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Role of AYUSH Doctors in Filling the Gap of Health Workforce Inequality in Rural India with Special Reference to National Rural Health Mission: A Situational Analysis

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Abstract Paucity of health workforce in rural India has always been a problem. Lack of interest of modern allopathic graduates in serving the rural poor has worsened the situation little more. The National Rural Health Mission brought an innovative concept of mainstreaming of AYUSH and revitalization of local health tradition by collocating AYUSH doctors at various rural health facilities such as community health centers and primary health centers. In this context a study was aimed, based on secondary data, to make a situational analysis of health workforce in rural India and thereby analyzing the status and role of AYUSH Doctors in filling this gap of health workforce inequality. As on 01/01/2010 there were 61% of Ayurveda, 31.40% of Homoeopathy, 6.50% of Unani, 0.90% of Siddha and 0.20% of Naturopathy doctors serving in India. AYUSH facilities had been collocated in 240 district hospitals, 1716 community health centers and 8938 primary health centers in 2010. About 39.8% District Hospitals (DH), 38% Community Health Centers (CHC) and 38.2% Primary Health Centers (PHC) had been collocated with AYUSH facilities by 2010. About 30.9 lakhs rural population were being served by district hospitals, 4.3 lakhs of rural population were being served by CHCs and 0.8 lakhs of rural population were being served by PHCs in various states/UTs wherever the corresponding facilities exist. Equitable distribution of health workforce is of paramount importance in achieving both the horizontal and vertical health equity in rural India which is doable with proper implementation of AYUSH workforce.

Keywords *AYUSH Doctors, Gap, Health Inequality, Health Workforce, NRHM, Rural India*

1. Introduction

India's steps towards universal health coverage began in the early years after independence but they faltered because of various factors, including resource constraints. The context has vastly changed since then but the need remains as urgent as it always was [1]. Among various resources contributing to universal health coverage and health equality the role of health workforce is of utmost importance especially in rural areas. Inequalities in health workforce distribution may impact adversely on better

health outcomes. Paucity of health workforce in rural India has always been a problem. Lack of interest of modern allopathic graduates in serving the rural poor has worsened the situation little more. The National Rural Health Mission brought an innovative concept of mainstreaming of AYUSH and revitalization of local health tradition by collocating AYUSH doctors at various rural health facilities such as community health centers and primary health centers. The concept of mainstreaming of AYUSH was an idea in the IXth five-year plan before it was actually implemented in the country by NRHM in 2005. NRHM came in to play in 2005 but implemented at ground level in 2006 and introduced the concept of mainstreaming of AYUSH and revitalization of local health traditions to strengthen public health services [2, 3, 4]. The present document tries to make a situational analysis on the status and role of AYUSH doctors in filling the gap of health workforce inequality in rural India with special reference to national rural health mission.

Table 1: *Health Man-Power in Rural India as on March 2010 [5]*

Sl. No.	Category	Required	Sanctioned	In Position	Vacant	Shortfall
1	ANM at SC	147069	140721	166202	9376	10793
	ANM at SC and PHC	170742	161794	191457	10214	15079
2	MPW(Male) at SC	147069	76074	52774	25853	94337
3	Health Assistant (Female)/ LHV	23673	20860	17034	5070	7275
4	Health Assistant (Male)	23673	22739	16565	6912	10029
5	Doctors in PHCs	23673	29639	25870	6148	2433
6	Specialists:					
	• Surgeon	4535	2607	1531	1295	2583
	• Gynecologist and Obstetrician	4535	2429	1939	890	2271
	• Physician	4535	2087	1165	1036	2949
	• Pediatrician	4535	2062	1311	1070	2991
	Total Specialist at CHC	18140	9825	6781	4156	11361
7	Radiographer at CHC	4535	2907	1817	1260	2724
8	Pharmacist at PHC & CHC	28208	23376	21688	4653	7655
9	Lab. Technician at PHC & CHC	28208	17858	15094	5183	14225
10	Nursing Staff at PHC & CHC	55418	56805	58450	10289	13683
11	BEE at PHC	NA	4587	3063	1821	NA

2. Objective

To make a situational analysis of rural health workforce with the status and trend of AYUSH doctors in filling the gap of health workforce inequality in rural India with special reference to National Rural Health Mission.

3. Methodology

Review based study. The study used secondary data obtained from various sources mainly from the Dept. of AYUSH, Ministry of Health and Family Welfare, Planning Commission Report on AYUSH and the policy document of National Rural Health Mission on mainstreaming of AYUSH and revitalization of local health traditions.

