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CRISIS OF PUBLIC HEALTH CARE IN KERALA

Introduction: A System in Decline — The Unmaking of Kerala's Health Legacy

Kerala's public health system, once the pride of India and an example for the world, stands today at a crossroads — not because of natural decay, but due to deliberate neglect and systemic weakening. The sd "Kerala Model" did not emerge in recent years, It was painstakingly built over decades — through visionary public investments, empowered local governance, missionary zeal, reformist movements, and, most notably, the leadership of successive governments committed to equity and access.

One of the most significant milestones in Kerala's health journey was the expansion of medical education through the establishment of government medical colleges across multiple districts. This initiative aimed to ensure equitable access to tertiary healthcare and to strengthen the training of medical professionals in underserved regions—from Idukki to Kasaragod. Foundation stones were laid, land was acquired, and construction began with the vision of decentralizing advanced medical care across the state.

However, in the years that followed, progress has stagnated. Very few new government medical colleges have been completed or made functional, and the state's tertiary care infrastructure remains under severe strain. Simultaneously, there has been a concerning rise in out-of-pocket health expenditure in Kerala—now among the highest in the country. Public hospital infrastructure shows visible signs of neglect, with reports of collapsing buildings, inadequate staffing, and delays in critical medical services. Healthcare workers continue to raise alarms about their working conditions, while many patients face increasing financial and emotional distress.

This policy brief presents an evidence-based assessment of the current state of public healthcare in Kerala. It examines the systemic issues—ranging from insufficient public investment and maintenance of health infrastructure to the growing dominance of the private healthcare sector—that are contributing to the erosion of public trust. Once considered a model of equitable healthcare, Kerala is now at risk of deepening disparities, especially as the burden of both communicable and lifestyle diseases grows in an ageing population.

The following pages aim to provide a comprehensive understanding of these challenges. This is not merely a critique—it is a call for urgent, corrective action. Strengthening public healthcare requires renewed investment, policy innovation, and a clear roadmap to restore the foundations of Kerala's health legacy. The people of Kerala deserve a system that is robust, inclusive, and truly responsive to their needs.

Historical Evolution of Kerala's Public Health System

Kerala's health foundations were laid during the princely states era, with Travancore and Cochin investing early in public health and vaccination systems as early as the 19th century.

Christian missionaries played a transformative role by establishing inclusive hospitals and pioneering medical technologies like the first X-ray machine in 1923 at Neyyoor.

The social reform movements of the Kerala Renaissance promoted equity, education, and access to healthcare, challenging caste-based exclusion in health services.

Public health institutions like the charitable hospital in Thycaud (1837) and Neyyoor Medical Mission Hospital (1838) demonstrated a long-standing culture of inclusive health care.

Successive governments continued this legacy, with the first state-sponsored medical college established in Thiruvananthapuram in 1951, followed by colleges in Kozhikode, Alappuzha, Thrissur, and Pariyaram.

The UDF government's 2011 policy to establish a government medical college in every district marked a major leap in democratizing access to medical education and care.

Kerala's decentralized model, where local self-governments actively plan and implement health programs, has been key in maintaining accountability and responsiveness.

The deployment of over 26,000 ASHA workers helped build a robust last-mile health delivery system, especially in rural and underserved areas.

The integration of central schemes like the National Health Mission with state missions strengthened the system's financial and institutional base.

Kerala's consistent focus on public investment, institutional continuity, and community participation made it a model of accessible and equitable healthcare—not an overnight success, but a product of decades of cumulative effort.

Real Analysis: Kerala's Public Health Spending and Outcomes

In evaluating a government's performance, Results-Based Management (RBM) asks a simple yet critical question: What measurable improvements were achieved during the government's tenure? In public health, one of the most important indicators of progress is the reduction in out-of-pocket expenditure (OOPE) — the amount of money that individuals spend directly for their healthcare needs.

Kerala has historically had some of the best health indicators in India, such as low infant and maternal mortality rates, high life expectancy, and strong immunization coverage. However, these were not achievements of the current administration alone — nor were they primarily attained in the last decade. They are the result of a century-long process involving community awareness, institutional investment, and robust health-seeking behavior among the people of Kerala.

Despite these legacies, Kerala's performance in reducing the financial burden of healthcare on its people has been dismal in recent years. According to National Health Accounts (NHA) data, from 2016–17 to 2021–22 , Kerala managed to reduce OOPE by only 7 percentage points. In contrast:

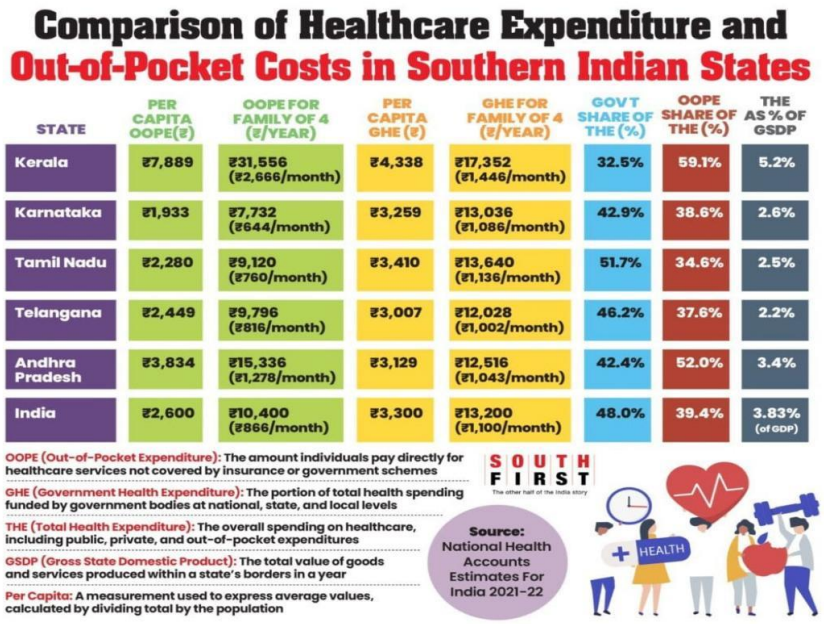
- Karnataka, Tamil Nadu, Assam, Chhattisgarh and Rajasthan reduced OOPE by 20 to 27 percentage points.
- The national average OOPE fell from 62.6% to 39.4% during this same period.
- Kerala's average per capita OOPE actually increased by 45%, rising from ₹5,419 to ₹7,889.

