

Analysis of Rural Households' Treatment-Seeking Behaviour Based on Allopathic, Ayurvedic, and Informal Medical Practitioners

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Abstract

This research examines rural households' treatment seeking behavior and identifies variables that prevent them from utilizing public health services. It also highlights the fact that most AYUSH doctors and Allopathic medical graduates work in urban areas, leaving thousands of rural households to rely on unqualified individuals for primary care. Unless there is a change in perspective, this problem will persist. Misdiagnosis, inappropriate medication use, and the subsequent emergence of multi-drug resistance are all risks that come with continuing to rely on incompetent practitioners. The educational foundations of accepting this method have also been outlined, along with the reality surrounding allopathic practice by AYUSH practitioners.

From our perspective, the rural poor lack access to quality medical care for urgent problems because of state restrictions that permit non-allopathic practitioners to lawfully practice allopathy. Furthermore, it makes little to no difference in supporting the legitimacy of traditional medicine, the most well-known of which being Ayurveda. First, we will contextualize our remarks inside the recently introduced National Medical Commission (NMC) Bill 2017.

The terms of this bill necessitate the evaluation of the resource needs of the health care workforce as well as the establishment of a strategy to address those needs. Second, we are in favor of reintroducing the system that existed prior to the country's independence. This system consisted of competent medical assistants who were registered on a new schedule from the medical registration of each state. These assistants were able to provide immediate medical care and make informed suggestions for additional diagnostics or specialist treatment.

Keywords: Allopathy, Ayurveda, AYUSH, Rural household.

Introduction

The purpose of this research is to investigate the conditions surrounding rural health care providers and the role of certified allopathic physicians and AYUSH practitioners in that environment. When developing initiatives to enhance medical care in rural areas, it is imperative to consider these attributes. This is due to the fact that societal factors play a significant part in defining poor health and the treatment decisions that people make as a result. It is crucial to pay attention to these qualities as a result. In India, 68.84% of the population lives in rural areas and 31.16% lives in urban areas, according to the 2011 census (1). Over fifty-five percent of

the 244 million homes are rural, and of those rural households, more than 179 million live in a single room that is constructed out of straw and mud. When it comes to the economic condition of this group, more than half of them are deemed to be poor because they are employed in manual labor (2). Waterlogging, poor sanitation, home pollution, and a lack of access to safe drinking water remain the main causes of waterborne, vector-borne, and respiratory infections in these communities, despite a decline in the overall prevalence of communicable diseases between 1990 and 2016 (3).

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These factors continue to be the primary causes of these infections. In order to achieve this goal, there are a number of ongoing initiatives. These include the recently announced Ayushman Bharat program, which includes the National Health Protection Scheme (NHPS), the establishment of Health and Wellness Centers, and the construction of hospitals similar to the All India Institutes of Medical Sciences (AIIMS). The purpose of the 2018 budget releases was to achieve this. According to the research, these methods won't help with the rural poor's day-to-day out-of-pocket costs, which include a broad range of acute ambulatory illnesses that need medicine right away. Among these conditions are infections that necessitate prompt medical intervention. Illnesses such as malaria, dengue, encephalitis, tuberculosis, HIV/AIDS, latent hypertension, and diabetes are also encompassed in this group of people. People who have not been diagnosed with any of these ailments are also part of these disorders, which include severe fatigue, vomiting, lung congestion, and diarrhea.

Because competent diagnosis and therapy are only sought out after a number of unsuccessful treatments from practitioners who are not qualified, such illnesses continue to go undetected among households who are economically disadvantaged.

This paper aims to show how urgent it is to take action to alleviate the nationwide and, more specifically, village-level shortages of qualified medical professionals who can attend to the urgent health care requirements of the majority of the population. Given the current state of affairs, which is not going to improve anytime soon, this has been proven using geographical data of rural people and the distance to trained medical personnel (4, 5).

With this strategy in mind, we have looked at a number of relevant aspects, such as the 2017 National Medical Commission (NMC) Bill, the PSC's recent recommendations, and what the Union Cabinet supposedly did in reaction to these recommendations (6).

During the upcoming legislative debate that will take place prior to the law being implemented, there will be an opportunity to facilitate a change in the manner in which medical treatment is provided at the village level (7, 8). The most significant obstacle is the incompatibility between the primary health care services that are now

accessible and the requirements that are seen to be necessary by less fortunate people living in rural areas.

Setting of Healthcare in Rural Villages Services Rendered by the Field of Public Health

Community health centers (CHCs), sub-centers, primary health centers (PHCs), and district hospitals are all parts of the state-run system that offers public health treatments and services to people. Every published study, including those accessible through the Ministry of Health's Rural Health Statistics portal, confirms that most villages are situated within a few kilometers of a primary health care center (PHC). This is the initial level of medical treatment that government doctors are assigned.

