-wise new enrolment, and demographic details of beneficiaries across various schemes, primarily addressing the “population coverage” dimension of the UHC Cube. It highlights the extent to which different segments of the population are included under the health protection umbrella, reflecting Kerala’s progress in ensuring equitable access to healthcare.

4.3.1 Overall Beneficiary Enrolment-KASP

Kerala, with an estimated population of over 35 million as of 2024, represents one of India’s most advanced demographic transitions. According to the Census of India (2011), the state had a total population of 33.4 million, with females constituting 52% and males 48%, and a sex ratio of 1,084 females per 1,000 males, the highest among Indian states (Census of India Provisional Population Totals – Kerala, 2011). Kerala’s population growth has significantly slowed, with a decadal growth rate of just 4.9% between 2001 and 2011, far below the national average (Kerala State Planning Board Economic Review, 2023). Age-wise, Kerala is witnessing a clear shift toward an aging population, with a rising proportion of people aged 60 years and above, and a consistent decline in the child population. The state’s Total Fertility Rate (TFR) has remained below the replacement level for over two decades, positioning Kerala firmly in the final stage of the demographic transition characterized by low fertility, low mortality, and increasing life expectancy (CSES, 2022).

Across all schemes, a total of 72.79 lakh beneficiaries and 42.48 lakh families are actively enrolled in Kerala. This includes KASP with Around 33.8 Lack beneficiaries and 1.97 million families, KBF with 50,406 beneficiaries and 48,904 families, RSBY with 3.67 million beneficiaries and 2.10 million families, and SECC with 183,313 beneficiaries and 130,244 families. This is approximately of 46% of total households. **Figure-4.3.1.1** illustrates the enrolment of total beneficiaries and households through different categories of enrolment..

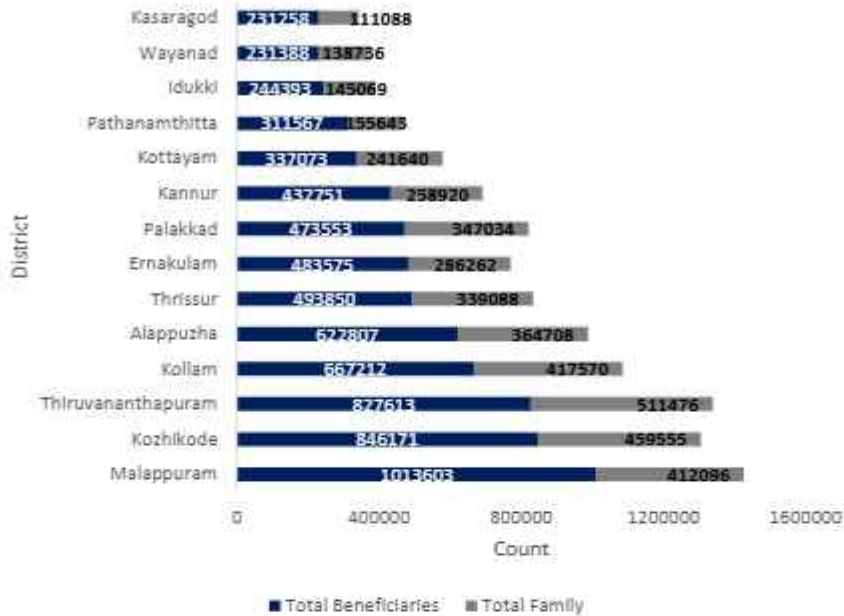
Figure 4. 3.1.1 Total beneficiary enrolment till date through different categories of enrolment



Data Source: State Health Agency-Kerala-Beneficiary Enrolment Statistics

The district-wise enrolment on different schemes is presented in **Figure-4.3.1.2**. The district-wise beneficiary enrolment data across the financial year 2020-2025 indicate that a total of 42,48,137 families and 72,79,901 individual beneficiaries have been enrolled across the state, reflecting wide program coverage. Thiruvananthapuram leads in family enrolment with 5,11,476 registered families, while Malappuram accounts for the highest number of beneficiaries at 10,13,603; suggesting larger household sizes and greater individual coverage in the district. Districts such as Kozhikode, Kollam, and Alappuzha also show substantial enrolment both in terms of families and individual beneficiaries, highlighting the program's strong uptake in densely populated regions. In contrast, less populated districts like Wayanad and Kasaragod reported comparatively lower enrolment figures, aligning with their smaller population base but still indicating significant reach within those communities. The figure-4.3.1.2 illustrates district-wise overall enrolment status.

Figure 4.3.1.2 District-wise Total Beneficiary Enrolment status (KASP, SECC,RSBY)



****There are 63,087 beneficiaries and 59,252 families with unspecified district information, most of whom are enrolled under the KBF scheme**

Data Source: State Health Agency-Kerala-Beneficiary Enrolment Statistics

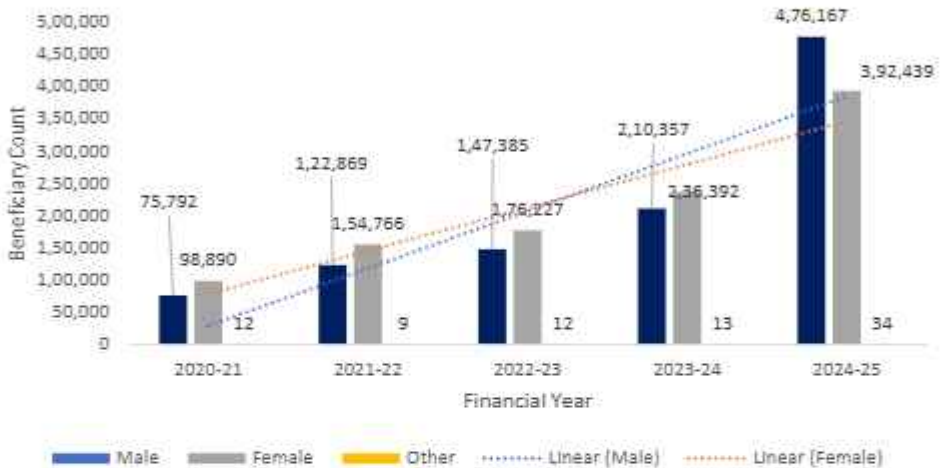
Districts like Malappuram, Kozhikode, and Thiruvananthapuram together account for a significant share of the total 7.28 million beneficiaries under KASP, reflecting both large population bases and active enrolment. Given Kerala's population of around 35 million, this coverage represents roughly 21% of the population, meaning one in five residents is enrolled in the scheme. This indicates substantial penetration across the state. The high concentration of beneficiaries in northern districts such as Malappuram and Kozhikode can help guide resource allocation, while districts with lower absolute numbers, including Wayanad, Kasaragod, and Idukki, highlight areas where enrolment has been relatively lower.

4.3.2 Year-wise New Enrolments

Year-wise new enrolment under KASP reflects Kerala's continued efforts to expand health coverage, particularly among vulnerable populations as it showing an increasing

trend (Figure 4.3.2.1). The increasing trend in enrolment can be due to the growing awareness, improved outreach, and enhanced inclusion, contributing significantly to the population coverage dimension of the UHC Cube and reinforcing the goal of equitable access to healthcare.

Figure 4.1.2.1 New Beneficiary Enrolment by Gender Across Years



Data Source: National Health Authority (NHA) Dashboard.

The new beneficiary enrolments under the scheme have shown a consistent year-on-year increase (Figure 4.3.2.1), demonstrating the growing reach of the programme. The enrolment figures rose from 174,694 beneficiaries in 2020-21 to 8,68,640 beneficiaries in 2024-25.

Gender-wise, the data reflects a steady increase across all categories, with male enrolments increasing from 75,792 to 476,167 and female enrolments rising from 98,890 to 3,92,439 during the same period. While the enrolment of individuals from the 'Other' gender category remains lower in absolute numbers, this growth pattern highlights the scheme's expanding coverage and its focus on reaching diverse population groups within the state.

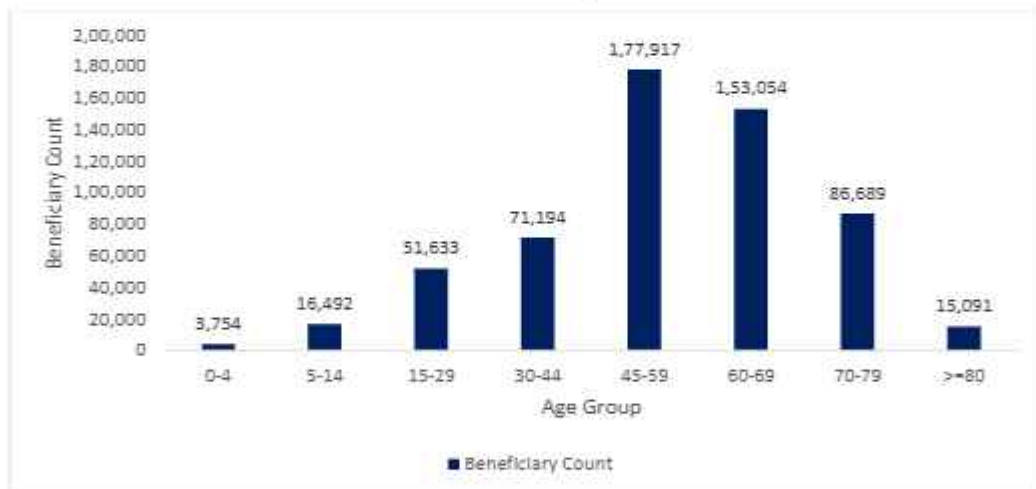
The new enrolments have also been increasing, showing a clear upward trend. This growth in beneficiary numbers underscores the need to address premium pooling requirements, as both the expanding total coverage and the rising pace of new

enrolments will place greater demand on financial resources to sustain the scheme's commitments.

4.3.3 Current Active Beneficiary Base-All Schemes provided through the State Health Agency

Active beneficiaries are those who have raised a claim during the financial year. The active beneficiary count serves as a key indicator to assess the effectiveness of enrolment retention and the ongoing access to health services, reflecting the depth of population coverage through various schemes including KASP, KBF etc. There is a year-on-year increase in active beneficiaries under Kerala's health protection schemes since the program inception is noted and it reflects the state's sustained commitment to advancing Universal Health Coverage (UHC) and the continued reach and impact of these schemes

Figure 4.3.3.1 -Age Group-wise Active Beneficiary - Financial Year 2024-2025 (Under All Scheme)



Data Source: State Health Agency-Kerala-Beneficiary Enrolment Statistics

The active beneficiary count for the financial year 2024–2025, (Figure 4.3.3.1) shows that the highest number of beneficiaries are in the 45–59 age group (1,77,917), followed by the 60–69 age group (1,53,054) and the 30–44 age group (71,194). The distribution is comparatively lower in the younger and oldest age brackets, with 3,754 beneficiaries in the 0–4 age group and 15,091 in the 80 and above category. This distribution highlights that scheme utilization is predominantly concentrated among the middle-aged and early

senior population, likely due to increased health needs and eligibility across multiple programs in these age groups.

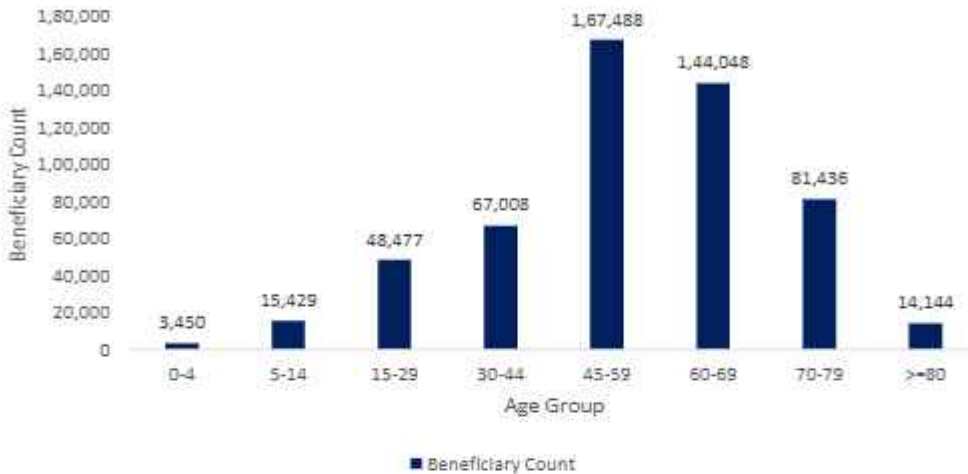
The consistent increase in beneficiaries, particularly within the 45–59 and 60–69 age groups, also aligns with Kerala’s epidemiological transition towards a higher burden of non-communicable diseases, underscoring the responsiveness of the scheme to population health needs. Importantly, the growing coverage among children and adolescents indicates improved scheme accessibility across life stages and supports Kerala’s efforts to ensure broad-based social protection. These trends collectively reflect the state’s strategic focus on expanding the population coverage dimension of the UHC cube, with an emphasis on equitable inclusion and financial risk protection.

4.3.4 Current Active Beneficiary Base-KASP-PMJAY

Between FY 2020–2021 and FY 2024–2025, the number of active beneficiaries under AB-PMJAY-KASP witnessed a substantial increase, rising from approximately 2.6 lakh to over 5.4 lakh. This upward trend can be due to the enhanced outreach efforts, growing public awareness, and improved enrolment mechanisms over time which is implemented by the State Health Agency (SHA) Kerala. The gender distribution for FY 2024–2025 shows a higher proportion of female beneficiaries (2.95 lakh) compared to males (2.45 lakh), reflecting gender-responsive health coverage. Notably, the inclusion of transgender beneficiaries also underscores Kerala’s commitment to equity and inclusivity in health service delivery. *(Source: NHA Dashboard).*

The active AB-PMJAY-KASP beneficiaries in Kerala across financial years highlights a dynamic pattern of scheme utilization, reflecting both Kerala’s demographic realities and evolving health system outreach. The active beneficiary base steadily expanded from FY 2020–2021, peaking in FY 2022–2023 with over 6,26,000 active beneficiaries, before witnessing a marginal decline in FY 2023–2024 and FY 2024–2025. Age-wise, the scheme consistently achieved the highest coverage among the 45–59 and 60–69 age groups, indicating that middle-aged and older populations remain the primary users of the scheme, in alignment with Kerala’s high burden of non-communicable diseases and aging population structure.