This surge in private healthcare costs directly contradicts the claim that public health infrastructure has improved. While health missions and schemes exist, their impact on reducing financial burden appears marginal at best.

State	Year	THE as % of GSDP	GHE as % of THE	OOPE as % of THE	OOPE as % of GSDP	OOPE per capita (₹)
Kerala	2016–17	4.5	26.6	67	3	5,419
	2021–22	5.2	32.5	59.1	3	7,889
Change		0.7	5.9	–7.9	0	2,470
Karnataka	2016–17	2.8	26.8	49.2	1.4	2,548
	2021–22	2.6	42.9	25.4	0.7	1,933
Change		–0.2	16.1	–23.8	–0.7	–615
Tamil Nadu	2016–17	2.8	27.3	62.1	1.7	2,938
	2021–22	2.5	51.7	34.6	0.8	2,280
Change		–0.3	24.4	–27.5	–0.9	–658
Chhattisgarh	2016–17	4	33.9	55.9	2.2	2,040
	2021–22	3.6	26.5	29.2	1	1,419
Change		–0.4	–7.4	–26.7	–1.2	–621
Assam	2016–17	3.3	26	53.8	1.8	1,378
	2021–22	3.6	64.4	27.6	1.3	1,180
Change		0.3	38.4	–26.2	–0.5	–198
Rajasthan	2016–17	3.3	30.3	56.7	1.9	1,934
	2021–22	3.5	49.2	37.1	1.3	2,048
Change		0.2	18.9	–19.6	–0.6	114

According to the 2021–22 NHA report:

- Kerala's total health expenditure was ₹48,034 crore.
- Of this, government spending accounted for ₹15,618 crore (32.5% of THE) or ₹4,338 per capita.
- Private expenditure, including OOPE, was ₹28,400 crore (59.1% of THE) or ₹13,343 per capita.
- A family of four in Kerala spends, on average, ₹32,000 per year (₹2,666 per month) out of pocket — significantly higher than in neighboring Karnataka, where the per capita OOPE is just ₹1,933.



Moreover:

- Government spending on health in Kerala stands at 1.7% of GSDP, while OOPE accounts for 3% — nearly double.
- Despite Kerala having the second-highest GSDP-to-health spending ratio (5.2%) after Uttar Pradesh, this expenditure has not translated into reduced financial hardship for citizens.

These figures expose a core contradiction: government health investments are not translating into effective public service delivery. Instead, citizens continue to depend heavily on expensive private care. This highlights a structural failure in health governance — not just of funding, but of equitable access, affordability, and trust in the public system.

Kerala's health sector today faces a set of complex and evolving challenges that threaten its long-standing reputation for strong public health outcomes. These challenges span across disease burden, human resources, public infrastructure, affordability, and administrative inefficiency.

1. Rising Disease Burden and Ageing Population

Kerala is one of the states most severely affected by non-communicable diseases (NCDs), including diabetes, hypertension, cardiovascular diseases, and cancer. In addition, mental health disorders, infectious diseases, and accidental injuries continue to rise.

- An ageing population has intensified the health burden, with elderly citizens requiring long-term care and regular outpatient (OP) support.
- High morbidity rates naturally escalate treatment costs, pushing vulnerable households into distress.

2. Human Resource and Staffing Deficits

Despite a visible expansion in treatment infrastructure, including upgrades in medical colleges and hospitals, there has not been a proportionate increase in medical personnel:

- Shortages of doctors, nurses, and paramedics continue to strain the system.
- Public hospitals frequently face burnout, overburdened staff, and lack of specialists in rural areas.
- Recent incidents at institutions like Thiruvananthapuram Medical College and Sree Chitra Medical Centre underscore the urgency of hospital administration reforms.

3. Outpatient Care and Medicine Affordability

While inpatient (IP) care is often free under government insurance schemes, the bulk of the financial burden falls on outpatient care and medicines, which account for the majority of treatment episodes.

- 10% of all medicines sold in India are consumed in Kerala, despite the state having only 3% of the population.The annual per capita expenditure on medicines in Kerala is Rs 2,567, as per the reply given by the Health Ministry to a question in the Lok Sabha.

- The annual medicine market in Kerala exceeds ₹15,000 crore.

Although the central government regulates prices of single-ingredient generic drugs, around 40% of drugs sold are fixed-dose combinations (FDCs), which are largely unregulated.

Patented drugs, especially for cancer, are exorbitantly priced and inaccessible to most.