According to recent statistics, more than 20% of all primary care physician positions are still available nationwide. The significant absence rates among medical professionals and support workers are not taken into account in these numbers (9).

An individual who had previously held the position of Vice-Chairman of the Niti Aayog stated that "the rampant employee absenteeism happens to be the primary culprit (among others such as the poor state of infrastructure and inadequate supply of drugs and equipment) that discourages people from seeking health services provided by the government system." According to reports, the average percentage of absenteeism seen across the nation is forty percent. The following is a paraphrasing of the original article that was cited before: It is (10). CHCs, also known as sub-divisional hospitals, are located at a higher level than primary health care centers (PHCs), and they are meant to be staffed by medical professionals. More than sixty-five percent of the positions in the CHCs are now vacant (11). Initiated in the 1980s, the primary health care centers (PHCs) aimed to supply twenty to thirty thousand locals with health and medical services. More than 6 lakh villages are served by the approximately 25,800 primary health care centers (PHCs) that are spread out over the entire country. First and foremost among public health workers is the Auxiliary Nurse Midwife (ANM). Although she oversees a single sub-center that provides services to 5,000 individuals (2,000 of whom live in hilly regions), she is not authorized to prescribe or

handle medications necessary for serious medical emergencies. Included in this category are treatments for severe respiratory illnesses, uncontrolled vomiting, and diarrhea. To use or prescribe pharmaceuticals specified in Schedule H and H1 of the pharmaceuticals and Cosmetics Act 1940, one must be a doctor who is registered with the state or central medical registration, which is maintained in line with the MCI Act-1956 and the Drugs and Cosmetics Act 1940. Included in this category are roughly 600 medicines (12).

To put it succinctly, this refers to an allopathic practitioner and no other practitioner. People from the working class who live in communities and do physical labor have enormous distances to travel. For this group, seeing a regular, competent primary care physician would be too costly in terms of opportunity cost. Reason being, the monetary benefits aren't worth the time, gas money, and missed paychecks caused by transportation costs.

For low-income families, going to the primary health care center (PHC) to receive treatment for acute diseases is counterproductive because of additional obstacles, such as the possibility of absenteeism and the reported lack of availability of medications, which are prevalent in public health facilities.

Peripheral Role of Sub-Centres and PHCs on Account of Distance

Since government doctors are exclusively assigned to primary health care facilities (PHCs), which are located at the block or taluka level, over two thirds of the village is more than five or even ten kilometers away from one. Jansankhya Sthirata Kosh (JSK) has district maps on their website [8]. Detailed on these maps are the locations of each taluka and hamlet, along with population estimates and distances to primary healthcare centers. The 2001 census provided the data used to create these maps.

The maps illustrate the number of villages that are located within 593 rural districts as well as the distances that must be traveled in order to reach the primary health care physician who is closest to the village.

In Figure 1, we can see the total number of villages in the Ujjain district of Madhya Pradesh, as well as the distance to the nearest primary health care institution, as well as the number of villages in each sub-division. This infographic, which shows the situation as it was in the 2011 census, was created by the National Informatics Centre (NIC), which is a branch of the Ministry of Electronics and Information Technology.