**Figure 4.3.4.1 Age Group-wise Active Beneficiary – Financial Year 2024-2025-
under KASP**



Data Source: State Health Agency-Kerala-Beneficiary Enrolment Statistics

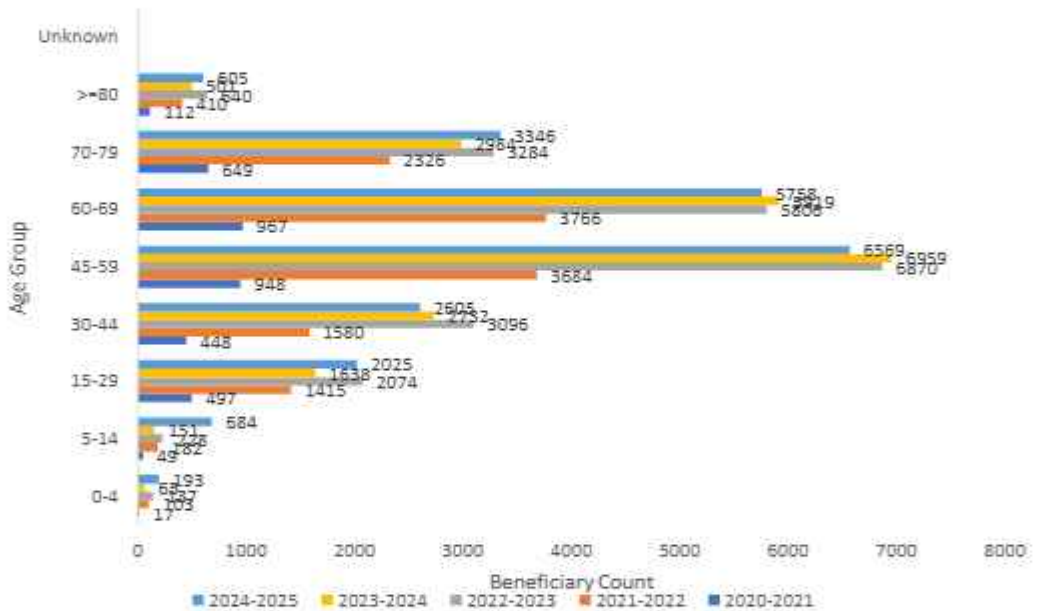
In FY 2024–2025, the scheme recorded 1,67,488 beneficiaries in the 45–59 age group, followed by 1,44,048 in the 60–69 group, and 81,436 among 70–79-year-olds (**Figure 4.3.4.1**). The working-age population also remains significantly represented, with 67,008 beneficiaries in the 30–44 age group and 48,477 in the 15–29 age group. Notably, the 5–14 age group saw a sharp increase to 15,429 beneficiaries in 2024–2025, compared to just 4,479 the previous year, indicating improved coverage among younger populations. The coverage among children and adolescents, particularly in the 5–14 years age group, showed a noticeable increase in FY 2024–2025, suggesting improved outreach to younger populations.

Gender-wise, female beneficiaries consistently outnumbered males across all years, underscoring the state's sex ratio and gender-responsive nature of Kerala's health protection efforts. Although the inclusion of transgender beneficiaries remains limited, the gradual increase in their enrolment reflects Kerala's broader commitment to social inclusion. Overall, these trends reflect Kerala's progressive strides towards population's financial protection.

4.3.5 Year-wise Growth of Active Karunya Benevolent Fund (KBF) Beneficiaries

The Karunya Benevolent Fund (KBF) is a state-sponsored health initiative launched by the Government of Kerala to provide financial assistance for life-saving treatments through the revenue generated from Kerala State Lotteries. KBF is designed to reduce the financial burden on poor families who may otherwise struggle to access high-cost medical care economically disadvantaged patients. The scheme primarily supports treatments such as cancer care, cardiac surgery, kidney transplantation, and other chronic disease management.

Figure 4.3.5.1 Age Group wise KBF-Active Beneficiaries-Across Financial Years-2020-2025



Data Source: State Health Agency-Kerala- KBF Beneficiary Statistics

The active beneficiary count under the Karunya Benevolent Fund (KBF) in Kerala has steadily increased over the years, demonstrating the scheme’s expanding role in providing financial protection for critical health needs. Beginning with 3,687 active beneficiaries in FY 2020–2021, the number consistently rose to reach a peak of 21,785 active beneficiaries in FY 2024–2025 (Figure-4.3.5.1). Across all years, the highest coverage was observed among the 45–59 and 60–69 age groups, reflecting the health demands of Kerala’s middle-aged and older populations, which align with the state’s growing non-communicable disease burden and also align with the utilisation pattern of

KASP. Elderly beneficiaries, particularly those aged 70 years and above, have also been prominently covered, indicating the scheme's critical role in geriatric protection. Gender-wise, male beneficiaries consistently outnumbered female beneficiaries, though females have made up a substantial share, typically contributing around 38–40% of the total active beneficiaries each year. The inclusion of transgender individuals, though in small numbers, signals Kerala's progressive approach toward inclusive health coverage. Overall, the increasing number of active KBF beneficiaries underscores the scheme's importance as a vital component of Kerala's social protection framework, contributing meaningfully to the state's efforts towards expanding population coverage.

Kerala has demonstrated a strong commitment to achieving comprehensive health coverage by expanding beneficiary reach through KASP and complementary schemes such as KBF and Arogya Kiranam. These initiatives collectively aim to provide financial protection and accessible healthcare to a broad segment of the population. The growing enrolment trends reflect the state's strategic efforts to ensure that no section of society is left behind, reinforcing Kerala's vision of inclusive and equitable healthcare delivery.

4.4 Service Coverage

This chapter highlights service provision under the health insurance scheme, addressing the "service coverage" dimension of the UHC Cube. It outlines the range of services covered, provider distribution and analyses how these offerings contribute to achieving broader health coverage goals, reflecting the state's efforts to ensure access to essential healthcare through an inclusive and structured service package.

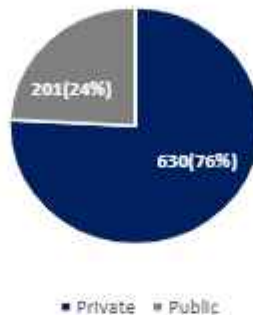
4.4.1 Year-wise Expansion of Hospital Empanelment under the Scheme

The empanelment process since 2019 reflects a progressive expansion of healthcare coverage under the scheme. Starting with 377 hospitals in 2019, the initial phase focused on building a strong base of facilities across both public (181) and private (194) sectors, along with 2 GOI hospitals. In the subsequent years, the scheme consistently added new facilities, enhancing service reach and patient access. The year 2020 added 162 more hospitals, followed by a further expansion in 2021 with 189 new empanelment. In 2022, an additional 75 hospitals were included. The years 2023 and 2024 saw gradual additions of hospitals, reflecting consolidation and targeted coverage enhancement in specific

areas. The total empaneled facilities reached 834 hospitals, comprising 630 private, 201 public, and 3 GOI hospitals.

Figure 4.4.1.1 Provider Mix-Distribution

Empanelled Providers



Data Source: State Health Agency-Kerala- EHCP Statistics

The provider mix under KASP shows a strong presence of the private sector, with 630 out of 834 empaneled hospitals belonging to private providers, compared to 201 public hospitals and 3 GOI institutions (**Figure 4.4.1.1**). This reflects a significant reliance on private healthcare facilities to complement the public system, ensuring wider service availability, faster access by reducing service waiting period, and greater choice for beneficiaries across districts. This distribution highlights the significant involvement of the private sector in service delivery under the scheme, while the public sector also plays a substantial role in providing accessible care.

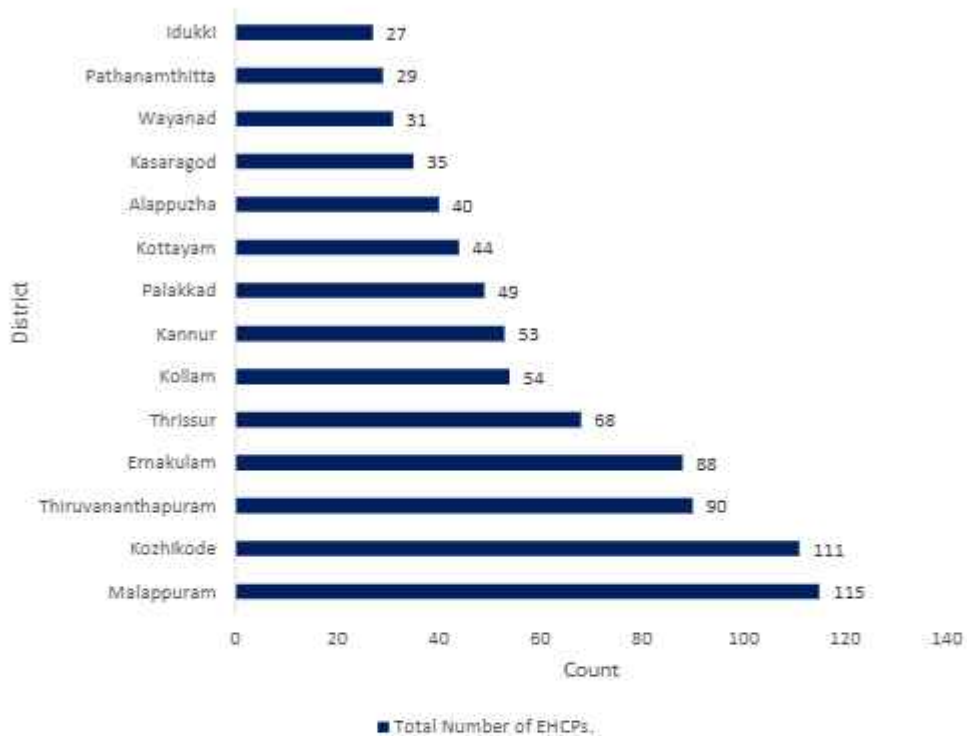
The findings indicates that in high-population districts like Malappuram, Kozhikode, and Thiruvananthapuram, the healthcare supply is being effectively maintained through a higher number of private-hospital empanelment. This reflects a strategic approach to meeting healthcare demand by leveraging private sector capacity, especially in densely populated areas where public infrastructure alone may not suffice.

4.4.2 Service Coverage: Empanelment Pattern of Public and Private

KASP delivers services through a wide network of both public and private empanelled hospitals, ensuring accessibility and choice for beneficiaries. The government continues to provide strong support and funding to sustain and expand these initiatives for

improved health coverage across the state. The total empanelment, along with district-wise details for public and private facilities, is presented below (Figure-4.4.2.1 and Table-4.4.2.1).

Figure 4.4.2.1 District wise Total Number of EHCPs



Data Source: State Health Agency-Kerala- EHCP Statistics

District-wise hospital empanelment under KASP includes a total of 834 hospitals, comprising 201 public, 630 private, and 3 Government of India (GOI) hospitals. Districts such as Malappuram (115), Kozhikode (111), and Thiruvananthapuram (90) have the highest number of empaneled hospitals, reflecting higher healthcare demand and greater population coverage needs, consistent with their status as the most populated districts as per the 2011 Census. Of the total, private sector empanelments account for 630 hospitals, while the public sector contributes 201 hospitals, indicating a significant reliance on private facilities across the state (Table-4.4.2.1).

Table 4.4.2.1 District-wise Empanelled Facilities

District	Private	Public	Grand Total
Malappuram	94	21	115
Kozhikode	94	17	111
Thiruvananthapuram	57	31	90
Ernakulam	69	19	88
Thrissur	56	12	68
Kollam	40	14	54
Kannur	38	15	53
Palakkad	34	14	49
Kottayam	28	16	44
Alappuzha	30	10	40
Kasaragod	24	11	35
Wayanad	24	7	31
Pathanamthitta	21	8	29
Idukki	21	6	27
Grand Total	630	201	834

***There are three GOI facilities, including two from Thiruvananthapuram and one from Palakkad.

Data Source: State Health Agency-Kerala- EHCP Statistics

4.4.3 KASP Health Benefit Packages and Services.

It is widely recommended that the benefit package under Universal Health Coverage (UHC) must be clearly defined, as no country can afford to provide all possible health services. Determining the scope of services to be covered—corresponding to the 'services coverage' dimension of the UHC cube—requires a strategic balance between technical assessments, such as prioritizing the most cost-effective and essential interventions, and political negotiations, as removing or restricting any service from an established benefit package is often a highly sensitive and contentious process. Defining these services is crucial to ensure that UHC remains both financially sustainable and equitably accessible.

Under the Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), the Health Benefit Package (HBP) is a comprehensive set of treatment packages that defines the services covered for beneficiaries, including clinical protocols, treatment costs, and package rates. These packages are periodically revised to incorporate emerging health needs, cost updates, and policy priorities. In Kerala, the Karunya Arogya Suraksha Padhathi (KASP) has aligned its benefit packages with the national PMJAY framework while adapting to local health requirements. As per the current data, Kerala's KASP offers 1,669 health benefit packages under HBP 2.1, reflecting an expansion from 1,393 packages under HBP 1.0 and 1,592 packages under HBP 2.0. Notably, 77 new packages have been added in the latest revision.

Table 4.4.3.1 Speciality-wise Services

Speciality	Medical	Surgical
Burns Management		21
Cardio Thoracic Vascular surgery (CTVS)	3	124
Cardiology	31	2
Diagnostic Laboratory	1	
Emergency Room Packages (Care requiring less than 12 hrs stay)	6	
General Medicine	141	1
General Surgery	5	197

Infectious Diseases	15	
Interventional Neuroradiology	18	4
Medical Oncology	267	
Mental Disorders	10	
Neonatal care	8	2
Neurosurgery	2	104
Obstetrics & Gynaecology	3	102
Ophthalmology	1	58
Oral and Maxillofacial Surgery		25
Organ and Tissue Transplant		6
Orthopaedics	3	163
Otorhinolaryngology	1	97
Paediatric Medical Management	155	
Paediatric Surgery	5	212
Plastic & Reconstructive Surgery		30
Polytrauma	2	20
Radiation Oncology	48	1
Surgical Oncology		233
Urology	23	136

Data Source: Health Benefit Packages-(HBP)-NHA

The Health Benefit Package (HBP) under KASP/PMJAY encompasses a wide range of medical and surgical procedures across multiple specialties to comprehensively address population health needs (Table-4.4.3.1). On the medical side, the most significant number of procedures are seen in medical oncology (267 procedures), paediatric medical management (155), general medicine (141), cardiology (31), and radiation oncology

(48), indicating strong emphasis on managing chronic diseases, cancers, and paediatric conditions.

On the surgical side, the majority of procedures fall under surgical oncology (233 procedures), paediatric surgery (212), general surgery (197), orthopaedics (163), cardio-thoracic vascular surgery (124), neurosurgery (104), and obstetrics and gynaecology (102). The inclusion of complex specialties like burns management, organ and tissue transplant, plastic and reconstructive surgery, and polytrauma further highlights Kerala's focus on comprehensive care.

However, there are a few specific exclusions to maintain focus on essential treatments. Broadly, the scheme does not cover conditions that do not require hospitalization (OP-Care), purely diagnostic or cosmetic procedures, infertility treatments not included in the national package, elective aesthetic surgeries, hormone therapy for gender reassignment, and treatments arising from intentional self-harm or persistent vegetative state. Routine dental care, vaccinations, and congenital external defects are also excluded unless hospitalization is medically justified. The scheme ensures coverage for almost all necessary and critical health services; a few exceptions are outlined to ensure appropriateness and alignment with national health priorities.

4.4.4 Service Coverage for High-End Consumable Coverage under KASP

A total of 645 high-end consumables were financed through the Karunya Arogya Suraksha Padhathi (KASP) across various medical specialties. Medical Oncology accounted for the highest number, with 302 consumables covered, followed by Radiation Oncology with 115, General Medicine with 70, and Orthopedics with 53. Other specialties with consumables supported include Cardiothoracic and Vascular Surgery (CTVS) with 25, Cardiology with 18, and Neurosurgery with 14. Consumables were also covered in specialties such as ENT, Interventional Neuroradiology, Ophthalmology, Surgical Oncology, Urology, Obstetrics & Gynecology, General Surgery, Plastic Surgery, Polytrauma, and Infectious Diseases. This pattern highlights the program's focus on high-cost, high-burden conditions, particularly in oncology and critical care, while still providing support across a wide range of specialties.

The high-end consumables financed under the Karunya Arogya Suraksha Padhathi (KASP) can be broadly categorized based on implant costs, with the most significant

services observed in the cardiology specialty. Implants costing above ₹2 lakh include the Implant for Cardiac Defibrillator Implantation (₹3,40,000) and Cardiac Resynchronization Therapy (₹3,00,000), both under cardiology, highlighting its prominence in high-cost interventions. The ₹1–2 lakh range features several critical procedures across specialties such as Interventional Neuroradiology (Implant for TIPS and CCF embolization), Cardiothoracic and Vascular Surgery (RV-PA Conduit and Composite Aortic Valved Conduit), and Orthopedics (Modular Custom Prosthesis, Revision Total Hip and Knee Replacements), reflecting their complex and resource-intensive nature. In the ₹80,000–1 lakh bracket, key CTVS consumables like Arch Graft, Coselli Graft, and complex grafts are included, alongside cardiology devices like the Double Chamber Pacemaker. In the tier, ₹70,000–80,000, includes devices such as the VSD (Ventricular Septal Defect) Device and Radio Frequency Ablation kit under cardiology. Overall, cardiology emerges as the specialty with the highest cost consumables, followed by notable contributions from CTVS, orthopedics, and interventional neuroradiology. **Table-4.4.4.1** presents specialty wise count of high end consumables covered under KASP.