4. Breakdown of Equipment and Maintenance Failures

Unofficial data indicates that up to one-third of medical equipment in government medical colleges is non-functional, due to:

- Lack of maintenance contracts
- Delays in procuring spare parts

Inefficient procurement systems and staff shortages

This equipment failure further limits the capacity of government hospitals to serve the public and pushes patients toward expensive private alternatives

5. Inadequate Public Infrastructure

Kerala has over one lakh hospital beds, but only 38,000 (about 38%) are in the public sector. This is severely inadequate when compared to the WHO recommendation of 5 beds per 1,000 people:

- Based on this standard, Kerala needs 1.78 million beds, indicating a massive shortfall in public provisioning.
- Emergency care for common conditions such as heart attacks and strokes remains inaccessible for large sections of the population, especially the Vulnerable Middle Class (annual income under ₹10 lakh) and Vulnerable Poor (under ₹3 lakh)

6. Limited Access to Health Insurance and Overdependence on Private Sector

- While 51.5% of households in Kerala have at least one member covered by some form of health insurance (as per a 2022 report), the majority of this coverage is under publicly funded schemes such as Karunya Arogya Suraksha Padhathi (KASP) and Ayushman Bharat. Private health insurance coverage remains limited, mostly accessible to salaried professionals, government employees, and high-income groups — particularly those earning over ₹15 lakh annually.
- According to NSS data from 2018, only about 33–35% of individuals in Kerala were covered under privately funded health insurance (PFHI). While private insurance uptake has grown modestly since then, it still remains low among vulnerable and self-employed populations, which form the bulk of the state's demographic.
- Crucially, around 80% of households in Kerala belong to either the vulnerable middle class (annual income below ₹10 lakh) or the vulnerable poor (below ₹3 lakh) (based on SECC 2011). Within this, an estimated 70% fall into the most economically fragile segment. Many are self-employed or work in the informal sector and lack any safety net beyond public health facilities.
- Despite this, close to 66% of patients in Kerala seek treatment from private hospitals(NSSO Analysis Data), often incurring high out-of-pocket expenses and debt, especially for outpatient care, diagnostics, and medication — services inadequately covered even under public schemes.
- This overdependence on the private sector is partly driven by the inadequacy of the public tertiary healthcare system. For a large section of the population, access to emergency medical care — for conditions like heart attacks or strokes — is either unavailable or delayed in government institutions. With only 38,000 beds in the public sector - just 38% of total beds in the state (Government of Kerala and the Center for Disease Dynamics, Economics & Policy), and the tertiary care system stretched beyond capacity, public hospitals often cannot meet the needs of a large and aging population.
- The situation is particularly alarming given the high cost of treatment in Kerala's private hospitals, which is among the highest in the country. For the vulnerable poor and middle class, this creates a scenario where healthcare becomes unaffordable, insurance inaccessible, and public options insufficient — a dangerous triad that increases financial risk and deepens inequality.

- **A look at the burden:**

Treatment / Procedure	Government Hospital Cost (INR)	Private Hospital Cost (INR)
Coronary Angioplasty	₹40,000 – ₹50,000 (including stent)	₹1,06,000 – ₹1,27,000 (including stent)
Pediatric Cardiac Interventions (e.g., ASD closure)	₹80,000 – ₹1,00,000	₹1,30,000 – ₹3,05,000
Pediatric Cardiac Surgeries (e.g., ASD closure)	₹65,000 – ₹2,00,000	₹2,20,000 – ₹4,50,000
Peripheral Artery Disease Surgery	Approx. ₹1,65,000	₹2,20,000
Coronary Artery Bypass Grafting (CABG)	₹30,000 (procedure charge)	₹1,80,000 – ₹3,50,000
Angioplasty (overall)	₹40,000 – ₹50,000	₹2,07,000 – ₹4,98,000

(PMC 2023 Study, Newspaper Articles)

7. Mental Health Infrastructure: The Neglected Pillar

Despite Kerala's reputation for high literacy and health awareness, mental health remains one of the most neglected components of the public healthcare system.

According to the National Mental Health Survey (NMHS) 2015–16, Kerala had one of the highest prevalence rates of mental disorders in India, with 12.43% of the adult population affected — significantly above the national average of 10.6%.Yet, the mental health infrastructure and funding remain grossly inadequate.

As of the Rural Health Statistics 2021–22, Kerala has only three government mental health hospitals (located in Thiruvananthapuram, Thrissur, and Kozhikode) to cater to a population of over 3.5 crore.

There is just one psychiatrist for every 100,000 people in Kerala — far below the WHO-recommended minimum of one per 10,000.

The state has not fully implemented the District Mental Health Programme (DMHP) in many districts, and where it exists, it suffers from lack of staff, trained counsellors, and regular medicine supply.

Mental health gets less than 1% of the state's total health budget, and most of that goes to the upkeep of large mental health institutions, not to community-based care or early intervention.

The COVID-19 pandemic, floods, and rising unemployment have worsened mental health outcomes, especially among youth, elderly, and migrant workers. Despite growing suicide rates and reports of depression and anxiety, mental health is still not integrated into primary health care systems or health insurance schemes in any meaningful way.

Kerala's Public Health System: Structural Weaknesses and Emerging Crisis

Despite Kerala's longstanding reputation for strong health indicators, recent trends reveal troubling signs of stagnation and systemic stress within the state's public health infrastructure. This policy brief highlights key areas where administrative bottlenecks, underutilization of funds, and staffing shortages have compromised healthcare delivery and widened the gap between need and access.