4. Discussion

The concept of mainstreaming of AYUSH was an idea in the IXth five-year plan before it was actually implemented in the country by NRHM in 2005. The department of Indian system of medicine was

created in March 1995 [6, 7] and renamed to AYUSH in Nov. 2003 [9] with a focus to provide increased attention for the development of these systems. This was felt in order to give increased attention to these systems in the presence of strong counterpart in the form of allopathic system of medicine which leads to an 'architectural correction' in the health service envisaged by NRHM. NRHM came in to play in 2005 [2, 3, 4] but implemented at ground level in 2006 and introduced the concept of 'Mainstreaming of AYUSH and Revitalization of Local Health Traditions' [2, 3, 4] to strengthen public health services. This convergence has been envisaged with the following objectives-

- Choice of treatment system to the patients,
- Strengthen facility functionally,
- Strengthen implementation of national health programmes [2, 3, 4, 9]

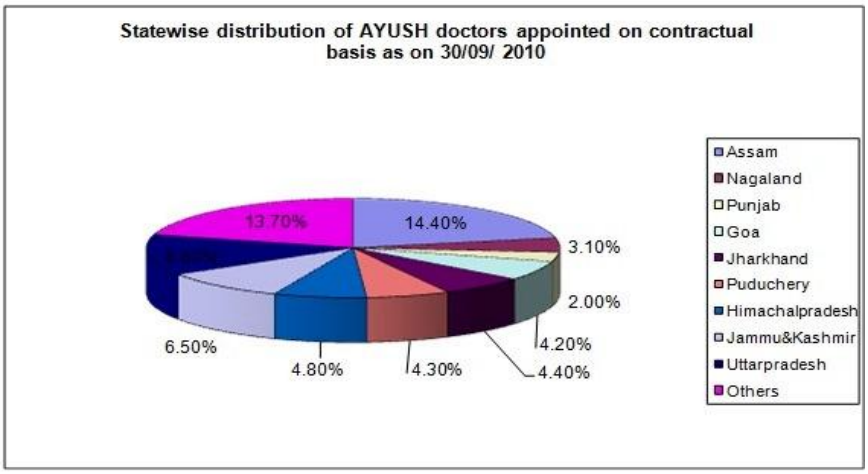

Figure 1: *State Wise Distribution of AYUSH Doctors Appointed on Contractual Basis under NRHM Till 2010*
Source- Department of AYUSH, MOHFW, Govt. of India (AYUSH till 2010) [8]

As on 30/09/2010, contractual appointments of 9578 AYUSH doctors and 3301 AYUSH paramedical staffs have been recorded.

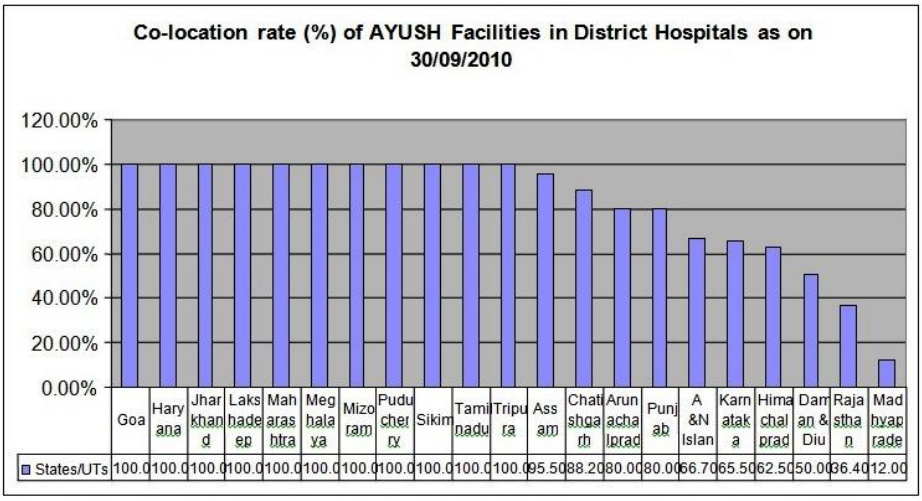

Figure 2: *Collocation Rate (%) of AYUSH Facilities in District Hospitals in Various States and UTs as on 30/09/2010*
Source- Department of AYUSH, MOHFW, Govt. of India (AYUSH till 2010) [8]