Table 4.4.4.1 Specialty-Wise Count of High-Cost Consumables Covered under KASP

Specialities	Number of services with Implant / High End Consumables are covered
Cardiology	18
CTVS	25
ENT	7
General Medicine	70
General Surgery	5
Infectious Diseases	1
Interventional Neuroradiology	7
Medical Oncology	302

Neurosurgery	14
Obstetrics & Gynecology	3
Ophthalmology	11
Orthopaedics	53
Plastic Surgery	2
Polytrauma	1
Radiation Oncology	115
Surgical Oncology	6
UnSpecified	2
Urology	3
Grand Total	645

Data Source: Health Benefit Packages-(HBP)-NHA

Through a comprehensive array of Health Benefit Packages—including both specified and unspecified packages under KASP—as well as the provision of high-end treatments and consumables through converged schemes, Kerala is actively expanding the range of services available, thereby strengthening the service coverage dimension of the UHC Cube and moving closer to comprehensive health coverage for all.

4.5 Financial Protection

This section highlights the "proportion of costs covered" dimension of the UHC Cube by analyzing claim utilization across empaneled facilities and the public-private provider mix. It offers insights into financial protection and how the state is working to reduce the financial burden on beneficiaries through improved service access and cost coverage mechanisms.

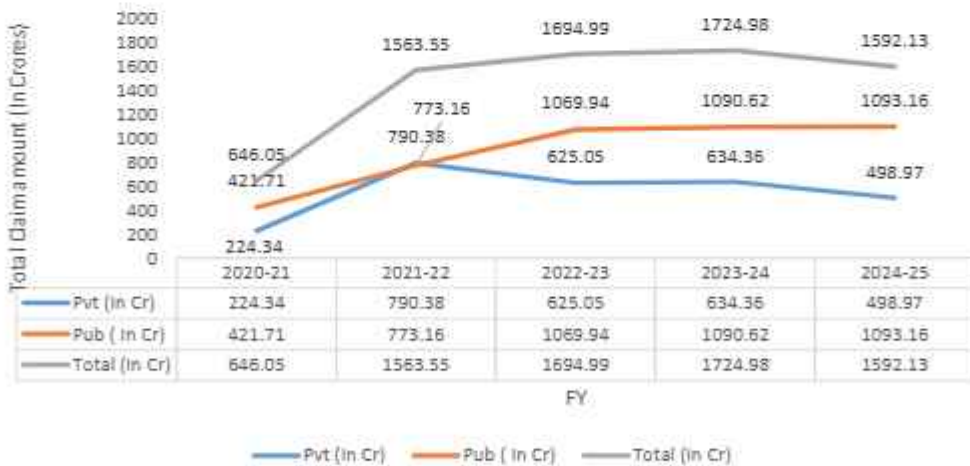
4.5.1 Overall Claim Pattern Analysis

This section provides a macro-level view of claim activities, identifying key trends and performance indicators related to claim processing and settlement.

4.5.2 Provider-wise Utilization: Public vs. Private

The total healthcare expenditure claimed by hospitals under the scheme has demonstrated a marked upward trend over the five-year period, reflecting increased service utilisation and deeper penetration of the health insurance programme (Fig-4.9.1). Starting from ₹646.05 crores in FY 2020-21, the total spending surged significantly to ₹1,563.55 crores in FY 2021-22, indicating a sharp rise in beneficiary coverage and provider engagement. This growth trajectory continued through FY 2022-23 and FY 2023-24, peaking at ₹1,724.98 crores before showing a marginal correction to ₹1,592.13 crores in FY 2024-25. The sustained high levels of claims in recent years highlight the increasing reliance on publicly funded health insurance mechanisms, particularly PMJAY, and underscore the effective stewardship of the State Health Agency (SHA) as the key payer. The data reflects a maturing system where both public and private hospitals actively participate, and where the financing architecture—anchored by PMJAY and SHA—has become a vital enabler of access, equity, and financial protection in healthcare delivery. **Figure-4.5.2.1** illustrates the total amount raised by public and private hospitals over the financial years.

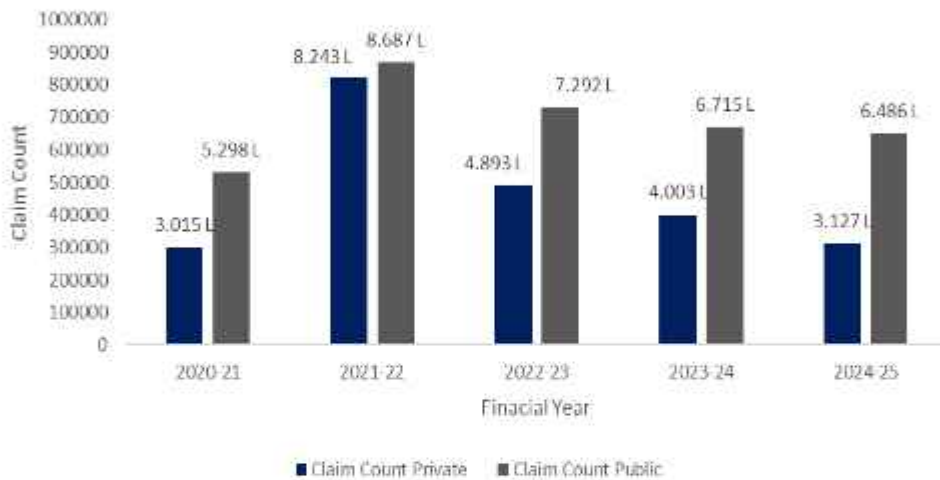
Figure 4.5.2.1 Public and Private Sector Claim Amount Across Years



Data Source: State Health Agency, Kerala

The claim trends over the financial years 2020-21 to 2024-25 clearly demonstrate that both public and private sector hospitals play a pivotal role in delivering healthcare services under the state's financial protection schemes. In terms of claim volume, both private and public claim counts peaked in 2021-22, driven by the COVID-19 surge, and subsequently showed a general decline in the following years. Across all years, the public sector consistently reported higher claim counts than the private sector. **Figure 4.5.2.2** shows the year-wise trend in claims raised.

Figure 4.5.2.2 Year-wise Claim Utilisation-Number of Claims Raised



Data Source: State Health Agency, Kerala

Public hospitals consistently handle a higher volume of claims and claim value despite having fewer empaneled facilities, indicating a strong reliance on and trust in the public health system. This suggests that beneficiaries continue to prefer public hospitals for service utilization, reflecting their efficiency in managing care delivery. At the same time, private hospitals have played a crucial role in service provision—especially in earlier periods like 2021-22—where their claim amounts were nearly on par with public hospitals, highlighting the complementary role of the private sector in ensuring service access.

This balanced utilization pattern highlights the Kerala State Health Agency's strategy of engaging both public and empaneled private hospitals to ensure wide accessibility and timely healthcare services. The state's schemes such as Karunya Arogya Suraksha

Padhathi (KASP) and others, provide cashless treatment options across both sectors, thus offering flexibility and financial protection to the beneficiaries.

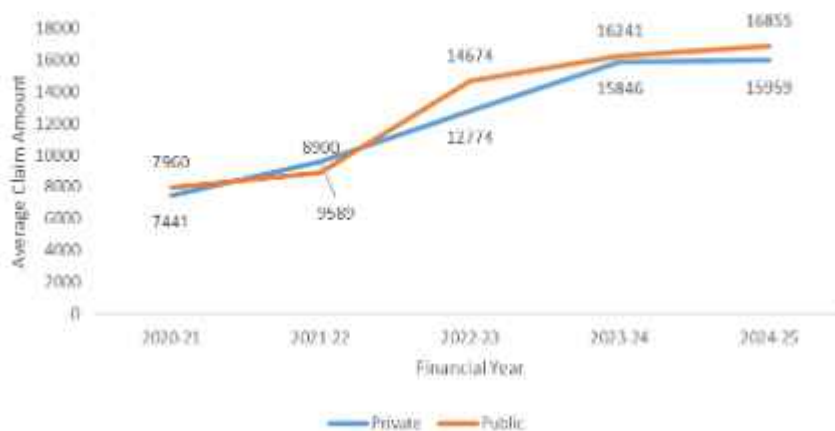
The sustained and increasing financial outlay for claims from both sectors across the years reflects the government's continued commitment to reducing out-of-pocket expenditure and ensuring that the services are accessible, affordable, and available through a mixed-provider approach. Also, the analysis of healthcare utilization patterns between public and private sector hospitals has revealed evolving dynamics in patient preference, access, and the scheme's financial impact on different provider types.

4.5.3 Year-wise Trends: Claims Management

Average Claim Size Trends and Public-Private Case Mix Differences

Case mix refers to the composition of patients treated, considering factors such as disease severity, complexity of conditions, required interventions, and associated resource use. Facilities managing more severe or complex cases generally incur higher treatment costs. Average claim size represents the average monetary value of claims raised, calculated by dividing the total claim amount by the number of claims. It serves as an indicator of the cost per treated case and can be influenced by the case mix, service utilization patterns, and pricing structures. The average claim size increased steadily for both private and public facilities from 2020-21 to 2024-25.

Figure 4.5.3.1 Average Claim Size (Value In Rupees) across Financial Years



Data Source: State Health Agency, Kerala

Throughout the Financial Years 2020 to 2025, the public sector consistently recorded a higher average claim size than the private sector, with the gap widening notably from 2021-22 onwards (**Figure-4.5.3.1**). This pattern suggests that public facilities are treating a larger share of complex and high-cost cases, such as advanced disease stages, multi-comorbidity patients, or specialized surgical procedures, which drive up the average claim amount. Differences in service utilization patterns also contribute to this disparity.

The annual progression of claims through the scheme's lifecycle reveals significant shifts in demand, efficiency, and financial disbursement over the five-year period. From the beginning year of 2020-21 the public sector played a dominant role, processing significantly more claims than the private sector and ensuring timely disbursements. In 2021-22, claim volumes rose sharply in both sectors, but the private sector's total claim amount slightly exceeded that of the public sector despite fewer claims compared to previous year, reflecting a higher average claim size and a different case mix. By 2022-23, the financial burden shifted more heavily to the public sector, which recorded a higher total claim amount despite decreased claims volume.

4.5.4 District-wise Trends

A granular analysis at the district level provides insights into regional healthcare utilization patterns and the geographical concentration of financial challenges. Kozhikode and Malappuram consistently emerged as leading districts for private sector claim counts and values across all years. This suggests a robust private healthcare infrastructure and a strong preference for private facilities among insured beneficiaries in these regions. Similarly, Thiruvananthapuram, Kozhikode, Kannur, and Kottayam consistently remained the top districts for both claim volume and value in the public sector, indicating high healthcare activity and a significant reliance on public facilities in these areas. These districts represent key centers of healthcare demand within the scheme.

4.5.5 Specialty-wise Average Claim Value Analysis-Across Providers

This section presents an overview of specialty-wise service utilization across public and private providers by analyzing average claim values. It highlights the most utilized specialties in each sector, offering insights into the cost intensity and service demand

patterns, and helps identify key areas where public and private sectors are contributing to healthcare delivery.

4.5.6 Specialty-wise utilisation pattern: Public

The top five specialities from public in the last 5 years by both volume and claim amount reflect the healthcare demand pattern in Kerala. **Figure-4.5.6.1** illustrates the top five specialities in terms of the total amount raised over the last five financial years, along with the number of claims raised.

General Medicine clearly dominates, indicating a high burden of general health conditions requiring frequent medical attention. Medical Oncology and Cardiology emerge as high-cost specialities, suggesting significant demand for specialised, long-term care. The presence of General Surgery and Orthopaedics in the top five points to a steady need for surgical and musculoskeletal interventions. Overall, the data highlights Kerala's growing need for both primary care and specialised services, particularly in chronic disease and cancer care. **Figure-4.5.6.1** represents the top 5 specialities by claimed amount and claim volume in the last five financial years combined.

Figure 4.5.6.1 Top 5 Specialities in Terms of Claim Volume and Amount-2020-2025-Public



Data Source: State Health Agency, Kerala

The top 15 specialities by claim amount (**Table-4.5.6.1**) from 2020-21 to 2024-25 reflect the high-cost nature of both chronic and acute care in the public sector-which is aligned with claim volumes distribution. General Medicine records the highest cumulative claim amount, followed closely by Medical Oncology and Cardiology, highlighting the financial impact of managing high-burden diseases such as cardiovascular conditions and cancer. General Surgery and Orthopaedics also feature prominently, indicating significant expenditure on surgical interventions. High-cost specialty care such as Radiation Oncology, Cardio Thoracic Vascular Surgery (CTVS), Surgical Oncology, and Neonatal Care demonstrates the resource-intensive nature of complex treatments. Other notable contributors include Urology, Paediatric Medical Management, Ophthalmology, and Interventional Neuroradiology, along with Otorhinolaryngology and Paediatric Surgery, which together capture the diverse mix of high-value services delivered in the state's public hospitals.

Table 4.5.6.1 Top 15 Specialties Based on Claimed Amount in the Public Sector

Speciality	2020- 2021 (Cr)	2021- 2022 (Cr)	2022- 2023 (Cr)	2023- 2024 (Cr)	2024- 2025(Cr)	Total (Cr)
General Medicine	84.15	141.69	230.33	244.51	257.68	958.35
Medical Oncology	87.99	167.80	201.33	229.95	212.04	899.12
Cardiology	63.17	139.23	208.83	202.13	206.75	820.10
General Surgery	26.10	48.58	73.97	78.76	83.92	311.33
Orthopaedics	26.73	53.34	80.73	78.14	83.10	322.04
Radiation Oncology	29.01	56.62	62.40	66.52	62.95	277.50
Cardio Thoracic Vascular Surgery (CTVS)	16.41	26.80	48.48	43.00	42.22	176.90

Surgical Oncology	11.72	18.90	19.32	19.66	17.43	87.05
Neonatal care	9.80	14.89	13.48	10.27	14.91	63.35
Urology	5.82	11.45	17.32	15.74	13.79	64.13
Paediatric Medical Management	1.44	2.34	8.22	12.13	9.71	33.83
Ophthalmology	2.35	4.77	9.01	8.25	8.81	33.18
Interventional Neuroradiology	1.82	6.43	10.69	8.68	8.70	36.32
Otorhinolaryngology	2.13	5.23	8.55	8.30	7.92	32.13
Paediatric Surgery	0.95	1.65	3.01	3.66	3.98	13.26

Data Source: State Health Agency, Kerala

The year wise utilisation trends of public sector healthcare services from FY 2020-2021 to FY 2024-2025 highlight the 15 specialties that consistently contributed to the highest claim volumes and financial weightage across the years (**Table 4.5.6.1 and 4.5.6.2**). The utilisation data from 2020-21 to 2024-25, the top 15 specialties by claim volume are led by General Medicine, showing consistently high utilisation each year. This is followed by Medical Oncology, General Surgery, Cardiology, and Orthopaedics, reflecting the high burden of both chronic and acute conditions. Other notable high-volume areas include Paediatric Medical Management, Ophthalmology, Radiation Oncology, Otorhinolaryngology, and Urology, alongside surgical specialties such as Surgical Oncology, Neonatal Care, Cardio-Thoracic Vascular Surgery (CTVS), Paediatric Surgery, and Mental Disorders. These patterns indicate a wide spectrum of demand, spanning from routine general care to complex tertiary-level interventions in the state's public hospitals.