1. Misleading Attribution of Health Gains

Kerala's low maternal, infant, and neonatal mortality rates are often cited as recent successes. However, these improvements are part of a broader historical trajectory and nationwide trend, not recent interventions. For example, Kerala's MMR declined from 43 to 19 in line with India's national decline (from 130 to 90), and much of the credit belongs to sustained efforts by grassroots health workers like ASHAs.

2. Dismantling of Previous Welfare Mechanisms

Several previously impactful public health schemes have been either diluted or restructured in ways that have reduced accessibility:

Karunya Benevolent Fund, which provided direct financial aid for treatments, was replaced with a more complex insurance-based model (KASP).

As of early 2025, over ₹1,500 crore remains pending under KASP, including ₹1,203 crore to government hospitals and ₹693 crore to pharmaceutical companies, contributing to medicine shortages and delayed treatments.

3. Stalled or Reversed Institutional Expansion

Key infrastructure projects have either been halted or significantly scaled down:

The proposed Indira Gandhi Medical College, intended to offer affordable medical education, was scrapped without an alternative.

The ₹500 crore upgrade promised for Thiruvananthapuram General Hospital has seen substantial cuts, slowing its development.

4. Underutilized Health Budgets

Despite increasing healthcare needs, Kerala's public health spending remains below both state policy targets and national averages:

Health spending is under 6% of the total state budget, compared to the National Health Policy recommendation of 8%.

The CAG audit (2016–2022) noted only 4.24% of total health expenditure went toward capital investments.

In 2025, major cuts included:

Cancer Centres: Budgets for Thiruvananthapuram, Malabar, and Kochi centres nearly halved.

Crucial programs (sports medicine, oncology, palliative care, etc.) delayed or underfunded.

Blood bank funding halved, from ₹30 lakh to ₹15 lakh.

5. Workforce and Infrastructure Crisis

An extensive audit of 53 government hospitals revealed systemic staffing and infrastructure shortages:

Over 1,100 doctors, 900 nurses, and 700 paramedics were found to be lacking statewide.

Nurse-to-bed ratios in some hospitals reached 1:60, far exceeding the recommended 1:6.

In Kozhikode Medical College, a 2,490-bed facility sees a 90% shortfall in nursing staff.

Drug stockouts were chronic, with over 62,000 instances between 2016 and 2022. Essential medications were unavailable for months or even years.

Additional findings included:

Non-functional cath labs and diagnostic delays.

Poor maintenance of medical equipment.

Digital health initiatives like e-Health are underutilized or abandoned, with continued reliance on manual record-keeping.

6. Medical Negligence and Safety Failures

Disturbing cases of negligence reflect systemic issues, such as:

Death during routine surgeries.

Patients transported in bamboo stretchers due to non-functional lifts.

Extended power outages in active hospital wards.

Reports of organ sample theft and mismanagement.

7. Privatization by Default

Approximately 66% of patients now rely on private care, despite the higher costs. The shift is especially hard on lower-income groups, 80% of whom lack private insurance coverage. The erosion of public services has indirectly incentivized this transition, pushing vulnerable populations toward debt and distress.

8. Stagnation in Public Health Infrastructure Expansion

Data from the Directorate of Health Services (DHS) highlights a concerning stagnation in the expansion of Kerala's public health infrastructure. Between 2016–17 and 2024–25, the number of modern medicine institutions—including Sub-centres—increased from 6,688 to just 6,705. This represents a net addition of only 17 institutions over nine years, despite rising demand.

This marginal growth is especially troubling in the context of:

An ageing population with growing healthcare needs

An increasing burden of non-communicable diseases

Recurrent outbreaks of communicable diseases

At a time when access to timely and affordable care is critical, the near-stagnant expansion of health facilities points to gaps in long-term health planning, prioritization, and investment. Infrastructure numbers are not just statistics—they reflect the system's capacity to meet the evolving health challenges of the population. Without deliberate efforts to scale up public health infrastructure, Kerala risks further deepening inequalities in healthcare access and overburdening existing institutions.

No of modern Medicine insistutions - DHS

Year	Total	Subcentres	Grand total
2016 – 17	1280	5408	6688
2024 - 25	1289	5416	6705

9. Crisis in Hospital Infrastructure and Safety Standards

Recent data reveals a concerning reality: over 300 government hospital buildings across Kerala — including major medical colleges and taluk-level institutions — have been officially deemed structurally unsafe. Many of these facilities are plagued by deteriorating infrastructure, including damaged walls, leaking roofs, exposed electrical wiring, and weakened ceilings. These are not isolated cases but part of a larger systemic issue tied to ageing infrastructure and delayed maintenance cycles.

On July 8, 2025, the Kerala High Court took suo motu cognizance of the issue, expressing deep concern over the lack of basic safety in public healthcare facilities. The Court questioned how a state that upholds the value of "healthcare for all" could overlook the physical safety of patients and healthcare workers within its institutions.

In response, the government announced the formation of a technical committee to audit hospital buildings over 30 years old. While well-intentioned, such committees have been constituted in the past with limited follow-through. Structural integrity should not be contingent on age alone; proactive and periodic assessments across all public health infrastructure are necessary.

This is not the first warning sign. In 2023, 206 hospitals across Kerala received fire safety violation notices, including some of the state's leading medical colleges. The consequences were tragic: a fire in the ICU of Kozhikode Medical College Hospital in May 2024 resulted in the deaths of five patients. A second fire incident occurred just days later in the same facility, underscoring serious lapses in fire safety preparedness, infrastructure maintenance, and institutional accountability.