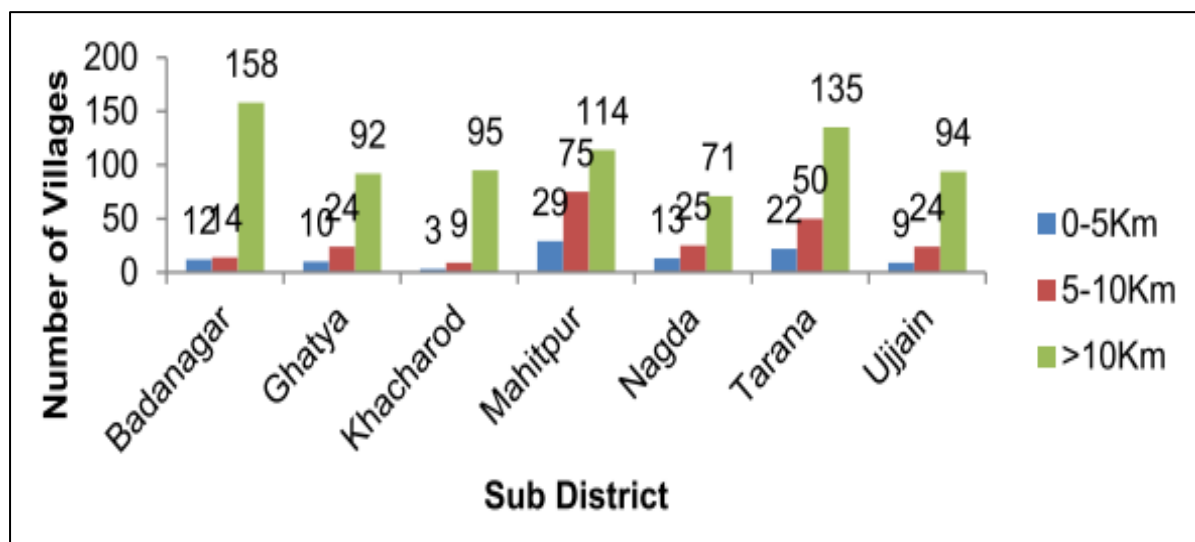


Figure 1: This is an example chart showing how far it is to go to a public hospital in the Ujjain district of Madhya Pradesh

This diagram was made public in response to a request because the census data had changed significantly during the last decade. Based on the 2011 census, NIC provided updated maps. Looking at the maps from the 2011 census or the ones from

the 2001 census, both sets of coordinates show very large distances. The fact that there has been no growth in the number of PHCs over the years makes this predictable.

Ayush Education- Answering the Dictates of the Market

Products of those systems, especially Ayurveda, are not involved in rural practice, as was already shown. But it's often said that AYUSH experts are a powerful force that could improve healthcare delivery. Over 7.7 million AYUSH practitioners in India currently practice the following subspecialties: Ayurveda (55.4% of the total), Unani (6.4%), Siddha (1.1% of the total), Naturopathy (0.3%), and Homoeopathy (36.8% of the total).

An approach to policymaking that aimed to integrate AYUSH into a biological curriculum for instruction, research, and education emerged in the 1970s. All Australian colleges are required by law to adhere to the CCIM's curriculum and standards, which it was given the responsibility of creating. The necessity to prepare graduates to offer an AUS approach to health and treatment has been overshadowed by their focus on graduates' future employment opportunities. Over the years, and especially in the past 20 years, CCIM has been greatly impacted by college administration, teachers, and students.

Only about twenty percent of graduates from Ayurveda colleges end up practicing their own systems, whereas eighty percent of graduates from Ayurveda colleges end up practicing allopathy. This is despite the fact that there has been a proliferation of those colleges. This article provides an explanation of the historical perspective of AYUSH in India.

Prospects for Ayurveda as a Medical System Given the Proclivity to Practice Modern Medicine

The central council of homoeopathy website and the annual report of the ministry of AYUSH for 2016 both indicate that there are 341 Ayurveda colleges, 10 Siddha colleges, 52 Unani colleges, and 196 homoeopathy colleges in operation at the present time.

Among these, there are 41 Homoeopathy colleges, 135 Ayurveda colleges, 3 Siddha colleges, and 14 Unani colleges that offer post-graduate degrees. A total of around 20,000 graduates from Arizona State University and 2,000 post-graduates graduate from these institutions each year on average.

One of the most important questions that is being discussed is why graduates of AYUSH choose to practice in allopathic medicine rather than in the system from which they graduated. There is a significant disparity in the quality of medical education that is offered by AYUSH institutes across the country. Most graduates are uncertain about whether or not they will be able to practice AYUSH after graduation, with the exception of a few reputable universities and schools. This issue has been exacerbated by the commercialization and corruption within the AYUSH education industry. Many factors have contributed to this situation, including the inadequate infrastructure in AYUSH colleges, an inadequate number of qualified teachers, an overemphasis on theory rather than clinical application, and insufficient exposure to a diverse range of clinical cases with different conditions. Here are only a few of the many additional reasons why Ayurvedic practitioners' practical knowledge, competencies, and abilities have declined. This is so even if some areas in other states, like Kerala, have very unusual data.

- Due to a lack of qualified instructors, medical school curricula have become less rigorous as the number of low-quality institutions has exploded. As an example, of the 341 Ayurveda colleges that are currently operational, around 165 (or 48.38%) were founded in the years following 2000. The systemic corruption has even allowed for the creation of universities where the majority of faculty and students simply exist in a digital form.
- Following the same pattern of subject classification and substance, the BAMS course curriculum is practically an exact replica of the MBBS program. (With the exception of institutions with an affiliated Allopathic college or hospital, which is unusual) AYUSH professors teach biomedical courses to undergraduates. The low volume of in-patient admissions at AYUSH institutions also means that they don't get much hands-on experience or practical training.
- Regarding the treatment of infectious diseases and other life-threatening situations, the Ayurvedic curriculum pays little attention to the system's limits. Additionally, it neglects or

- downplays the significance of addressing nutrition-related problems, lifestyle-related diseases, chronic non-infectious conditions, and palliative care for patients undergoing chemotherapy or terminal illness. There is a huge chance to reimagine Ayurveda education and bring its potential mainstream, especially given the exponential growth of noncommunicable diseases (NCDs) in both urban and rural areas (3). However, so far, patients' interests have been the primary driving force behind the pursuit of Ayurvedic treatment for chronic diseases.
- Acquiring the necessary skills to administer Allopathic medications has already been approved by the governments of various states, including Maharashtra, Punjab, Tamil Nadu, Assam, and Himachal Pradesh, among others. There is no longer any need for Ayurveda.