Table 4.5.6.2 Top 15 Specialties Based on Claim Volume in the Public Sector

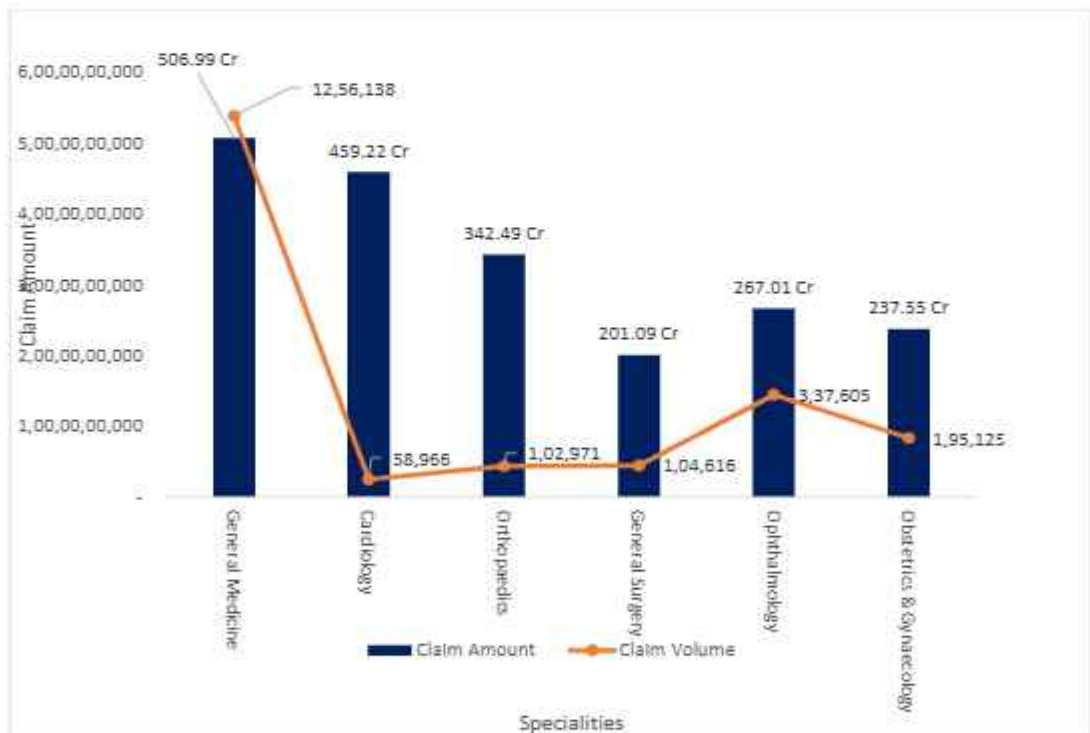
Specialty	2020- 2021	2021- 2022	2022- 2023	2023- 2024	2024-2025
General Medicine	3,65,135	5,76,488	3,72,994	3,14,612	3,18,542
Medical Oncology	63,802	1,17,210	1,34,731	1,48,571	1,26,280
General Surgery	15,440	27,648	41,298	39,702	39,751
Cardiology	9,370	19,507	28,128	25,980	30,507
Orthopaedics	11,974	19,879	27,834	26,249	25,552
Paediatric Medical Management	1,925	3,600	15,244	22,608	15,857
Ophthalmology	3,956	8,260	15,464	14,017	15,125
Radiation Oncology	7,034	13,385	15,011	15,200	14,052
Otorhinolaryngology	1,473	3,271	5,782	5,738	5,627
Urology	2,217	4,485	6,645	5,795	4,951
Surgical Oncology	2,999	4,068	4,205	4,504	4,187
Neonatal care	2,694	3,552	3,623	2,933	3,873
Cardio Thoracic Vascular surgery (CTVS)	1,329	2,206	3,755	3,290	3,192
Paediatric Surgery	598	993	1,717	2,133	2,159
Mental Disorders	419	905	1,643	1,451	1,396

Data Source: State Health Agency, Kerala

4.5.7 Speciality-wise Utilization Pattern-Private.

Private sector under KASP, General Medicine records the highest claim amount and volume, indicating its role as the core service for a wide range of acute and chronic conditions. Cardiology ranks second in expenditure despite a comparatively lower claim volume, reflecting the high cost of cardiac interventions. Orthopaedics and General Surgery contribute substantially to both value and volume, highlighting demand for surgical care. Ophthalmology and Obstetrics & Gynaecology feature prominently, with significant utilisation and costs, underscoring the strong role of private facilities in delivering vision care and maternal-child health services (Figure-4.5.7.1).

Figure 4.5.7.1 Top 5 Specialities in Terms of Claim Volume and Amount-2020-2025-Private



Data Source: State Health Agency, Kerala

Kerala's private sector under KASP, claim utilisation patterns from 2020-21 to 2024-25 are led by General Medicine, which accounts for the largest share of cases across the years. Ophthalmology follows, reflecting significant demand for vision-related care, while

Obstetrics & Gynaecology ranks third, highlighting utilisation for maternal and reproductive health services. Surgical and procedural care, such as General Surgery, Orthopaedics, and Cardiology also feature prominently. **Table-4.5.7.1** shows the top-15 specialities based on the claim amount raised from private EHCPs. Specialities including Urology, Neonatal Care, and Paediatric Medical Management demonstrate utilisation for both acute and paediatric care needs. ENT services (Otorhinolaryngology), Mental Disorders, Cardio-Thoracic Vascular Surgery (CTVS), and Paediatric Surgery contribute to the service mix, while Emergency Room Packages and Burns Management reflect specific episodic care needs in the private setting. This distribution underlines the breadth of private sector engagement, spanning high-volume general care to specialised interventions.

Private sector under KASP, claim amounts from 2020-21 to 2024-25 reveal a concentration of high-value care in select specialities (**Table 4.5.7.1**). General Medicine accounts for the largest expenditure, reflecting the high treatment load for acute and chronic illnesses, followed by Cardiology and Orthopaedics, which highlight the financial impact of cardiac interventions and orthopaedic procedures. Ophthalmology and Obstetrics & Gynaecology emerge within the top five cost-intensive specialities in the private sector, underscoring strong demand for vision-related services and maternal-child healthcare. This stands in contrast to their placement in the public sector, where they appear further down the ranking, between the 10th and 15th positions, indicating a relatively lower share of expenditure. Other high-cost areas include General Surgery, Urology, Cardio-Thoracic Vascular Surgery (CTVS), and Neonatal Care, reflecting the cost-intensive nature of surgical and critical care. Specialities such as Otorhinolaryngology and Paediatric Medical Management demonstrate diverse utilisation, while Mental Disorders, Paediatric Surgery, Radiation Oncology, and Burns Management contribute smaller but notable shares. These trends highlight Kerala's reliance on private sector capacity for high-value and specialised services, complementing the public system to ensure comprehensive access to advanced treatments.

Table 4.5.7.1 Top 15 Specialities Based On Claim Amount Raised -Private

Sl. NO	Speciality	2020-2021 (Cr)	2021-2022 (Cr)	2022-2023 (Cr)	2023-2024 (Cr)	2024-2025 (Cr)	Total (Cr)
1	General Medicine	29.36	86.25	128.63	141.85	120.91	506.99
2	Cardiology	37.40	91.53	121.31	115.94	93.06	459.24
3	Orthopaedics	20.90	55.99	85.60	100.11	79.88	342.49
4	General Surgery	11.61	33.91	51.83	54.43	49.31	201.09
5	Ophthalmology	22.59	50.86	73.90	70.63	49.04	267.01
6	Obstetrics & Gynaecology	22.00	49.55	65.32	57.30	43.38	237.55
7	Urology	6.01	15.01	22.88	26.90	18.22	89.02
8	Cardio Thoracic Vascular surgery (CTVS)	4.50	14.81	16.64	16.75	13.79	66.49
9	Otorhinolaryngology	2.34	6.90	9.91	11.28	8.34	38.77
10	Neonatal care	4.09	9.24	13.08	11.48	6.63	44.53
11	Paediatric Medical Management	0.38	1.89	6.25	5.62	3.30	17.44
12	Mental Disorders	0.44	1.14	2.01	2.29	2.46	8.35
13	Paediatric Surgery	0.34	0.89	1.21	1.28	0.88	4.60
14	Radiation Oncology	0.01	0.01	0.12	0.13	0.31	0.58
15	Burns Management	0.09	0.17	0.31	0.49	0.28	1.34

Data Source: State Health Agency, Kerala

In the private sector, General Medicine consistently records the highest claim volumes, reflecting its broad coverage of chronic disease management and common medical conditions. Ophthalmology and Obstetrics & Gynaecology follow, driven by high-volume elective procedures such as cataract surgery and maternity care. Mid-tier contributors

include General Surgery, Orthopaedics, and Cardiology, each maintaining stable volumes after peaking in 2021-22 or 2022-23. Specialties such as Urology, Neonatal Care, and Paediatric Medical Management show moderate activity, catering to specific patient segments. Low-volume areas like Otorhinolaryngology, Paediatric Surgery, Emergency Room Packages, and Burns Management represent a small share of total claims, indicating their more specialised and less frequent nature. Overall, the distribution reflects a concentration of claims in general and high-volume surgical specialties, with a gradual decline in volumes across most specialties after 2021-22. **Table-4.5.7.2** illustrates the top 15 specialties based on claim volume in the private sector.

Table 4.5.7.2 Top 15 Specialties Based on Claim Volume in the Private Sector

Sl.NO	Speciality	2020- 2021	2021- 2022	2022- 2023	2023- 2024	2024- 2025
1	General Medicine	2,06,644	5,37,676	2,28,156	1,55,392	1,28,270
2	Ophthalmology	28,363	64,552	94,088	89,026	61,576
3	Obstetrics & Gynaecology	18,670	41,799	53,549	45,882	35,225
4	General Surgery	7,135	18,510	26,728	27,630	24,613
5	Orthopaedics	7,657	18,899	25,938	27,714	22,763
6	Cardiology	4,640	11,449	14,860	14,029	13,988
7	Urology	2,206	5,409	6	9,126	6,207
8	Neonatal care	3,473	9,145	11,426	9,518	6,196
9	Paediatric Medical Management	664	3,572	12,018	10,252	5,393
10	Otorhinolaryngology	1,117	2,937	4,605	5,317	4,039
11	Mental Disorders	262	541	966	1,137	1,090

12	Cardio Vascular (CTVS)	Thoracic surgery	337	1,083	1,191	1,250	992
13	Paediatric Surgery		170	427	531	585	382
14	Emergency Packages	Room (Care requiring less than 12 hrs stay)	56	111	146	115	107
15	Burns Management		19	41	106	132	106

Data Source: State Health Agency, Kerala

The utilisation patterns across public and private sectors from FY 2020-2021 to FY 2024-2025 shows that the top 10 specialties consistently dominate the service landscape under the health protection scheme implemented through empanelled hospitals by the State Health Agency. Both sectors demonstrate high volumes and significant financial weightage in specialties such as Cardiology, General Medicine, Ophthalmology, Obstetrics & Gynaecology, Orthopaedics, General Surgery, Neonatal Care, Urology, and Otorhinolaryngology (ENT). Cardiology and General Medicine are the most utilised specialties across both sectors, indicating the sustained burden of cardiovascular and chronic medical conditions. Specialties like Ophthalmology, Obstetrics & Gynaecology, Orthopaedics, and General Surgery also maintain consistently high utilisation, reflecting the broad spectrum of surgical, maternal, and eye care services delivered through the empanelled network. Neonatal care and Urology remain critical components of service provision in both sectors, ensuring access to specialized pediatric and urological interventions. The utilisation of services under Infectious Diseases showed a significant surge particularly in the private sector during FY 2021-2022, likely influenced by public health emergencies during that period. The data clearly indicate that both public and private empanelled hospitals play a crucial role in meeting the healthcare demands of the population across these top specialties, enabling service accessibility and financial protection under the stewardship of the State Health Agency. General Medicine consistently leads in both claim counts and amounts across public and private sectors. In

public hospitals, it is followed by Medical Oncology, General Surgery, Cardiology, and Orthopaedics, reflecting the predominance of chronic disease management and essential surgical care. In private facilities, Cardiology, Orthopaedics, and General Surgery remain prominent, with Ophthalmology and Obstetrics & Gynaecology ranking among the top five by claim amount—unlike in the public sector, where they are positioned much lower (10th–15th), indicating a greater concentration of these services in private hospitals.

4.5.8 Package-Utilisation Across -Providers.

Package utilisation across specialties helps identify which services or treatment packages are most frequently used. This section provides details on the most utilised packages in both public and private sectors."

4.5.9 Package-wise-Utilization-Public

Public-sector utilisation data for the top packages shows a clear dominance of NCD-driven and high-cost interventions, which aligns closely with specialty-wise financial trends. PTCA consistently ranks as one of the highest claim-value packages, directly contributing to the large expenditure seen under Cardiology (₹820 Cr cumulative),-in the last five Financial Years. Similarly, oncology-related services, including Chemotherapy drugs and non-KMSCL-listed chemotherapy regimens — drive a substantial portion of the Medical Oncology spend (₹899 Cr), reflecting the scheme's significant financial commitment to cancer care. **Table-4.5.9.1** presents the package-wise claim performance for public facilities, highlighting the top eight packages by claim amount along with the corresponding number of claims raised.

Table 4.5.9.1 Top-7 High utilised Packages/Treatment Services - Public

Financial Year	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025
Packages	No. of Claims Amount (Cr)	No. of Claims Amount (Cr)	No. of Claims Amount (Cr)	No. of Claims Amount (Cr)	No. of Claims Amount (Cr)
PTCA, inclusive of diagnostic angiogram	6043 55.29	19578 45.73	19,578 176.83	18,840 169.51	18,936 169.31
Chemotherapy drugs as Add-On for MG072KLa	9981 12.40	33,165 38.72	33,165 46.98	39,412 61.59	41,121 71.45
Chronic Haemodialysis	2,61,417 23.68	1,02,021 17.30	1,02,021 45.73	43,522 47.11	45,976 48.30
In addition to ward cost, if the treating Doctor suggest chemotherapy for a	7352 9.28	29,138 21.67	29,138 38.72	34,706 51.87	22,368 38.31

malignancy condition not enlisted here, the cost of that drug as per KMSCL rate has to be reimbursed based on the request submitted in the Template	11,181	13.46	14,375	46.98	14,375	17.30	9,399	11.30	8,148	9.83
Caesarean Delivery	6211	3.95	23,385	8.57	23,385	25.10	25,320	29.50	25,291	31.02
High end radiological diagnostic (CT, MRI, Imaging including nuclear imaging)	7415	4.57	33,202	11.77	33,202	23.50	34,153	26.12	37,517	27.94
Skin and soft tissue infections										

Data Source: State Health Agency, Kerala

Chronic Hemodialysis stands out for its very high claim volumes but relatively modest claim size. High-end radiological diagnostics show steady growth in utilization, contributing to the Radiology specialty's financial footprint and indirectly supporting diagnostic needs for cardiology, oncology, and neurology cases. Caesarean deliveries represent a smaller but important maternal health expenditure, while skin and soft tissue infection packages contribute moderately to General Medicine and General Surgery costs. The pattern confirms that a small set of high-volume, high-value packages drive the majority of scheme expenditure in the public sector, heavily skewed towards chronic disease management, oncology, and advanced cardiac care.