Despite earlier announcements to amend the Kerala Healthcare Service Institutions (Prevention of Violence and Damage to Property) Act to incorporate hospital safety standards, policy action remains pending.

Basic safety features such as:

Emergency exits
Functioning fire alarms and extinguishers
Periodic fire drills
Proper storage of flammable materials

…are often missing even in large public hospitals. In some cases, post-operative wards are located next to storerooms or corridors with poor ventilation and inadequate emergency preparedness. The lack of clean drinking water and hygienic facilities further compounds risks to patient safety and comfort.

This situation calls for urgent, coordinated action. The right to healthcare is incomplete without the guarantee of physical safety in healthcare settings. Institutional neglect of safety norms not only compromises care delivery but also erodes public trust in the healthcare system.

Year	No of Govt Hospital Beds
2011	31960
2016	38004
2022	38525

www.ceicdata.com

Year	No of Govt Doctors
2012	3878
2016	5239
2022	6169

www.ceicdata.com

Kerala's Government Medical Colleges: A System in Distress

Government medical colleges in Kerala serve as the primary providers of affordable, advanced medical care for nearly 80% of the state's population—particularly the vulnerable middle class and low-income families. Yet, these institutions are increasingly unable to meet even the basic health needs of the communities they serve. Despite the state's reputation for progressive health indicators, the ground realities tell a very different story.

1. Declining Access and Infrastructure Gaps

Kerala's medical colleges, once considered flagship institutions, are now overwhelmed by staff shortages, infrastructure decay, and treatment delays. In several colleges:

Patients lie on floors, verandahs, or wheelchairs due to ward overcrowding and incomplete infrastructure, as seen in Thiruvananthapuram after demolition of surgical blocks.

Surgical backlogs span months; cardiac patients wait 3–4 months for procedures in Kozhikode and Thrissur.

Human resource gaps are critical: nurses in ICUs are managing 1:8 patient ratios (ideal is 1:1), while doctors report burnout, resignations, and retirements.

New facilities are inaugurated without additional staffing, and many campuses continue to follow outdated staffing norms from the 1970s.

2. Financial and Operational Strain

The medical college system is under acute financial pressure:

Over ₹100 crore is pending to Thiruvananthapuram Medical College alone.

₹59 crore in pending payments to surgical equipment suppliers have led to stockouts and halted surgeries across multiple colleges.

Cath labs remain non-functional for months due to lack of stents and overdue bills, despite being showcased as centers of excellence.

In several instances, hospitals are forced to request patients to buy surgical consumables privately, despite being "free" under public schemes.

3. Administrative Bottlenecks and Equipment Failure

Even newly procured equipment lies idle due to bureaucratic delays:

A ₹5.5 crore CT scanner remains unused, while the functional unit malfunctions frequently.

In many hospitals, essential drugs and consumables are unavailable, radiology equipment is outdated, and buildings—including hostels—are crumbling.

Medical colleges in Idukki and Kottayam operate in visibly unsafe conditions, with collapsed buildings, broken infrastructure, and unfinished work.

4. Systemic Delays and Scheme Inefficiencies

Flagship health insurance schemes like Karunya Arogya Suraksha Yojana (KASP) and RSBY are facing execution delays:

Payments to hospitals and suppliers are delayed by up to 18 months, directly impacting service quality.

Shortages in medicines, surgical tools, and even basic amenities like lifts and power backup continue to plague hospital campuses.

5. A Humanitarian Emergency in Slow Motion

This is not a question of medical expertise—Kerala's public doctors and health workers are highly skilled and committed. What's missing is the infrastructure, equipment, and resources they need to deliver effective care.

The current state of Kerala's medical colleges is more than a governance issue—it is a structural health emergency. Without urgent reform, the system risks collapse under rising demand and chronic underinvestment.

https://www.onmanorama.com/news/kerala

Table: Crisis Summary of Major Government Medical Colleges in Kerala		
Medical College	Key Issues	Shortage Highlight
Thiruvananthapuram	Patients forced to lie on the floor due to bed shortages; surgical block not completed even after 3 years of demolition; critically ill patients lying on structures and verandas; delay of 3-4 months for cardiac surgeries; months-long delays for ECHO; equipment procurement stalled due to bureaucratic hurdles; doctors expressing helplessness; patients purchasing surgical equipment on their own; staff overworked throughout the year.	Beds, surgical tools, nurses, doctors, administrative responsiveness
Kozhikode	196 patients awaiting heart surgery; resignation and VRS by doctors due to poor working conditions; orthopaedics department non-functional; pharmacies unable to stock medicine due to 65 crore unpaid dues; limited basic medication availability; suppliers slashing deliveries; cumulative dues to suppliers exceed 100 crore; 18-month delay in KASP payments, 11-month RSBY delay.	Cardiologists, orthopaedists, surgeons, medicine stock, operational funds
Kannur	Gastro department reduced from 4 doctors to 1; OP only once a week; gastrosurgery department shut for 4 years; cardiology department only handles emergencies; 2-month wait for non-emergency surgeries; cobalt therapy for cancer treatment non-functional since 2020; old equipment lying abandoned.	Gastroenterologists, oncologists, cardiologists, operational equipment
Thrissur	Open-heart surgeries paused for weeks; surgical technician inefficiency; patients awaiting surgery for over 6 months; recent cancellations of multiple surgeries; over 50 patients still waiting.	Technicians, surgeons, operational schedule
Alappuzha	Crumbling infrastructure; critical departments understaffed; long waits for scanning reports; non-availability of prescribed medicines; shortage in multiple departments (gastro, neuro, medicine, radiology, ortho, surgery, etc.); outdated ultrasound machines; long queues for ultrasound and OP; emergency units missing key doctors; radiology reports delayed by a week; limited bypass surgeries due to lack of perfusionist and nurses; abandoned heart-lung machine due to lack of space.	Doctors, technicians, scanning equipment, ICU staff, building maintenance
Kottayam	Collapse of hospital building; poor maintenance of infrastructure; dilapidated hostels; frequent power outages; no generator backups; septic leakages; unopened newly constructed blocks; neglected buildings despite deterioration.	Structural safety, hostel conditions, basic utilities
Idukki	Incomplete infrastructure; unfinished elevator; patients forced to use ramps; waiting areas in reception lacking seating; dumping of waste in construction zones; neglect of ophthalmology and other departments due to lack of funds.	Infrastructure, ophthalmology staff, cleanliness and sanitation