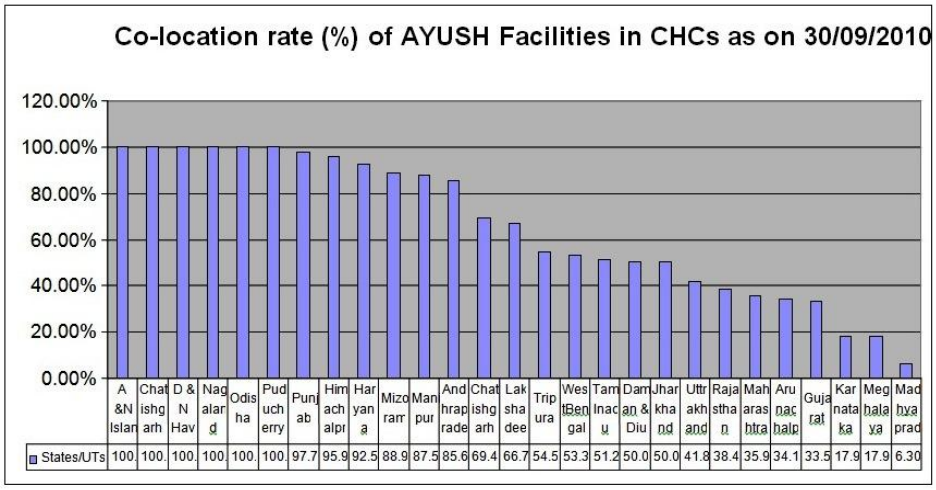

Figure 3: *Co-Location Rate (%) of AYUSH Facilities in CHCs in Various States and UTs as on 30/09/2010*
Source- Department of AYUSH, MOHFW, Govt. of India (AYUSH till 2010) [8]

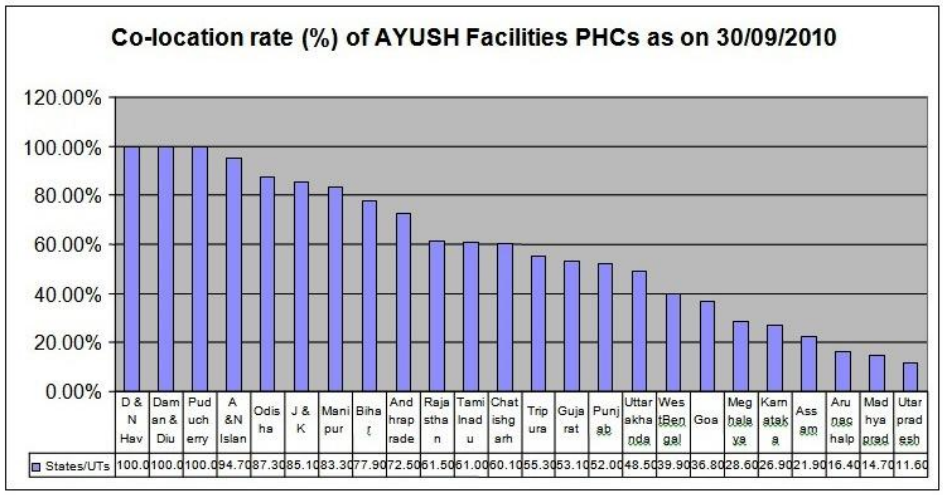

Figure 4: *Collocation Rate (%) of AYUSH Facilities in PHCs in Various States and UTs as on 30/09/2010*
Source- Department of AYUSH, MOHFW, Govt. of India (AYUSH till 2010) [8]

AYUSH facilities had been collocated in 240 district hospitals, 1716 community health centers and 8938 primary health centers in 2010. About 39.8% District Hospitals (DH), 38% Community Health Centers (CHC) and 38.2% Primary Health Centers (PHC) had been collocated with AYUSH facilities by 2010. Figure 2 clearly shows various states/UTs involved in AYUSH collocation in district hospitals whereas 14 out of them had no collocation facility by 2010. Similarly Figure 3 shows collocation in CHCs out of which 8 states/UTs had no involvement and Figure 4 shows collocation in PHCs and again 11 states/UTs had no involvement by 2010.