4.5.10 Package -Utilisation Pattern-Private

The top five high-value packages in the private sector, based on cumulative claim amounts, include PTCA (angioplasty), Chronic Haemodialysis, Cataract Surgery, Total Knee Replacement (TKR), and CABG (Coronary Artery Bypass Grafting). PTCA consistently leads in total claim amount, witnessing a sharp surge in 2023–2024, with the highest single-year claim value exceeding ₹1,000 crore, despite a slight drop in the number of claims in 2024–2025. Chronic Haemodialysis, while showing a decrease in claim count over the years (from 423,128 in 2021–2022 to 54,949 in 2024–2025), remains the second highest in total claims value. Cataract surgery has shown a steady claim volume, peaking in 2022–2023 and 2023–2024, with high cumulative claim amounts reflecting Kerala's ageing population and demand for eye care, as well as increased dependency on the private sector for cataract surgery. Total Knee Replacement exhibits a consistent rise in claim count and amount, reflecting increased access to elective orthopaedic procedures. CABG maintains a stable claim pattern with moderate growth in value and count, underlining ongoing demand for cardiac surgeries.

Table-4.5.10.1 presents the package-wise claim performance for private facilities, highlighting the top eight packages by claim amount along with the corresponding number of claims raised.

Table 4.5.10.1 Top-7 High utilised Packages/Treatment Services -Private

Financial Year	2020-2021		2021-2022		2022-2023		2023-2024		2024-2025	
	No. of Claims	Claimed Amount (Cr.)	No. of Claims	Claimed Amount (Cr.)	No. of Claims	Claimed Amount (Cr.)	No. of Claims	Claimed Amount (Cr.)	No. of Claims	Claimed Amount (Cr.)
PTCA, inclusive of diagnostic angiogram	4253	36.20	10,104	4.99	12,963	7.33	12,093	106.80	9,877	83.88
Chronic Haemodialysis	186,547	17.42	423,128	15.58	141,624	18.26	63,019	69.68	54,949	60.51
Cataract surgery IOL (S300031)	22,640	17.51	51,678	15.58	77,221	59.96	74,410	58.03	37,313	29.34
Primary - Total Knee Replacement	520	4.22	1,448	4.99	2,373	7.33	3,259	30.73	2,787	25.01

Coronary artery bypass grafting (CABG).	265	337	795	10,69	864	11.77	883	11.94	667	9.11
Normal Vaginal delivery	7,564	553	17,066	4.99	20,513	7.33	16,608	12.43	12,872	9.84
Groin Hernia Repair - Inguinal - Open (New Package)	1,197	203	2,584	4.99	3,637	7.33	3,261	6.75	1,916	4.02

Data Source: State Health Agency, Kerala

Private-sector utilisation is concentrated in high-cost surgical interventions, chronic disease management, and high-volume elective procedures. PTCA and CABG dominate cardiology spending (₹459.24 Cr), reflecting a strong focus on advanced cardiac care. Chronic Haemodialysis drives a large share of burden of chronic kidney disease in the insured population. Cataract surgery accounts for a major portion of Ophthalmology expenditure (₹267.01 Cr), benefiting from its high-volume, moderate-cost nature.

Total Knee Replacement contributes significantly to Orthopaedics (₹342.49 Cr), while Normal Vaginal Delivery is a key cost driver within Obstetrics & Gynaecology (₹237.55 Cr). Groin Hernia Repair adds to General Surgery expenditure (₹201.09 Cr). The pattern indicates that a small set of procedures across cardiology, nephrology, ophthalmology, orthopaedics, obstetrics, and general surgery account for most private-sector scheme spending, with a mix of chronic care, life-saving interventions, and high-volume planned surgeries.

In conclusion public facilities predominantly provide chronic disease management services, maternity care, essential surgical procedures, dialysis, chemotherapy, and diagnostic imaging, reflecting a broader service base. Private facilities, on the other hand, focus more on specialised and high-value procedures such as cardiac interventions, orthopaedic surgeries including joint replacements, ophthalmic surgeries, and selected chronic care services like dialysis, indicating a narrower but more complex and resource-intensive case mix

4.6 Conclusion

Kerala's approach to Universal Health Coverage (UHC) reflects a comprehensive and equity-driven model that actively addresses all three dimensions of the UHC Cube population coverage, service coverage, and financial protection. Through strategic convergence of schemes, the state has successfully extended health coverage to significant number of beneficiaries, especially targeting economically and socially vulnerable populations.

The provider mix of both public and private hospitals across districts particularly in high-population regions demonstrates Kerala's commitment to expanding service accessibility and reducing geographic disparities. The inclusion of a broad spectrum of health benefit packages under KASP, ranging from essential primary care to high-end tertiary

procedures and costly consumables, reflects significant progress in the service coverage dimension of UHC.

While financial protection remains relatively restricted and minimal primarily limited to hospitalization and specific treatments the state's focused efforts in improving claim management, minimizing out-of-pocket expenditure, and enabling cashless access are notable steps forward. The rise in active enrolment from 2.6 lakh in FY 2020–21 to over 5.4 lakh in FY 2024–25 indicates improved outreach, increased awareness, and sustained public trust in the system.

Overall, Kerala's structured and inclusive approach demonstrates meaningful progress toward UHC, with strong foundations laid in population and service coverage, and continuous advancements in financial risk protection. The state's experience serves as a replicable model for achieving equitable and comprehensive health coverage, even within existing fiscal constrain.

Chapter 5

Fiscal Space for Health Insurance Scheme/KASP

5.1. Introduction to Fiscal Space in Health Insurance

The concept of fiscal space is paramount in the realm of public finance and in ensuring the sustainability and effectiveness of social welfare programs, including health insurance schemes. In essence, fiscal space refers to the room a government has to raise resources and incur expenditures without jeopardizing its financial stability or the sustainability of its debt. For health insurance schemes, this translates into the consistent availability of adequate financial resources to meet current and future obligations, cover beneficiary claims, and support administrative functions, all while adapting to evolving healthcare needs and cost pressures.

A robust fiscal space is not merely about having sufficient funds; it also encompasses the efficiency of resource utilization, the ability to mobilize additional resources when required, and the predictability of funding flows. Without this crucial financial breathing room, health insurance schemes risk succumbing to financial distress, leading to a range of detrimental outcomes such as delays in claim settlements, reduction in covered services, compromised quality of care, and ultimately, a loss of public trust. Such financial instability undermines the very purpose of these schemes: to provide financial protection against catastrophic health expenditures and improve access to quality healthcare for the population. Therefore, understanding and actively managing fiscal space is foundational to achieving and maintaining Universal Health Coverage (UHC) goals.

In the Indian context, and particularly within the state of Kerala, the Karunya Arogya Suraksha Padhathi (KASP) stands as a significant government-sponsored health insurance scheme. KASP was launched with the primary objective of providing comprehensive financial protection to vulnerable households against the high costs associated with secondary and tertiary healthcare treatments. Crucially, KASP operates in convergence with the central government's flagship health insurance scheme, Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY).² This convergence means that KASP effectively subsumes the benefits of AB-PMJAY, extending its coverage and financial protection to a wider base of beneficiaries in Kerala. This integrated scheme,

² Joseph and Sanker, *Bridging the Healthcare Divide*.

often referred to as AB-PMJAY-KASP, aims to reduce catastrophic health expenditure, improve access to quality healthcare, and minimize out-of-pocket expenses for poor and vulnerable families in the state.

Its core aims include alleviating the burden of out-of-pocket health expenditures for eligible beneficiaries, enhancing equitable access to a wide range of medical services across both public and empanelled private hospitals, and thereby contributing to the overall improvement of public health indicators and financial well-being within the state.³ As a publicly funded initiative, KASP's success is intrinsically linked to the stability and adequacy of its fiscal foundation.

This chapter is dedicated to a thorough examination of the fiscal space available for KASP. We will systematically explore the following key dimensions to provide a holistic understanding of the scheme's financial landscape:

1. **Financial Expenditure Patterns:** This section will meticulously analyze the scheme's financial outflows, including detailed claim patterns, premium-to-expenditure ratios, claim settlement efficiency, and any observed financial deficits. This will shed light on how resources are currently being utilized and the demand-side pressures on the scheme.
2. **Resource Allocation:** Here, we will delve into the sources of funding for KASP, specifically examining the contributions from both state and central governments, the timeliness and adequacy of these releases, and how administrative funds are allocated and utilized for critical functions such as IEC, capacity building, and fraud control.

By dissecting these areas, this chapter aims to offer valuable insights into the financial dynamics of KASP, identify areas for strategic intervention, and propose actionable recommendations to bolster its fiscal resilience and ensure its continued success in safeguarding the health and financial security of Kerala's citizens.

5.2. Resource Allocation for Health Insurance Programs

This section delves into the intricate financial landscape of the PMJAY-KASP scheme and its supporting state-specific initiatives. We will explore the resource allocation strategies,

³ Thekur and Faizan, "Magnitude of Health Expenditure Induced Removable Poverty in India."

examining the contributions from both the state and central governments, and scrutinize the timeliness and adequacy of these financial releases from fiscal years 2020-21 to 2024-25. Additionally, the analysis extends to the funding mechanisms of vital state-specific health schemes like the Karunya Benevolent Fund (KBF), Arogyakiranam, and Sruthitharangam, highlighting their unique roles and contributions to the broader health coverage. Finally, we will dissect the administrative fund utilization by the State Health Agency (SHA), shedding light on how these crucial resources are managed to ensure the efficiency and integrity of the schemes, including allocations for human resources, IT infrastructure, Information, Education, and Communication (IEC) and fraud control.

5.2.1. Funding Mechanism: State and Central Contributions to PMJAY-KASP

The funding mechanism for PMJAY-KASP in Kerala, involves significant contributions from both the state and central governments. PMJAY-KASP is a converged scheme, integrating the national Ayushman Bharat PM-JAY with Kerala's own Karunya Arogya Suraksha Paddhati. This convergence implies shared financial responsibility, with the state often covering beneficiaries beyond the PMJAY eligibility criteria.

Under the Ayushman Bharat PM-JAY framework, the standard cost-sharing ratio for states like Kerala (excluding North-Eastern and Himalayan states) is **60% from the Central Government and 40% from the State Government.**⁴ However, the overall state contribution to PMJAY-KASP often appears higher than the central share due to Kerala's commitment to extending coverage to additional beneficiaries under the KASP component, whose costs are borne entirely by the state. Funds from both central and state sources are typically channelled to an escrow account managed by the State Health Agency (SHA) in Kerala.

Tables A1 through A3 in the annexures section provide a comprehensive overview of the financial allocations for the period spanning fiscal years 2020-21 to 2024-25. Specifically, these tables detail the annual fund releases, categorized as follows:

- **Table A1:** State Share Details (2020-21 to 2024-25)
- **Table A2:** Central Share Details (2020-21 to 2024-25)
- **Table A3:** Summary of Total Annual Fund Releases (State & Central)

⁴ Vitsupakorn et al., "Early Experiences of Pradhan Mantri Jan Arogya Yojana (PMJAY) in India."

5.2.2. Timeliness and Adequacy

An in-depth analysis of the fund release patterns from 2020-21 to 2024-25 reveals significant trends in the timeliness and adequacy of resource allocation for PMJAY-KASP in Kerala:

1. Growth in Total Funding (2020-21 to 2021-22):

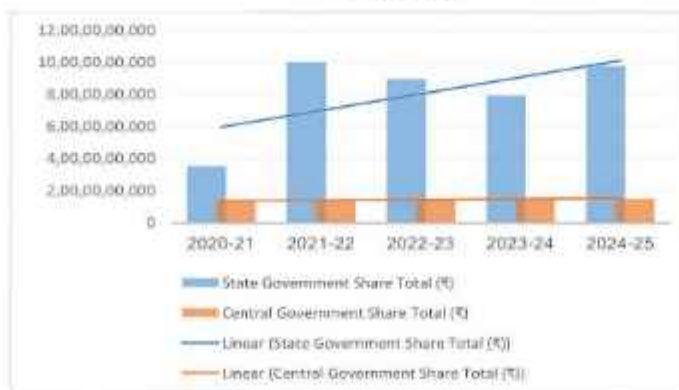
Figure 5.2.2.1: State and Central Government Share Trends (2020-21 to 2024-25)



There was a substantial increase in total funding from ₹494.68 crore in 2020-21 to ₹1,141.39 crore in 2021-22. This nearly 130% increase indicates a robust scaling up of the scheme's operations and financial requirements, likely driven by increased utilization, expanded beneficiary base, or enhanced package costs post-COVID-19. This surge suggests a responsive mechanism to growing demands.

2. State's Dominant Contribution and KASP's Role:

Figure 5.2.2.2: State and Central Government Share with Trend Lines (2020-21 to 2024-25)



Across all years, the State Government's share consistently far outweighs the Central Government's contribution. For instance, in 2021-22, the state share was approximately ₹1,002.50 crore, while the central share was ₹138.90 crore. This pattern highlights Kerala's unique approach to health insurance through the converged KASP scheme. While PMJAY mandates a 60:40 Centre-State ratio for its beneficiaries, the additional financial burden for KASP beneficiaries (those beyond PMJAY eligibility) is entirely borne by the state. This clearly demonstrates the state's significant financial commitment to comprehensive health coverage for its populace, expanding beyond the national scheme's direct beneficiaries.

3. Pattern of Releases – Phased and Regular:

Both state and central funds are consistently released in multiple tranches throughout each financial year.

- **State Releases:** State funds show a clear pattern of regular releases, often with an initial large tranche early in the financial year (e.g., April/May) followed by subsequent disbursements in mid-year and towards the fiscal year-end (e.g., March of the subsequent calendar year for the ongoing financial year). This phased approach allows the State Health Agency (SHA) to manage cash flow and respond to ongoing expenditure requirements, such as claims payments to empanelled hospitals.
- **Central Releases:** Central funds also demonstrate a multi-tranche release pattern. While sometimes consolidated into fewer, larger transfers (e.g., 2021-22's significant June 2021 release), they generally occur throughout the year, suggesting a demand-driven mechanism based on utilization certificates and state reporting.

4. Timeliness of Releases:

- **Initial Releases:** For both state and central shares, releases generally commence within the first few months of the financial year (April-August). This ensures that the scheme has foundational funds to begin operations, and process claims from the outset.
- **Year-end Releases:** Significant state releases are observed in February-March (e.g., March 2022, March 2023, Feb 2025). This year-end push suggests efforts to clear

outstanding liabilities or prepare for the upcoming fiscal year, potentially indicating that funds are released to align with expenditure cycles.

- **Lags in Central Releases (2023-24, 2024-25):** A notable observation for central releases in 2023-24 and 2024-25 is that all recorded releases for the entire financial year occurred on a single date, April 1st of the *subsequent* financial year (e.g., April 1, 2024, for FY 2023-24). This could indicate a delay in the administrative process of receiving official sanction orders and transferring funds. While the total amount is eventually received, such a lag could potentially strain the scheme's liquidity if timely central funds are crucial for immediate operations. However, for 2024-25, subsequent releases are dated towards the end of the calendar year (November-December 2024) which is somewhat unusual compared to prior years where early year releases were more prominent. This might reflect a shift in the central release cycle or specific administrative reconciliation for that year.

5. Adequacy of Funds:

- **Overall Trend:** The increasing total fund allocation from 2020-21 onwards (with a slight dip in 2023-24 but projected recovery in 2024-25) generally suggests an attempt to meet the growing demands of the scheme.
- **State's Proactive Funding:** The substantial and consistent state funding, often exceeding the central share multiple times over, indicates that the State Government is proactively ensuring the financial viability of PMJAY-KASP, particularly for its expanded KASP component. This proactive stance is crucial for maintaining the scheme's services, especially if central funds experience any delays.
- **Limitations in Assessment:** **Without actual expenditure data (e.g., claims paid, administrative costs incurred) for each financial year, a definitive judgment on the "adequacy" of these funds is difficult.** However, the consistent flow and the magnitudes involved suggest that the State Health Agency has been adequately resourced to manage its operations, even with potential delays in central disbursements in some years. The overall increase in state contributions points to rising healthcare costs or an expansion in the scheme's reach and benefits.