The Changing Face of Private Healthcare in Kerala: From Community Care to Corporate Consolidation

Kerala's private healthcare sector has undergone a dramatic transformation—from a decentr al= ized, community-rooted system of small hospitals and clinics to one increasingly dominated by corporate hospital chains and private equity investments. While the private sector has long played a complementary role in Kerala's health ecosystem, recent trends raise pressing concerns about accessibility, affordability, and equity.

1. A Historical Shift Toward Private Provision

As early as the 1990s, the private sector had overtaken the public sector in terms of hospital and dispensary numbers. By 1991:

95.3% of hospitals and 97.1% of dispensaries in Kerala were privately operated.

The presence of small private clinics was key to Kerala's early achievements in vaccination and primary care access, including high child immunization rates.

Small and medium-sized hospitals—with fewer than 50 beds—were historically vital in ensuring healthcare access in both rural and urban areas. Even today, 58% of private hospitals in Kerala fall into this category.

2. Why Do Patients Prefer the Private Sector?

Despite Kerala's strong health indicators, systemic shortcomings in public hospitals push patients toward private providers:

Long waiting times, outdated equipment, and understaffing in public hospitals.

Proximity, shorter queues, and faster diagnosis in smaller private clinics.

As a result, 66% of the population now relies on private healthcare—not always by choice, but due to necessity.

3. The Rise of Corporate Healthcare

Kerala's private health sector has seen a rapid wave of mergers and acquisitions (M&A) in the past decade. This shift has been fueled by NRI investments, remittances, and private equity capital. Major developments include:

KKR's $300M investment in Baby Memorial Hospital (BMH).

Blackstone-backed QCIL's Rs 3,500 crore acquisition of KIMS Health.

Aster DM Healthcare's merger with QCIL to form a mega-chain, with Blackstone holding 30.7%.

Caritas and Lisie Hospitals' expansion through acquisition of local competitors.

The consolidation strategy mirrors national trends: build large hospital networks via M&A, realize scale efficiencies, and eventually seek public listings. However, this model is sidelining smaller hospitals that cannot compete, leading to the closure of at least 99 small hospitals in recent years.

4. The Cost to Households

Kerala now has one of the highest per capita health expenditures in India. Over 75% of medical costs are paid out-of-pocket, placing immense financial pressure on households.

Kerala leads India in household debt, averaging ₹1.98 lakh per family—nearly twice the national average (NABARD).

Health-related expenses consume 30–36% of non-food expenditure, contributing to financial distress and impoverishment.

Patients often take on loans or sell assets to afford care, especially when insurance fails to offer real protection.

Further, insurance-driven care in large hospitals may lead to over-testing and inflated bills, as hospitals maximize claims—compounding the financial burden on patients.

5. A Healthcare Crossroads

Kerala's once-celebrated healthcare model is at a critical juncture. As:

Public hospitals remain underfunded and overcrowded,

Small private hospitals struggle to survive, and

Corporate chains dominate care with high-cost models,

the net result is that healthcare is increasingly out of reach for the poor and middle class.

Healthcare Providers Technology Insurance Finance Regulatory People Communities

Home / Finance / Blackstone's QCIL Acquires Kerala's KIMS Health Management For ₹3,500 Crore

Blackstone's QCIL Acquires Kerala's KIMS Health Management For ₹3,500 Crore

Aster DM, Blackstone-backed Quality Care merger gets CCI nod

The combined entity will have a network of 38 hospitals and over 10,150 beds across 27 cities, making it one of the top three hospital chains in the country

ETPrime

KKR set to acquire Kerala's Baby Memorial Hospitals, make a comeback in hospital segment

Medical and Transport Expenditure – Rural

Major State	Conveyance (%)	Medical (%)	Total (%)
Andhra Pradesh	16.52	15.17	31.69
Assam	12.72	7.57	20.29
Bihar	10.24	14.13	24.37
Chhattisgarh	15.08	9.74	24.82
Gujarat	16.36	12.37	28.73
Haryana	14.57	11.53	26.1
Jharkhand	12.56	12.03	24.59
Karnataka	15.56	11.05	26.61
Kerala	19.06	17.33	36.39
Madhya Pradesh	15.66	11.67	27.33
Maharashtra	16.23	14.03	30.26
Odisha	12.76	13.1	25.86
Punjab	16.44	14.87	31.31
Rajasthan	15.27	10.35	25.62
Tamil Nadu	18.96	11.93	30.89
Telangana	14.23	12.2	26.43
Uttar Pradesh	13.1	13.75	26.85
West Bengal	8.71	16.17	24.88
All-India	14.32	12.9	27.22