The Role of Unqualified Practitioners in Rural Health Care

In light of the above, it should come as no surprise that neither state nor private sector AYUSH doctors nor contemporary medicine doctors are readily available to treat acute disease episodes in rural families. Due to the dispersed nature of the communities and their relative lack of access to medical care, residents have resorted to risky measures. Someone from each of these three categories has stepped up to fill the hole:

- (i) People who do not possess any medically recognized qualification are known as Unqualified Medical Practitioners (UMPs). These providers make up the greatest portion of the overall business.
- (ii) Chemists, many of them do not possess any qualifications in the field of pharmacy and are acting as proxies for a person whose name is carried out by the pharmacy (Dawai store).
- (iii) Traditional healers, local traditional herbalists, faith healers, snake venom removers, and bone-setters are all practitioners of traditional medicine. There are also traditional medicine practitioners who are not institutionally qualified. There is an enormous scale of informal providers in India who provide allopathic therapy under the guise of "doctors" (referred to by the World Health Organization as UMPs). The abbreviation "RMP" stands for "Rural (not Registered) Medical Practitioner," and it describes these unlicensed

doctors and nurses who often work in rural areas without formal training. They are all over the nation. Tens of thousands of communities rely on them as their sole source of primary healthcare. According to a report published by WHO Geneva (2016), the number of UMPs in India exceeds that of conventional doctors. As many as 57.3% of allopathic doctors lacked a medical degree, and 31.4% had just finished high school. Among doctors practicing in metropolitan areas, just 58% held a medical degree, but in rural regions, that number dropped to 19%. These findings only corroborate those of other study publications published on a national and international scale. Before starting their own practices, UMPs work closely with licensed doctors as affordable assistants. Once the UMPs have established themselves, the doctors refer patients to them and receive a commission of up to 30%.

The pervasive practice of UMP remains unaddressed by any state. The recent story of a UMP who infected more than 50 people with HIV/AIDS exemplifies the hidden dangers of disregarding the issue; this story received extensive coverage in both national and international media. Irrational drug use also contributes to the development of resistance to many drugs. Immediate action is required to resolve the matter. As an example, consider tuberculosis diagnosis and treatment. The only way to stop tuberculosis transmission is with a prompt and accurate diagnosis, but unfortunately, many people utilize broad-spectrum antibiotics, which are often sold over the counter and used by unskilled medical professionals, leading to inadequate treatment and only a brief alleviation of symptoms.

The recently published research "Unqualified Medical Practitioners - the legal, medical and social determinants of their practice." describes in detail the services that UMPs provide to patients with modest incomes. This study looks at the reasons why it won't be able to legalize or eliminate these practitioners any time soon and how the poor rely on them now. Nevertheless, parents' illogical medicine use, steroids, antibiotics, fluids, injections, and even the assumed use of tuberculosis treatments in the absence of a diagnosis can have serious repercussions for the spread of HIV/AIDS, blood-related infections, and multi-drug resistance

Discussion and Conclusion

The policy about medical education is inextricably tied to the demographics and illness prevalence of a country, as well as the change that occurs inside that country. Since this is the case, it is necessary to maintain a continual process of anticipating the need for medical personnel in order to meet the requirements of all age groups and economic segments of the general population. Despite the fact that most people live in rural areas, the quality of healthcare options for those people is severely lacking. Regardless of whether it is the National Health Protection Scheme or another state-run medical program, insurance only covers catastrophic illnesses that are hospital-based.

In order to create the envisaged wellness centers and provide them with the capability to perform diagnostic tests, it will require some time. The majority of health issues are of an immediate kind and necessitate the administration of medication quickly near the places where people live. Though well-intentioned, strategies like expanding access to AYUSH practitioners to address healthcare workforce shortages will persist, as this article has demonstrated, they will largely benefit urbanites and suburbanites rather than rural residents.

Abbreviation

None.

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Author Contributions

All authors are equally contributed.

Conflict of Interest

The authors declare no conflict of interest.

Ethics Approval

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