In conclusion, the funding mechanism for PMJAY-KASP in Kerala relies heavily on the State Government's substantial contributions, complemented by the Central Government's share under PMJAY. The state's proactive funding, especially for the broader KASP beneficiaries, plays a critical role in ensuring the scheme's financial resilience and its ability to provide comprehensive health coverage to its target population.

5.2.3. Other State-Specific Health Schemes and Their Contributions

Beyond the integrated PMJAY-KASP framework, the Government of Kerala demonstrates its broader commitment to universal health coverage through several other significant state-specific health initiatives. These schemes address particular healthcare needs and vulnerable populations, augmenting the overall resource allocation for health insurance programs within the state. This section details the funding mechanisms and contributions of the Karunya Benevolent Fund (KBF), Arogyakiranam, and Sruthitharangam schemes.

Karunya Benevolent Fund (KBF)

The Karunya Benevolent Fund (KBF) is a unique state assurance scheme designed to provide financial aid to economically disadvantaged individuals suffering from serious ailments, including cancer, haemophilia, kidney and heart diseases, and those requiring palliative care. A distinctive feature of KBF is its funding source: it is primarily financed by the proceeds from the Kerala State Lotteries, managed by the State Lotteries Department (Taxes). This innovative funding mechanism ensures a dedicated revenue stream for critical illness support. **Table 4** in the annexures details the state share received by the Kerala Budget Fund (KBF) from the Lottery Department for the financial years spanning 2020-21 to 2024-25.

Analysis of KBF Funding: The KBF demonstrates a consistent and substantial flow of funds, directly linked to the state lottery system. The annual contributions have shown fluctuations, with a significant increase from ₹43.39 crore in 2020-21 to ₹70 crore in 2022-23, followed by a dip to ₹50 crore in 2023-24, and then a projected surge to ₹86.10 crore in 2024-25. These variations could reflect the performance of the lottery sales, or a dynamic allocation strategy based on the demand for critical illness treatments. The KBF plays a vital role in providing a crucial financial safety net for high-cost critical care,

complementing the broader coverage offered by PMJAY-KASP, especially for conditions that might require extensive or long-term treatment.

Arogyakiranam

Arogyakiranam is a state-initiated entitlement scheme in Kerala focused on providing free investigation and treatment for children aged 0 to 18 years. This scheme covers health conditions not specifically addressed by the Central Government's Rashtriya Bal Swasthya Karyakram (RBSK), aiming to ensure nil out-of-pocket expenditure for eligible beneficiaries.⁵ The scheme was initially managed by the Director of Health Services (DHS) and the National Health Mission (NHM) but transitioned to implementation through the State Health Agency (SHA) Kerala from November 2020, integrating its in-patient services with the PMJAY/KASP IT platform (Transaction Management System).

The state share received for Arogyakiranam in 2022-23 is documented as:

Table 5.2.3.1 The state share received for Arogyakiranam in 2022-23

Year	Scheme	Fund Received (State Share - ₹)
2022-23	Arogyakiranam	8.65 Cr.

Analysis of Arogyakiranam Funding: The scheme's focus on children's health, irrespective of APL/BPL differentiation (for most services), highlights Kerala's commitment to early intervention and comprehensive care for its younger population. Its integration with the SHA and PMJAY/KASP IT platform suggests efforts towards streamlined service delivery and financial management.

Sruthitharangam

Sruthitharangam is a specialized state government scheme aimed at providing critical support for children with profound hearing loss. The scheme offers financial assistance for cochlear implantation surgery, post-surgical rehabilitation therapies (Auditory Verbal Habilitation - AVH), and the maintenance/upgrades of cochlear implant spares and accessories.⁶ It primarily targets children aged 0-5 years (with potential extensions for specific cases) from low-income families (annual family income below ₹2 lakhs).

⁵ Madhavan et al., "Functioning of Arogyakiranam Programme in Kerala."

⁶ Kunnath et al., "Disability Empowerment in Kerala."

Initially launched under the Social Justice Department, its implementation was transferred to the Health and Family Welfare Department through the State Health Agency in 2023-24.

The state share received for Sruthitharangam in 2023-24 is recorded as:

Table 5.2.3.2 State share received for Sruthitharangam in 2023-24

Financial Year	Scheme	Amount (₹)
2023-24	Sruthitharangam	12.10,Cr

Analysis of Sruthitharangam Funding: For 2023-24, Sruthitharangam received a state allocation of ₹12.10 crore. This specific allocation underscores the state's focus on high-cost, specialized medical interventions for a particular health challenge. The scheme's existence demonstrates a nuanced approach to healthcare funding, addressing specific, often life-changing, medical needs that might not be fully covered by broader insurance schemes. The transfer of its implementation to the SHA further suggests a move towards integrating specialized care into the broader health agency's oversight for better coordination and resource utilization.

Collectively, the Karunya Benevolent Fund, Arogyakiranam, and Sruthitharangam schemes represent significant state-driven efforts to build a robust and inclusive health safety net in Kerala. While PMJAY-KASP provides comprehensive general health insurance, these additional schemes offer targeted support for critical illnesses, pediatric care, and specialized medical conditions. Their distinct funding mechanisms (like the lottery-funded KBF) and specific beneficiary focus demonstrate a multi-pronged strategy to reduce out-of-pocket expenditure and ensure access to essential healthcare services for diverse vulnerable segments of the population, thereby enhancing the overall effectiveness and reach of health insurance programs in the state.

5.2.4. Administrative Cost Reduction: A Financial Benefit of Transition to Trust Mode

One of the significant advantages of transitioning from the insurance mode to the trust mode under the Karunya Arogya Suraksha Padhathi (KASP) has been the substantial reduction in administrative expenses. This shift represents a fundamental re-engineering

of the scheme's operational framework, moving away from a third-party, profit-driven insurance mechanism towards a direct, government-managed system.

Under the traditional **insurance model**, health schemes typically contract with private insurance companies to manage claims, process payments, and administer the program. While this approach can leverage existing infrastructure, it inherently involves a profit margin for the insurer, along with various operational overheads such as marketing, underwriting, extensive claims processing departments, and regulatory compliance costs. These administrative costs typically range between 8% and 12% of the total claims, representing a significant outflow of public funds that does not directly contribute to healthcare delivery⁷. Furthermore, governments often face challenges in ensuring transparency, controlling cost escalations, and aligning the incentives of private insurers with public health objectives. Managing these contracts, auditing claims, and resolving disputes with large insurance entities can also add to the government's administrative burden and require specialized oversight.

In stark contrast, the **trust model**, as implemented by the State Health Agency (SHA) for KASP, involves the direct management of the scheme's finances and operations by a government-controlled entity. This eliminates the profit motive of private intermediaries and allows for greater control over administrative expenditures. The SHA can streamline internal processes, leverage existing government infrastructure, and focus solely on efficient service delivery rather than profit generation. This direct management approach has enabled the SHA to maintain an annual administrative budget of less than ₹5 crore consistently, a remarkable feat given the scale of claims processed. However, this model also presents challenges for the government, including the need to build robust in-house capacity for claims processing, fraud detection, grievance redressal, and IT infrastructure. Ensuring the efficiency and integrity of these internal systems is paramount to the success and sustainability of the trust model.

The table below clearly illustrates the financial impact of this transition by comparing the total claims raised each year with the estimated administrative cost at a conservative rate

⁷ Nourani et al., "Evaluating Traditional, Dynamic and Network Business Models"; Teeng et al., "Administrative Costs Associated with Physician Billing and Insurance-Related Activities at an Academic Health Care System."

of 8% (the lower end of the insurance model's range) against the actual expenditure under the trust model. (Table-5.2.4.1)

Table 5.2.4.1: Comparison of Estimated vs. Actual Administrative Costs for the KASP Scheme

Financial Year	Total Claims (₹ Crores)	Estimated Administrative Cost (Insurance Model @ 8%)	Actual Administrative Expenditure (Trust Model)	Approximate Savings (₹ Crores)
2020-21	646.05	51.68	2.35	49.33
2021-22	1563.55	125.08	4.7	120.38
2022-23	1695	135.6	5.25	130.35
2023-24	1724.98	138	5.03	132.97
2024-25	1592.13	127.37	5.27	122.1
Total	7221.71	577.74	22.6	555.14

This conservative estimate unequivocally demonstrates that Kerala has saved over ₹550 crore in administrative costs over five years by moving away from the insurance mode. The trust model, by enabling in-house claim management and significantly reducing dependency on insurance intermediaries, has proven to be a financially prudent strategy. This substantial amount represents new fiscal space that can be directly reinvested into the health insurance scheme, reinforcing its financial sustainability and expanding its capacity to serve beneficiaries. These funds can be reallocated to enhance the benefit package, increase coverage, improve healthcare infrastructure, or address other critical public health needs, thereby directly contributing to the scheme's core objectives without requiring additional budgetary allocations.

Beyond direct financial savings, the transition to a trust model yields several intangible benefits that indirectly contribute to fiscal space and overall scheme effectiveness. These

include enhanced transparency and accountability in financial management, as the SHA operates under direct government oversight and public scrutiny. This fosters greater public trust in the scheme's operations and financial integrity. Furthermore, direct management allows for greater flexibility and responsiveness in adapting to evolving healthcare needs and policy changes, by passing the bureaucratic hurdles often associated with external insurance partnerships. The ability to directly implement policy adjustments, introduce new services, or respond to public health emergencies without renegotiating complex contracts can lead to more efficient resource utilization and prevent potential cost escalations in the long run. This agility, while not directly quantifiable in monetary terms, strengthens the scheme's long-term viability and reduces the risk of unforeseen expenditures, thus indirectly expanding the effective fiscal space available for healthcare.

5.2.5. Financial Challenges and Policy Recommendations for AB PM-JAY-KASP in Kerala

Kerala's implementation of the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) faces severe financial strain due to disproportionate central assistance and rising healthcare demands. Despite covering 41.98 lakh families under the scheme, only 22.25 lakh families receive central support. This leaves a significant portion entirely funded by the state, further stretching Kerala's resources.

A critical issue is the central premium ceiling of ₹1,052 per family, fixed in 2018, which has not been revised to reflect inflation or the rising costs of healthcare. Consequently, the central government's contribution is capped at ₹631.20 per family annually, while Kerala bears the remaining burden. The state's actual net per-family cost of ₹3,848 is drastically higher than the national ceiling, making it the highest in the country. For instance, in the financial year 2023-24, the central government contributed only ₹151.34 crore to Kerala's AB PM-JAY program, covering approximately 10% of the total costs, whereas the overall expenditure was ₹1,419.32 crore, reflecting a disproportionate financial burden on Kerala. The state's healthcare system is further strained by the lack of adequate financial assistance for the inclusion of senior citizens aged 70 years and above. Kerala's aging population, constituting 7.6% of the total population, brings additional financial responsibilities, with an estimated annual expenditure of ₹456 crore.

A committee constituted by the National Health Authority (NHA) in 2022 proposed phased premium ceiling increases—₹1,598 in 2023-24, ₹1,710 in 2024-25, and ₹1,830 in 2025-26, based on a compound annual growth rate (CAGR) of 7%. While acknowledging the methodology, Kerala has highlighted a critical limitation: this approach relies on national averages and fails to account for unique state-specific healthcare demands. Average net per-family costs do not adequately address outliers or variations that may exist across different states; they are not comprehensive nor equitable. For example, Kerala's burning cost of ₹3,848 and Uttarakhand's ₹3,026 are being equated with states like Bihar and Arunachal Pradesh, which have significantly lower net per-family costs of ₹189 and ₹187 respectively. Such an approach fails to capture the nuances of diverse healthcare landscapes, including variations in beneficiary awareness, health-seeking behavior, utilization rates, disease profiles, availability of healthcare providers, and Health Benefit Package (HBP) rates. Notably, NSSO utilization data indicates that Kerala reports the highest percentage of utilization at 8.73%. These proposed revisions fall short of addressing Kerala's financial challenges, leaving the state to bear the brunt of rising costs. Without a realistic adjustment in central support, Kerala's ability to sustain the program is at risk, potentially affecting healthcare access for nearly half the state's population.

In response, Kerala has reiterated the need for the central government to cover at least 60% of the actual expenditure incurred for centrally assisted families, as utilization reflects all state-specific characteristics. As an alternative approach, Kerala proposes utilization-based premium ceiling adjustments that consider state-specific factors such as disease burden (NSSO utilization rate), healthcare infrastructure (bed strength per 1000 population), and package utilization rates (HBP variation). This method would involve segregating states and Union Territories into distinct quintile groups based on their burning costs, calculating the average burning cost for each quintile, and then applying weightages to various components alongside the CAGR.

Furthermore, Kerala strongly advocates transitioning from the outdated Socio-Economic Caste Census (SECC) 2011 data to the more dynamic and updated National Food Security Act (NFSA) database for determining eligibility under AB PM-JAY. The SECC data, now over a decade old, no longer reflects current socio-economic realities and demographic shifts, resulting in the exclusion of many deserving families. The NFSA database, which is

regularly updated and incorporates real-time information on Antyodaya Anna Yojana (AAY) and Priority Households (PHH), offers a more accurate and equitable framework for identifying vulnerable populations. Aligning AB PM-JAY eligibility with the NFSA would ensure the inclusion of families genuinely in need of healthcare support, enhancing the scheme's relevance and fairness while addressing the evolving socio-economic landscape of states like Kerala. These measures are essential to ensure equitable funding and the long-term viability of AB PM-JAY in Kerala.

5.2.6. Administrative Fund and Its Utilization

This section details the budget allocated for various administrative functions, including Information, Education, and Communication (IEC), capacity building, fraud control, and discusses how these funds are utilized to ensure the scheme's efficiency and integrity.

Allocation for Administration

The administrative budget for the State Health Agency (SHA) in Kerala encompasses various critical functions necessary for the smooth running of the PMJAY-KASP scheme. Table 5, located in the annexures, outlines the key heads under which administrative funds are allocated. This table provides a detailed breakdown for the current fiscal year, Budget 2024-25, the corresponding Expenditure 2024-25 incurred so far, and the Proposed Budget 2025-26. The total administrative budget for the financial year 2025-26 is proposed at **₹10.72 crore**, which is the same as the budget allocated for 2024-25.

Utilization and Efficiency

The utilization of these administrative funds is critical for the effective functioning and integrity of the PMJAY-KASP scheme. An analysis of the expenditure in 2024-25 against the allocated budget reveals insights into the efficiency of fund utilization across various heads:

- **Human Resources:** Expenditure on "Salary and allowances" (₹3.43 Crore against a budget of ₹4 Crore) and "Consultancy & Professional service" (₹38.03 Lakhs against ₹40 Lakhs) shows a high utilization rate. This indicates that human capital, which is fundamental to scheme management, operations, and technical expertise, is adequately resourced and actively engaged.