Medical and Transport Expenditure – Urban

Major State	Conveyance (%)	Medical (%)	Total (%)
Andhra Pradesh	13.91	10.41	24.32
Assam	14.22	7.78	22
Bihar	10.89	11.6	22.49
Chhattisgarh	15.19	7.95	23.14
Gujarat	11.05	9.28	20.33
Haryana	13.82	7.3	21.12
Jharkhand	13.55	8.93	22.48
Karnataka	13.38	8	21.38
Kerala	16.5	14.42	30.92
Madhya Pradesh	14.97	9.4	24.37
Maharashtra	12.78	9.63	22.41
Odisha	14.11	7.99	22.1
Punjab	14.57	12.75	27.32
Rajasthan	15.56	8.26	23.82
Tamil Nadu	16.14	9.46	25.6
Telangana	13.25	7.65	20.9
Uttar Pradesh	13.1	13.55	26.65
West Bengal	10.5	14.84	25.34
All-India	14.03	9.7	23.73

Kerala's Health Paradox: Low Mortality, High Morbidity

Kerala is often hailed as a public health success story, with indicators such as high life expectancy, low infant and maternal mortality, and widespread health literacy. Yet, the state now faces a critical paradox: while people are living longer, they are increasingly spending a greater portion of their lives in poor health. This paradox is driven by a sharp rise in both non-communicable diseases (NCDs) and resurgent communicable diseases, compounded by systemic weaknesses and lifestyle shifts.

1. The Surge of Non-Communicable Diseases

NCDs—including cardiovascular diseases, diabetes, chronic respiratory illnesses, and cancer—are now the leading cause of morbidity and mortality in Kerala.

Recent Aardram mission screenings show that 45% of the population is at risk for lifestyle diseases.

20% diabetes prevalence, more than double the national average.

Hypertension affects 37% of adults; obesity and high cholesterol are also widespread.

CAD mortality: 382 per 100,000 men and 128 per 100,000 women—higher than Japan or rural China.

Kerala now records a 40-fold increase in heart attacks among men under 40 compared to the 1970s.

Cancer is another growing concern:

~35,000 new cases annually.

Breast cancer accounts for 30–35% of female cancers.

High incidence of tobacco-related and colorectal cancers linked to lifestyle and diet.

2. Persistent Threat of Communicable Diseases

Despite public health achievements, Kerala continues to report regular disease outbreaks:

Leptospirosis: 5,000+ annual cases since 2022; 394 deaths in 2024 alone.

Dengue and malaria remain endemic, especially during monsoons in urban centers like Kochi and Thiruvananthapuram.

Tuberculosis: Over 7,000 cases in 2023.

Re-emergence of cholera, H1N1, amoebic meningoencephalitis, and West Nile virus signal systemic sanitation vulnerabilities.

Climate events such as flooding exacerbate waterborne diseases due to contamination and poor waste management.

3. Health Infrastructure Under Strain

Kerala's public health system is ill-equipped to handle the growing disease burden:

Many ICUs in secondary hospitals are non-functional due to staff shortages.

PCR testing capacity and diagnostic access remain limited.

In rural and tribal areas, patients face significant access barriers, including limited specialist care, lack of labs, and under-resourced PHCs.

Urban hospitals face overcrowding, air pollution-linked illnesses, and unmanageable caseloads.

4. The Economic Burden of Illness

The growing disease load is translating into severe financial hardship:

Cardiovascular diseases alone account for nearly 20% of Kerala's domestic product.

Among low-income households, 80% experience catastrophic expenditure after hospitalization for heart-related conditions.

According to NSS 2022–23, average OOPE on health in Kerala is:

₹8,655 in rural households

₹10,341 in urban households

(More than double the national average)

Kerala also leads in household debt (₹1.98 lakh per family) and has one of the lowest savings rates (only 35% of households report any savings).

5. A Growing Crisis Among the Young

Perhaps the most concerning trend is the rise of NCDs among Kerala's youth:

25% of heart attack victims are under the age of 30.

Teen obesity, early-onset diabetes, and hypertension are on the rise due to poor diets, alcohol use, sedentary behaviour, and pollution exposure.

Without urgent intervention, this will place an unsustainable burden on future healthcare systems.

	Urban	Rural	Overall
Total Diabetes	24.7%	23%	23.6%
Pre-diabetes	16.1%	19%	18.1%
Hypertension	44.6%	44%	44.3%
Hypercholesterolemia	51.7	49.1	
Hypertriglyceridemia	30.9	30.7	
Low HDL Cholesterol	73.6	69.3	
Generalised Obesity	47.5	42	
Abdominal Obesity	62	56.6	
Physical Inactivity levels	72.4	70.2	

All in %

STATE UNDER FEVER SPELL

Disease	Confirmed cases	Deaths
Leptospirosis	1,258	67
Hepatitis A	3,241	25
Cholera	17	
West Nile	26	4
H1N1	919	15
Amoebic meningoencephalitis	5	3
Dengue	9,359	23