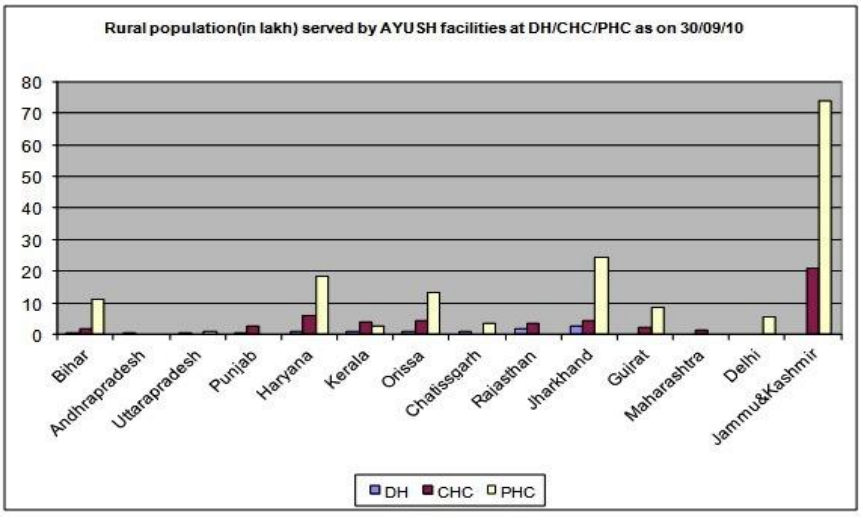

Figure 5: *Rural Population (in Lakh) Served by AYUSH Facilities at Various DH/CHC/PHC as on 30/09/2010*
Source- Department of AYUSH, MOHFW, Govt. of India (AYUSH till 2010) (Data of other States/UTs are not available) [8]

Figure 5 shows the pool of rural population served by District Hospitals, Community Health Centers and Primary Health Centers in various states/UTs. About 30.9 lakhs were being served by District hospitals, 4.3 lakhs of rural population were being served by CHCs and 0.8 lakhs of rural population were being served by PHCs in various states/UTs wherever the corresponding facilities existed.

Estimates show that almost 60% of health workers live in urban areas, which account for 26% of the country's population. Health worker density in urban areas at the rate of 42 per 10,000 is nearly four times higher than rural areas which have only 11.8 workers for a similar size of population, which is geographically more spread out given much lower population densities in rural India. This skew is consistent across cadres. Doctors, both allopathic and AYUSH as well as nurses have a density in urban areas that is three to four times higher than in rural areas [10]. This is one of the major problems faced by the rural population in India. The following tables clearly show a heavy distribution of AYUSH doctors in rural India. Table 2, shows higher population served in rural areas in all the three institutions such as DH, CHC, and PHC where AYUSH facilities are co-located in contrast to health infrastructure without AYUSH facilities. This does not otherwise indicate that AYUSH facilities in rural areas are sufficient enough for equitable health care distribution rather acts as synergist to the existing rural health facilities.

Table 2: *Average Rural Population Served Per Rural Health Infrastructure as* on 30/09/2010 [8]

Sl. No.	Rural Population Served Under Rural Health Infrastructure (in Lakh)			Rural Population Served Under Rural Health Infrastructure Co-Located with AYUSH Facilities (in Lakh)		
	DH	CHC	PHC	DH	CHC	PHC
1	12.3	1.6	0.3	30.9	4.3	0.8

Table 3: *National Level (All India) Contractual Appointments under AYUSH as on 30/09/2010* [8]

Sl. No.	Number of Contractual Appointments Under AYUSH		Percent Distribution of Contractual Appointments Under AYUSH	
	Doctors	Paramedical Staff	Doctors	Paramedical Staff
1	9578	3911	100.0%	100.0%

Another stark observation from the Table 3 is the distribution of AYUSH doctors in rural areas which shows that all parts of the country are fully distributed by the AYUSH doctors. The table illustrates 100% distribution of AYUSH doctors in rural India which literally means no part of the rural India is escaped from health workforce. Here, one can raise a question that, can the AYUSH doctors function as credibly as their allopathic counterparts? The answer to this question is certainly "NO" because of the obvious reasons but comparatively the service rendered by a qualified AYUSH doctor would be better than that of a paramedical staffs in any of the rural health institution where ever a medical officer is absent. Most importantly the TOR (Term of References) of AYUSH doctors is designed in such a manner that they could definitely be able to manage a rural health facility in collaboration with other paramedical staffs. Let us pick up some responsibilities mentioned in the TOR of AYUSH doctors in Orissa; [11] conducting minor surgery, abscess surgery, conducting normal delivery and insertion of IUCD (Intra Uterine Contraceptive Device) are some of the clinical skills that an AYUSH doctor is expected to have to work efficiently in a rural health facility. Similarly planning and implementation of national disease control programme, national health programmes such as immunization programme, Reproductive and Child Health programme, supervision of Village Health Nutrition Day and Pustikar Divas, implementation of IMNCI (Integrated Management of Neonatal and Childhood Illnesses) are some of the public health leadership skills will definitely enable them to provide better health services to the rural population provided these doctors are trained and reoriented from time to time on the above mentioned subject areas.

5. Conclusion

AYUSH workforce could be a better alternative to have equitable health workforce distribution in rural India if proper policy is made towards their recruitment and sustainability. Equitable distribution of health workforce is of paramount importance in achieving both the horizontal and vertical health equity in rural India which is doable with proper implementation of AYUSH workforce. As the curriculum of AYUSH system is different from that of their allopathic counterparts, these doctors need to be reoriented from time to time on certain areas of health care. This will undoubtedly patch up the health workforce inequality and contribute to the equitable distribution of health facilities in rural areas.

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