- **Office Expenditure:** Most office-related expenses like vehicle, office expenditure, rent, telephone, and internet charges show reasonable to high utilization, suggesting active day-to-day operations.
- **Capital Expenditure (Purchase of Equipment, Furniture & Fixture, Civil/Electrical Works):** There was no reported expenditure for "Civil/electrical/electronic works," "Purchase of equipment's," and "Furniture and Fixture" in 2024-25, despite allocations of ₹2 Lakhs, ₹50 Lakhs, and ₹30 Lakhs respectively. This could mean that these capital expenditures were either deferred, not required, or processed under different heads not explicitly shown. Such zero utilization for capital items might affect long-term operational efficiency if infrastructure upgrades are indeed needed.
- **Information, Education, and Communication (IEC) & Capacity Building:** The budget for "Publicity & Capacity building & IEC Activities" was a substantial ₹2 Crore, but the expenditure stood at only ₹49.62 Lakhs. This significantly lower utilization (less than 25%) is a critical area for review. Effective IEC and capacity building are crucial for increasing scheme awareness among beneficiaries and stakeholders, promoting proper utilization, and enhancing the skills of personnel involved. Under-utilization here could impede outreach efforts, beneficiary enrollment, grievance redressal, and overall scheme visibility.
- **IT Infrastructure:** The budget for "Computer and Peripheral expenditure" (₹100 Lakhs), "Software" (₹50 Lakhs), and "AMC & Maintenance" (₹50 Lakhs) for IT infrastructure also shows very low utilization for software (₹0.98 Lakhs) and AMC & Maintenance (₹1.76 Lakhs), and no expenditure for computer and peripheral purchases. In a technology-driven scheme like PMJAY-KASP, robust IT infrastructure is vital for claims processing, data management, and fraud detection. Low utilization in these areas could point to deferred IT upgrades, reliance on existing infrastructure, or potential bottlenecks in procurement and implementation.
- **Overall Efficiency:** The total expenditure for 2024-25 was ₹5.27 Crore against a total budget of ₹10.72 Crore, representing an overall utilization rate of approximately 49.18%. While some core operational areas show good utilization, the significant under-utilization in key strategic areas like IEC, IT infrastructure

development, and capital expenditures suggests that either budgeted funds were overestimated, or there were delays/challenges in executing projects under these heads. Efficient utilization of administrative funds directly impacts the scheme's reach, beneficiary satisfaction, and the smooth flow of operations.

Anti-Fraud Unit Resources and Activities

While specific detailed data for "Resources allocated for anti-fraud unit at state & district level" is not explicitly broken out as a separate budget line item in the provided table, the administrative budget implicitly supports anti-fraud activities through various heads:

- **Human Resources:** The allocation for "Salary and allowances" and "Consultancy & Professional service" would cover the personnel working within or supporting anti-fraud units, including forensic auditors, data analysts, and legal experts.
 - **IT Infrastructure:** "Software" and "Computer and Peripheral expenditure" are essential for developing and maintaining sophisticated fraud detection algorithms, data analytics tools, and IT systems used by anti-fraud units to identify suspicious patterns in claims data. The low utilization in these IT categories could potentially impact the technological capabilities of fraud control efforts.
 - **Office Expenditure & Travel:** Funds for "Office expenditure," "Traveling expenses," and "Telephone & Internet charges" would support the day-to-day operations of anti-fraud units, including field investigations, meetings, and communication.
 - **Capacity Building:** The IEC and Capacity Building budget would ideally include training programs for anti-fraud personnel, equipping them with the latest techniques and knowledge in fraud detection, prevention, and investigation.
- Activities of Anti-Fraud Units:

Anti-fraud units (AFUs) within health insurance schemes are critical for maintaining financial integrity and ensuring that resources are utilized for legitimate beneficiary care. Their typical activities include:

- **Data Analytics:** Using advanced algorithms and big data analytics to identify suspicious claims patterns, provider behaviours, and beneficiary profiles.

- **Investigations:** Conducting thorough investigations into flagged cases, which may involve site visits to hospitals, verification of beneficiary identities, and scrutiny of medical records.
- **Audits:** Performing concurrent and post-payment audits of claims to detect billing errors, upcoding, or unnecessary procedures.
- **Legal Action & Recovery:** Initiating legal proceedings against fraudulent providers or beneficiaries and recovering defrauded amounts.
- **Awareness & Prevention:** Engaging in awareness campaigns among providers and beneficiaries about fraud and abuse and implementing strong internal controls to prevent fraudulent activities.

The effective functioning of these units is paramount to building trust in the scheme, preventing financial leakages, and ensuring that funds are available for genuine healthcare needs. While the current budget lines do not explicitly detail an "Anti-Fraud Unit" head, the efficient allocation and utilization of funds across various administrative categories, particularly in human resources and IT, are crucial for supporting a robust anti-fraud mechanism within PMJAY-KASP. The significant under-utilization in IT and IEC/capacity building, if persistent, could be a point of concern regarding the scheme's proactive fraud detection and prevention capabilities.

5.3. Discussion

Karunya Arogya Suraksha Padhathi (KASP) reveals a complex and evolving fiscal landscape. While the initial years of the scheme demonstrated commendable operational efficiency and robust payment rates, significant challenges in financial health have emerged, leading to substantial payment backlogs, especially within the public healthcare sector.

A significant trend is the substantial growth of outstanding amounts, particularly for public sector claims. From a state of minimal outstanding liabilities in 2020-21, these figures increased to over ₹722 Crores for the public sector by 2024-25, alongside a notable increase for the private sector. This represents a significant gap between claim approval and actual financial disbursement. While claims are being processed and approved, the funds are not consistently reaching the healthcare providers in a timely manner, leading to an accumulation of unpaid liabilities for services already rendered.

A key insight from the resource allocation analysis is the State Government's proactive financial commitment to PMJAY-KASP. The state's share consistently outweighs the central government's contribution, primarily due to its expanded coverage under the KASP component, which extends beyond PMJAY eligibility. This demonstrates Kerala's strong political will and fiscal effort to ensure comprehensive health coverage for its populace. Funds are generally released in multiple tranches throughout the financial year, suggesting a responsive mechanism to ongoing expenditure requirements.

The overall utilization rate of approximately 49.18% in 2024-25 suggests that a notable portion of the administrative budget remains unspent. Notably, there is under-utilization in strategic areas such as IEC, capacity building, and IT infrastructure development. Effective IEC and capacity building are vital for enhancing scheme awareness, promoting proper utilization, and improving grievance redressal, all of which are foundational to beneficiary satisfaction and scheme success.

Similarly, robust IT infrastructure is indispensable for claims processing, data management, and fraud detection. The low expenditure in these areas could affect the scheme's operational efficiency, its ability to detect and prevent fraud, and its overall outreach efforts, potentially contributing to existing payment and management challenges. While the administrative budget implicitly supports anti-fraud activities through human resources and IT, the underutilisation of IT categories raises questions about technological capabilities and proactive measures for fraud control.

The existence of other state-specific health schemes like the Karunya Benevolent Fund (KBF), Arogyakiranam, and Sruthitharangam demonstrates Kerala's multi-pronged strategy to build a comprehensive health safety net. These schemes, with their distinct funding mechanisms (like the lottery-funded KBF) and targeted support for critical illnesses, pediatric care, and specialized conditions, augment the overall fiscal space for health. While their direct financial contributions are separate from the PMJAY-KASP payment situation, they collectively underscore the state's broader commitment to reducing out-of-pocket expenditure and ensuring access to essential healthcare services. In essence, while the state has demonstrated a strong commitment to creating fiscal space for health insurance through substantial financial contributions, the efficacy of this space is influenced by challenges in expenditure management and resource utilization. The current situation is not merely about mobilizing more resources but fundamentally about

ensuring their efficient and timely disbursement to healthcare providers, particularly in the public sector, and optimizing administrative functions to support the scheme's integrity and outreach.

5.4. Conclusion

The analysis of fiscal space in Kerala's health insurance landscape reveals a scheme facing challenges. Despite substantial and proactive financial contributions from the State Government, the scheme is experiencing a growing payment backlog, most acutely impacting public sector healthcare providers. This notable discrepancy between claim approval and actual payment indicates a significant systemic challenge in fund disbursement, rather than a deficit in resource mobilisation. This situation can impact the financial stability of hospitals, potentially affecting the quality and accessibility of care, and may influence public and provider trust. Furthermore, the underutilisation of administrative funds, especially in crucial areas like IT infrastructure and IEC, points to opportunities for enhancing operational efficiency, fraud detection, and beneficiary engagement. Strategic interventions are important to streamline payment mechanisms, optimize administrative resource utilization, and bolster the scheme's fiscal resilience, thereby safeguarding its pivotal role in achieving Universal Health Coverage goals for Kerala's citizens.

Chapter 6

Way forward

Kerala has long been recognized for its progressive health indicators and extensive public health infrastructure. Yet, despite the achievements, the state continues to grapple with a disproportionately high out-of-pocket expenditure and rising financial burden on households seeking medical care. As per national data, Kerala reports the highest rate of hospitalization per 1,000 population, and a large share of household income is still spent on health, particularly at the outpatient level and for chronic illnesses. This underscores the need to expand financial protection while ensuring that such expansion leads to better value, not just higher spending.

A crucial prerequisite for expanding coverage and improving quality is institutional strengthening. Kerala must enhance the capacity of its State Health Agency to design, manage, and monitor complex health financing systems. This includes building robust data analytics and digital capabilities, improving provider empanelment and audit systems, and professionalizing scheme administration at the state and district levels. Strengthening institutional structures will ensure that expanded coverage is delivered efficiently, with adequate checks on cost, quality, and equity.

The following sections outlines a strategic framework for expanding health coverage to the currently uninsured population segments in Kerala through a targeted, fiscally sustainable approach. It proposes the use of the Public Distribution System (PDS) database as a dynamic tool for beneficiary identification, draws on existing state-sponsored health financing programs for service design, and introduces a roadmap for outcome-based quality improvement through Value-Based Care (VBC). Together, these approaches are aimed at creating a health system that is inclusive, responsive, and value-driven.

6.1 Need for Expanding Health Protection

Kerala has the highest in-patient care seeking with 105 individuals admitted per 1000 population as per the health consumption data released by National Statistical Office (NSS 75th Round - Jul 2017 to Jun 2018). As per the latest National Health Accounts (NHA) Estimates report for India 2018-19, Kerala's Total Health Expenditure (THE) against the Gross State Domestic Product (GSDP) and out of pocket expenditure (OOP) for health care

are highest in the country (4.4% and 68.6% respectively). The situation would have been worse had there been no government schemes that provide financial assistance for meeting healthcare needs.

NITI Aayog in its report on 'Health Insurance for India's Missing Middle' published in October 2021, could only make inferences and estimates of "Missing Middle" based on AB PM-JAY beneficiary database and National Sample Survey 75th round expenditure quintile and coverage in health insurance. Identification and outreach of this missing middle are listed as the key challenge in supply side. Identifying the missing population is a challenge in the absence of a unified database that captures the vulnerability and coverage under one or many health protections programmes.

This fragmentation can be addressed through use of common beneficiary database similar to that of National Food Security Act (NFSA) under Food & Civil Supplies. The advantage of NFSA is that it is dynamic in nature, information on vulnerability of individuals/families is available and is being widely used by multiple departments.

The beneficiary database that is currently being used for PM-JAY/KASP implementation was carried over from RSBY/CHIS scheme in 2018. No new enrolments, other than SECC 2011 vulnerable categories and KBF, were allowed after 2018. This poses multiple threats to the current system such as

- Left out vulnerable beneficiaries who could not renew their RSBY/CHIS during 2018-19
- Left out vulnerable families who have created new ration card detaching from their old families that were eligible under RSBY/CHIS

Further, an exercise was carried out by State Health Agency, Kerala to map the existing beneficiaries with the NFSA (ration card) database and found that families categorised as vulnerable, such as Antyodaya Anna Yojana (AAY) and Priority House Holds (PHH), are not covered under the existing population. A summary of this analysis is furnished below. (Table-6.1.1)

Table 6.1.1 Families covered under Public Distribution System in Kerala

Families covered under Public Distribution System in Kerala				
NFSA		NON-NFSA		
1	2	3	4	5
Antyodaya Anna Yojana (AAY)	Priority Households (PHH)	Non-priority Non-Subsidised (NPNS)	Non-priority Subsidised (NPS)	Non-priority Individuals (NPI)
5.91 lakh	35.92 lakh	29.63 lakh	22.74 lakh	28,621

Table 6.1.1 above shows the number of families having ration cards in Kerala as of May 2024, categorised by priority and non-priority groups as per the National Food Security Act (NFSA) 2013.

Out of the 94.49 lakh rations cards issued, 41.83 lakh families are covered under NFSA 'Priority' category and get subsidised food grains. Another 22.74 lakh families and 0.28 lakh individuals fall under non-priority but get subsidised benefits under PDS and the remaining 29.63 lakh families fall under non-priority non-subsidy (NPNS) category.

(6.1.2)

Table 6.1.2 Summary of Ration Cards (RCs) based on the PMJAY data in SHA, Kerala as on

Summary of Ration Cards (RCs) based on the PMJAY data in SHA, Kerala as on 26-05-2024		
Sl. No.	Description	Total Count
1	Modified RCs* (Missing in NFSA but present SHA)	17.28 Lakh
2	New RCs (present in NFSA but not in SHA)	18.88 Lakh
3	Existing RCs in PDS DB as it is	22.93 Lakh

4	Total AAY+PHH	41.84 Lakh
* Due to RC Surrender, Transfer of RC, Deletion of Bogus RC, Reduction of All Members, Transfer Return of RC and Card Type change to NPNS (N), Subsidy (S) and NPI(I)		

From the above mapping exercise, it's evident that

- There are 18.88lakh vulnerable (AAY+PHH) families that are not covered under the existing PMJAY- KASP scheme.
- Further, it was also found that there are 17.28lakh non-vulnerable families (neither AAY nor PHH) are covered under PM-JAY/KASP who belongs to different labour welfare boards and corporations.
- Since there were no exclusion criteria for families enrolled under the scheme in the past, some ration card belonging to Govt. employees were also found in the process

In addition to the above, SHA constantly receives telephonic and written enquiries regarding new enrolment for the scheme. The public grievances received during "Nava Kerala Sadas", and recommendations made during the last "Loka Kerala Sabha" also points to the need for new enrolment of beneficiaries.

An ideal option for expanding the financial protection for health services is to introduce a pre-payment system through a combination of subsidy and equitable contribution from the general public.

6.2 Policy Considerations and Recommended Phased Implementation Model

Before a designing a scheme that covers the missing middle or provides a universal health coverage, it is important to address the key policy considerations,

- a) What is the State objective for providing financial protection to its population
- b) Should health protection be provided for everyone for everything or selected group for selected health care needs or a combination of both
- c) How much and the source of revenue for sustained programme implementation

Kerala being a State with better health index score and at the same time having limited resources, should find a balance between these. Further, with strong public health

system, the strategic purchasing decision should also be appropriately taken that balances supply, quality and price.

Considering the above, State Health Agency put forward a phased approach for providing health protection to Keralites for further deliberation for the State Government.

Phase 1:

- a) Dynamic inclusion of all the AAY-PHH households, as per NFSA database in the PM-JAY/KASP beneficiary list
- b) Limiting the treatment benefits to essential services (preventing catastrophic health expenses) for all the non-AAY- non-PHH beneficiaries who are currently covered under PM-JAY/KASP, with beneficiary contribution)
- c) Extension of minimum services to all the Keralites in the State, with beneficiary contribution)
- d) KBF eligible families (financially vulnerable) will also get access to essential services

Phase 2: Provision for general population to avail complete benefits through a subsidised beneficiary contribution programme

The family definition for KASP will also be retained for determining the family bucket sum assured. The dynamic inclusion of beneficiaries based on the NFSA will eliminate reliance on outdated RSBY/CHIS databases. Moreover, it will ensure that changes in vulnerability are aligned across various social protection programs.

The concept of essential services is based on models tested both internationally and nationally, including Kerala's CHIS Plus introduced in 2011. Karnataka has also introduced the APL coverage with critical care packages in 2015 later expanding to full coverage in 2018. This model aims to protect individuals from catastrophic health expenses, such as emergency or high-cost treatments related to trauma care, cancer, and heart or kidney diseases. Essential services could be restricted to public hospitals if cost containment is a priority. For other services, all the existing PM-JAY/KASP facilities could be engaged. New empanelment of hospitals should be based on supply analysis in specific regions.

Including the KBF category aims to cover the financially vulnerable population who may not have been identified as AAY/PHH in the NFSA database, thereby preventing omissions and ensuring comprehensive coverage.