7 deaths due to fever were also reported this year

Cases reported from Jan 1- July 11, 2024

Source - Directorate of Health Services

DISTURBING DATA

DISTRICTS	PEOPLE SCREENED	DIAGNOSED WITH DIABETES, HYPERTENSION
T'Puram	1,89,134	11,771
Kollam	2,23,072	15,848
Alappuzha	3,04,287	18,866
P'Thitta	50,810	4,149
Kottayam	1,37,083	7,547
Ernakulam	1,59,680	11,909
Thrissur	1,85,241	12,623
Malappuram	3,40,434	15,839
Kozhikode	3,20,431	14,258
Kannur	3,97,440	21,975
Palakkad	3,83,315	9,979
Idukki	1,80,730	7,928
Wayanad	2,02,989	8,101
Kasaragod	2,02,417	7,803
Total	32,77,063	1,68,596

(Screening conducted to identify prevalence of non-communicable diseases among those in 30-59 age group)

Source: State Health Department

Budgetary Decline Undermining Kerala's Health Commitments

The National Health Policy, 2017 recommends that states allocate at least 8% of their Gross State Domestic Product (GSDP) to the health sector. However, Kerala's health expenditure has shown a worrying downward trend—dropping from 1.24% of GSDP in 2021–22 to just 0.75% in 2024–25. For a state often cited as a model for public health, such declining fiscal prioritization signals a troubling departure from its own legacy of healthcare leadership. Rather than reinforcing its public health system in the face of rising disease burdens and infrastructure challenges, Kerala appears to be moving in the opposite direction.

State Health Expenditure as Percentage of GSDP

YEAR	HEALTH EXPENDITURE	GSDP	HE %of GSDP
2021-22	11629	934541	1.24
2022-23	9850	1046188	0.94
2023-24	9577	1146109	0.83
2024-25	9583	1275412	0.75

Policy Recommendations for Strengthening Kerala's Public Health System

In light of the growing challenges faced by Kerala's healthcare sector, a multi-pronged approach is essential to restore efficiency, equity, and resilience. The following recommendations outline actionable policy measures to address systemic gaps:

1. Reform Procurement Systems and Emergency Protocols

Streamline procurement rules for essential medicines and medical equipment, especially during emergencies, to minimize bureaucratic delays.

Enhance financial autonomy of institutional heads—such as Medical College Superintendents, Principals, and the Director of Medical Education—to enable timely decision-making in critical situations.

2. Modernize Hospital Administration and Build Professional Capacity

Introduce administrative reforms to improve service delivery, reduce wait times, digitize patient records, and strengthen patient care protocols.

Establish specialized academic programs in hospital administration (certificate, diploma, and degree levels) under the Kerala University of Health Sciences, potentially anchored at the School of Public Health, Thiruvananthapuram.

Integrate trained administrators into hospital leadership structures to support RMOs and Superintendents.

3. Expand and Strategically Deploy Human Resources

Address persistent staffing shortages by recruiting doctors, nurses, pharmacists, technicians, and allied health professionals in a phased and fiscally sustainable manner.

Prioritize high-need regions, especially rural and high-morbidity districts, during recruitment and postings to improve equitable healthcare access.

4. Strengthen Preventive Health and Early Detection Programs

Develop and scale community-level preventive health campaigns targeting non-communicable diseases (NCDs), lifestyle risk factors, and early detection of chronic conditions.

Leverage ASHA workers, PHCs, and local governments to implement regular screening and health education initiatives at the grassroots level.

5. Improve Regulation of Private Healthcare Providers

Implement and enforce the Clinical Establishments (Registration and Regulation) Act to standardize treatment protocols, ensure pricing transparency, and promote ethical practices.

Establish a state-level regulatory authority with oversight functions and a patient grievance redressal mechanism to monitor compliance and protect patient rights.

6. Ensure Medicine Availability and Affordability

Strengthen public sector supply chain systems to prevent stockouts and ensure the regular availability of outpatient medicines and consumables.

Expand the Jan Aushadhi network and similar state-run outlets to increase access to affordable essential medicines, especially in underserved areas.

7. Undertake a State-Level Health Financing Study

Commission a comprehensive study on health financing and affordability, led by public health and economic experts, to assess out-of-pocket expenditure trends, coverage gaps, and guide long-term strategies for sustainable public health investment.

8. Expand and Decentralize Mental Health Services

Equip Family Health Centres and PHCs with trained staff to provide basic mental health screening, counselling, and referral services.

Ensure that all 14 districts have fully operational District Mental Health Program (DMHP) units, supported by mobile mental health teams and school-based programs.

Allocate at least 5% of the state health budget for mental health, emphasizing community-based care, early intervention, and digital mental health platforms.

9. Upgrade Secondary Care Infrastructure

Modernize and equip Taluk and District Hospitals with critical diagnostic and treatment infrastructure such as MRI and CT scanners, dialysis units, and fully functional ICUs to reduce overdependence on tertiary institutions.

Prioritize capital investment in secondary-level hospitals, particularly in underserved regions, to develop a robust and decentralized referral system that enhances access, reduces delays, and improves outcomes across the healthcare continuum.

10. Commission an Independent Audit on Service Delivery Efficiency

Establish an independent commission comprising retired health administrators, clinical experts, and public policy professionals to conduct a time-bound audit of all government medical colleges and major public hospitals.

The audit should assess key metrics such as:

Surgical and diagnostic delays

Availability and functionality of ICUs, imaging units, and specialist care

Bed occupancy and patient flow

Responsiveness of grievance redressal mechanisms

Ensure that findings are made publicly available and linked to hospital-specific corrective action plans, with follow-up monitoring by the Health Department and State Planning Board to ensure accountability and sustained improvement.

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