The complete coverage as specified in the phase 3 will be an optional add-on benefit package which the general public can pre-purchase for a specific duration, a portion of which will be subsidised. In long run, this subsidy may be reduced as the population will be educated on the importance of pre-purchase of care.

6.3 Improving Quality of Care through Value-Based Care and Outcome Measurement

As Kerala moves closer toward universal health coverage (UHC), there is a pressing need to transition from a volume-driven healthcare system to one that delivers value for every rupee spent and every life touched. Ensuring better treatment outcomes, not just more treatments, is the cornerstone of this transition. In this context, the adoption of a Value-Based Care (VBC) approach offers a transformative pathway to improve quality of care across the board.

Traditional health financing models reward providers based on the quantity of services delivered, often without adequately measuring their effectiveness or long-term outcomes. This model, while essential in expanding access, does little to ensure that the care provided actually improves patient lives.

By contrast, Value-Based Care focuses on optimizing health outcomes per unit cost. It aligns the interests of patients, providers, and payers by linking payments to measurable health improvements. This shift requires rethinking how care is measured, delivered, and paid for.

6.4 Outcome Measurement as the Core of Quality Improvement

True quality improvement must be rooted in patient outcomes including both clinical indicators and patient-reported outcomes such as pain relief, functional ability, and overall quality of life. Kerala has already taken a significant step in this direction by piloting outcome tracking through tools such as the EQ-5D-5L, as well as Patient Reported Outcome and Experience Measures (PROMs and PREMs) via the DISHA call center system. These tools capture the voice of the patient and measure what truly matters: the ability to return to normal life, avoid complications, and feel better.

Outcome measurement enables:

- Identification of unwarranted variation in care across facilities
- Feedback loops that inform providers on their performance
- Patient empowerment, allowing individuals to make informed decisions
- Policy decisions based on real-world performance, not assumptions

Reducing Waste and Misuse

Another benefit of outcome-oriented care is the ability to detect and reduce low-value or inappropriate care. Audits and real-world utilization data have shown that not all services rendered, especially high-cost procedures, lead to better outcomes. Strengthening pre-authorization systems, clinical audits, and utilization reviews based on outcomes can ensure that care is necessary, appropriate, and effective.

Building the Infrastructure for Value-Based Care

To implement VBC at scale, the health system must invest in:

- Digital health infrastructure to capture and analyse outcome data
- Standardized outcome and cost metrics across public and private providers
- Capacity building for care teams on care coordination, communication, and data use
- Feedback and benchmarking tools to monitor performance and encourage continuous improvement

Kerala's high literacy, robust health network, and the existing health claims and digital systems provide a strong foundation for this transformation.

6.5 Conclusion

The path toward Universal Health Coverage in Kerala must be both equitable and sustainable. Expanding health protection to the missing middle population is not only a social imperative but also a fiscal responsibility that requires innovation in financing, targeting, and service delivery. Leveraging dynamic beneficiary databases such as NFSA, adopting bundled payment mechanisms, and building on the strengths of existing programs like KASP and Arogya Kiranam provide a solid operational base.

However, expanding access alone is not sufficient. The state must also ensure that healthcare services lead to improved health outcomes. A transition to Value-Based Care

is essential to align incentives, measure real-world outcomes, and reduce unnecessary interventions. By investing in digital infrastructure, standardizing performance metrics, and embedding patient feedback into the care cycle, Kerala can pioneer a model that delivers not just more care, but better care.

The proposed framework offers a pragmatic yet forward-looking blueprint for Kerala's next phase in health sector reform. With strong political will, institutional readiness, and a citizenry that values health and equity, the state is uniquely positioned to lead the country in demonstrating how health coverage, quality, and accountability can be meaningfully integrated.

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Annexures

Annexure 1: Scheme wise benefit package

Scheme Designation	1. RBY-CMS Schemes	2. CMS Plus	3. RBF	4. Cancer Saraksha	5. Thalassin	6. CM's Disease Fund	7. Anugrahastham (ASST)	8. Suburban
Beneficiaries	IPF & Category registered in State Govt.	All covered families under RBY-CMS	IPF and APF with the State Govt. Income (Rs.1.17 Lacs)	1. All IPF newly registered for Cancer Treatment (N.S.L. 01/01/04)	Children of 14 years	IPF with chronic diseases	1000000	Families suffering from biological or neobiological cancer, IPF & HIV and children
Coverage	5 members in a family	Members enrolled in RBY card	Over 100 members up to 250 for a family	All children under the age of 18	All children under the age of 18	All ages	All children under the age of 18	All cancer patients irrespective of the type of cancer/stage of disease
Financial Benefits	Rs. 10000/- for yearbook family annually upto removal of financial burden. Additional Coverage of Rs. 60,000/- for acute illness.	Rs. 10000/- for yearbook family annually upto removal of financial burden.	Rs. 10000/- as routine benefit to a family.	Initial Amount of Rs. 10000/- and further treatment is free of cost.	Initial Amount of Rs. 10000/-, higher amount on discretion of Hospital Super/CEO	From Rs. 1000/- to 10000/- as emergency assistance + 1% coverage for the accidental death of RBF	Coverage: (post RBY-CMS, CMS Plus, Thalassin, Anugrahastham)	Ceding of Rs. 2 Lakh and expert panel to approve any treatment above Rs. 5Lakh
Package	All diseases that require at least 24 hrs of hospitalization. Scheme covers pre-existing diseases also. Day procedures like dialysis, chemotherapy etc are also included.	Cancer, Kidney, Liver, Heart, and Trauma case	Cancer, Hemophelia, kidney and heart diseases and also for Palliative Care	Cancer treatment	Kidney, Gastrointestinal, Central Palsy, Herpes, HIV, Hemophelia, Rheumatoid, Sickle Cell Anemia, Orthopedic, obstetrics and other Neurodevelopmental, Disabilities, congenital anomalies (trichotrichia, etc) and accident cases which needs surgery	Cancer, cardiac, surgery, kidney, Trans, Liver and Multi Organ failure etc.	Early detection and management of defects at birth, disease in children, deformities, and developmental disabilities in children. OP and IP treatments like, genetics and drug are provided free of cost up to PK level.	All Cancer irrespective of the stage of the disease
Source of Funding	Insurance Mode Premium paid by Centre and State Govt (Joint)	State Budget	State Budget & profit generated through sale of Keralam and Keralam Plus Lottery	State Budget	State Budget	State Budget	State Budget & Coverage (post RBY-CMS, CMS Plus, Thalassin, Anugrahastham)	Centre fund to the hospitals
Service Providers	Private and Public Hospitals	DRG, DR, DL, GI, MC, SAS, ACC, MCC and SCMS	Private & Public Hospitals	DRG, DL, DL, GI, MC, SAS, ACC, MCC and SCMS	DRG, DL, DL, GI, MC, SAS, ACC, MCC and SCMS	All Public and Private Facilities	Public facilities from PK level to PK	Public Facilities having the facility for cancer treatment
Governance and Management	CHAM, under Labour Dept in the Social Agency, apart from it platform, popular schemes. Each district has an assistant director coordinate for management of scheme headed by assistant director at the state level. Insurance company looks after the claim processing and payment to service providers, via a district grievance redressal committee	CHAM acts as the State Model Agency. Apart from it platform, and separate schemes, CHAM directly manages the claims and payments. PPOs at concerned hospital manage the scheme at facility level	State agency, department of schemes, claim management unit and other staff director. RSM manages the scheme. RSM has appointed their coordinators at the District Collector to manage the operations and approve the amount. State level committee will approve the recommendations of district committee after scrutiny. District coordination committee activities at the district.	Department of Social Justice, Kerala Social Agency. Kerala acts as the state agency. State coordinator under Director RSM manages the scheme. RSM has appointed their coordinators at the facility level to manage the scheme. Claim processing is office.	Department of Social Justice, Kerala Social Agency. Kerala acts as the state agency. State coordinator under Director RSM manages the scheme. RSM has appointed their coordinators at the facility level to manage the scheme. Claim processing is office.	Directly under the supervision of CM's Office and Secretary/Commissioner. Applications are channelled through the relevant department offices like, Village, Taluk and Lallakannur Office.	State Department of Health and Family Welfare. Scheme managed by National Health Mission through their District Level Intervention Manager and RBE District. PPOs manage the scheme at the facility level. Claims are managed office.	Scheme managed by ICI, MCI and Department of Oncology in Alachal College.

Table A1: State Share Details (2020-21 to 2024-25)

Financial Year	Amount (₹ Crore)	Total (₹ Crore)
2020-21	83.76	356.57
	36.25	
	18.06	
	56.07	
	77.43	
	56.88	
	28.12	
2021-22	175.00	1002.50
	110.61	
	260.00	
	130.00	
	127.50	
	85.00	
	114.39	
2022-23	101.75	900.00
	305.25	
	100.00	
	200.00	

	100.00	
	23.25	
	69.75	
2023-24	88.50	793.39
	100.00	
	150.00	
	104.00	
	100.00	
	150.00	
	100.89	
2024-25	119.00	978.54
	100.00	
	50.00	
	68.00	
	100.00	
	109.54	
	300.00	
	50.00	
	50.00	
	32.00	

Table A2: Central Share Details (2020-21 to 2024-25)

Financial Year	Amount (₹ Crore)	Total (₹ Crore)
2020-21	51.71	138.11
	34.43	
	51.97	
2021-22	128.62	138.90
	9.19	
	0.94	
	0.15	
2022-23	62.12	151.34
	6.32	
	1.01	
	62.12	
	6.32	
	1.01	
	0.18	
	1.13	
	11.13	
2023-24	67.69	151.34
	6.88	

	1.10	
	67.69	
	6.89	
	1.10	
2024-25	67.69	151.34
	6.89	
	1.10	
	67.69	
	6.89	
	1.10	

Table A3: Summary of Total Annual Fund Releases (State & Central)

Financial Year	Total State Share (₹ Crore)	Total Central Share (₹ Crore)	Combined Total (₹ Crore)
2020-21	356.57	138.11	494.68
2021-22	1002.50	138.90	1141.40
2022-23	900.00	151.34	1051.34
2023-24	793.39	151.34	944.73
2024-25	978.54	151.34	1129.88

Table A4: State share received by the KBF from the Lottery Department over the financial years 2020-21 to 2024-25

Year	Scheme	Fund Received (State Share - ₹)	Source of Fund
2020-21	KBF	43.39	Fund received from Lottery Department (Taxes)
2021-22	KBF	44.22	
2022-23	KBF	70.00	
2023-24	KBF	50.00	
2024-25	KBF	86.10	

Table A5: Key heads under which administrative funds are allocated

Head	Budget 2024-25 (₹ in Lakhs)	Expenditure 2024-25 (₹ in Lakhs)	Proposed Budget 2025-26 (₹ in Lakhs)
Human Resource			
Salary and allowances	400.00	342.66	400.00
Wages	15.00	12.08	15.00
Consultancy & Prof. service	40.00	38.03	40.00
Office Expenditure			
Vehicle expenses	30.00	26.28	30.00
Printing & Stationary Charges	5.00	0.62	5.00
Office expenditure	10.00	9.11	10.00
Postage charges	1.00	0.15	1.00

Traveling expenses	20.00	14.82	20.00
Rent	32.00	28.95	32.00
Telephone & Internet charges	3.00	2.09	3.00
Civil / electrical / electronic works	2.00	-	2.00
Purchase of equipment's	50.00	-	50.00
Furniture and Fixture	30.00	-	30.00
Hospitality Expense	19.00	-	19.00
Software & IT Technical Support	5.00	0.05	5.00
IEC (Information, Education, and Communication)			
Publicity & Capacity building & IEC Activities	200.00	49.62	200.00
IT Infrastructure			
Computer and Peripheral expenditure	100.00	-	100.00
Software	50.00	0.98	50.00
AMC & Maintenance	50.00	1.76	50.00
Contingencies	10.00	-	10.00
Total Admin Fund (Rs.)	1,072.00	527.20	1,072.00

State Health Agency - Officials

Sl.No.	Name	Designation
1	Dr. Arun S Nair IAS	Executive Director
Joint Director		
2	Smt. Allirani A M	Finance & Administration
3	Dr. Bijoy E	Operations / Medical (i/c)
4		Medical
FINANCE & ADMINISTRATION DIVISION		
Finance Section		
5	Sri. Vipin C Mathew	Manager
6	Sri. Sivakumar S	Senior Accountant
7	Smt. Vijaya Lakshmi L	Accountant
8	Smt. Honey Happy	Accountant
9		Data Entry Operator
HR & Administration Section		
10	Sri.Nirmal M Kumar	Manager
11	Smt. Arya G L	Executive / Confidential Assistant to ED i/c
12		Confidential Assistant to ED
13	Smt. Jiji S	Data Entry Operator
14	Smt. Aswathy M P	Data Entry Operator

OPERATIONS DIVISION		
IT Section		
15	Sri. Vivek Krishnan P K	Manager
16	Smt. Remya R V	Executive
17		Executive
Grievance, Redressal, Monitoring & Evaluation (GRME) Section		
18	Smt. Bismi S J Nair	Manager
19	Smt. Laya Unnithan	Executive
20	Sri. Rohith Mohan	Data Analyst
21	Sri. Rohil B	Office Assistant
Information Education Communication & Capacity Building (IEC & CB) Section		
22	Sri. Thejus Thomas Uzuvath	Manager
23	Sri. Vipin V	Executive
Policy & Field Operations Section		
24	Sri. Vineeth V	Manager
25	Smt. Devi P Balan	Executive (Policy & Field Operations)
26		Executive (Convergence)
27	Miss. Anaswara Vijayan	Senior Assistant
28	Smt. Dhanya R V	Data Entry Operator
MEDICAL DIVISION		

Audit & Compliance		
29	Dr. Unnikuttan C.I.	Manager / Manager (HNQA) i/c
30	Dr. Megha Mohan	Medical Auditor
31	Dr. Sujith V G	Medical Auditor
32	Dr. Divya J S	Medical Auditor
33		Regional Medical Auditor
34		Regional Medical Auditor
35		Regional Medical Auditor
36	Dr. Jeevandas A K	Claims Coordinator / Audit Coordinator i/c
37		Audit Coordinator
38	Smt. Sumi L	Data Entry Operator
Hospital Networking and Quality Assurance		
39		Manager
40	Dr. Abitha George	Executive (Quality Assurance)
41		Executive (Hospital Networking)
Last Grade Servants		
42	Smt. Sreekala G.S.	LGS
43	Sri. Amal J.S.	LGS
District Project Coordinator (Operations Division)		
44	Aswathy K L	Trivandrum

45	Linoj Thomas	Kollam
46	Fabin J Joseph	Alapuzha
47	Dennis John	Pathanamthitta
48	Toney Thomas	Kottayam
49	Rojith Mathew	Idukky
50	Hema K.R.	Ernakulam
51	Reny Kuriakose C.	Thrissur
52	Arun C.A.	Palakkad
53	Jinesh K.P.	Malappuram
54	Harikrishnan S	Kozhikode
55	Ajay Das K.	Wayanad
56	Mithun T.	Kannur
57	Sibin Joseph	Kasaragod
Field Officers (Medical Division)		
58	Lekshmy G Kumar	Trivandrum
59	Vidhya Jagannadh	Kollam
60		Pathanamthitta
61	Archana J Pillai	Kottayam
62	Aneesha E	Alapuzha
63	Savitha Maria Thomas	Idukky

64	Harsha B	Palakkad
65	Vijesh K V	Thrissur
66	Sruthi S Kamal	Ernakulam
67	Tijomon Thomas	Malappuram
68	Harsha K V	Wayanad
69		Kozhikode
70	Nijisha P	Kannur
71	Ramya S P	Kasaragod