

Evaluating AYUSH Integration in Delhi NCR: A PRISMA-Framework Study

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Abstract

As the Indian government attempts to mainstream the AYUSH (Ayurveda, Yoga, Naturopathy, Unani, Siddha, Homoeopathy, and Sowa-Rigpa) system into the healthcare sector, it is plagued by the problem of a policy-perception paradox, whereby persistent low utilisation of these services exists despite significant infrastructure development and investment. Focusing on the Delhi National Capital Region (NCR), a systematic review of the literature is employed to explain this phenomenon. The findings reveal that Delhi NCR is recognised as a centre for several apex institutions, extensive co-location with modern-medicine facilities, and digital integration. However, this is in sharp contrast to a consistent pattern of severe demand-side underutilisation, as AYUSH accounts for a disproportionately low fraction of outpatient visits compared to modern medicine, which results in increased government spending per patient in AYUSH facilities. The analysis further reveals that even though AYUSH is preferred in managing chronic conditions, its widespread acceptance is hampered by perceived lack of scientific validation and operational challenges in integrated settings. The study concludes by emphasising the need for solutions that move beyond infrastructural expansion to effectively address the determinants of low public utilisation.

Keywords: AYUSH, Healthcare, Health, Delhi.

Introduction

India's traditional healthcare system has preserved a wealth of medical wisdom (Khan et al., 2022). Its long history of using traditional medicine has flourished for centuries. A significant portion of the population, especially in developing countries, receives healthcare through these medicinal plant-based traditional systems (Manasi et al., 2016). While the biomedical paradigm may have been proven effective, the World Health Organisation (WHO) points out that this model still falls short in addressing chronic

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diseases and fostering overall well-being (Roberti di Sarsina & Tassinari, 2015). According to the Global Report on Traditional and Complementary Medicine (T&CM), traditional medicinal systems may be able to prevent and treat chronic diseases associated with lifestyle choices (WHO, 2019). Presently, in industrialised countries like Germany, Canada and the USA, T&CM has been used by a significant portion of the population, showing the need for more patient-centric treatment (Thyagarajan, 2022).

The Indian healthcare system acknowledges six community-based indigenous systems, therefore making it the biggest in the world. This system is collectively known as AYUSH, an acronym for Ayurveda, Yoga & Naturopathy, Unani, Siddha, Homoeopathy, and Sowa-Rigpa (Manasi et al., 2016). Ayurveda and Siddha help in understanding the metabolic balance and human constitution (Prakriti) (Singh, 2010; Muthiah, 2019), while Yoga emphasises body-mind integration. Unani focuses on the balance of four humours, i.e., blood, yellow bile, phlegm, and black bile. Homoeopathy works on the principle of 'like cures like' (Tripathi et al., 2024). Since the Department of AYUSH was replaced by the Ministry of AYUSH (MoA) in 2014, the sector, particularly in the last one decade, has experienced multi-dimensional growth, evident from the rising allocation within the Union Budget, surge in herbal medicine exports, expansion of educational institutions, establishment of integrated AYUSH hospitals, and so on (Kumar et al., 2025). Presently, AYUSH holds a strong global appeal as a health supplement. India recently signed cooperation agreements with the WHO to support the development of T&CM, the WHO Global Strategy (2025-2034), and the creation of benchmark documents for practices (WHO, 2023; PIB, 2023). Out of the 194 WHO member nations, more than 170 countries acknowledged the use of traditional medicine. About 80 per cent of people use some kind of T&CM (Thamizhoviya, 2025). This shows global commitment, as does the recent establishment of the WHO Global Centre for Traditional Medicine in Jamnagar, India (WHO, 2022).

The National Health Policy (NHP) 2017 supported the institutional foundation and promoted the concept of medical pluralism. The policy's objective was to make AYUSH services more common in public healthcare (Saxena et al., 2024). Another initiative operating in alignment with the objectives of the National Health Policy is the National AYUSH Mission (NAM). Launched in 2014, NAM is a centrally sponsored scheme, aimed to strengthen AYUSH based-services by making them more accessible and affordable (Kumar et al., 2025). Additionally, Ayushman Bharat was launched, under the recommendation of NHP 2017, as a flagship scheme of the Government of India to achieve Universal Health Coverage (UHC). Under this scheme, the Government made efforts to establish Ayushman Aarogya Mandirs (AAMs), transforming primary health centres into comprehensive wellness units. As of August 2025, more than 178,000 AAMs are operating throughout India (MoHFW, 2025).

The infrastructure boom in the AYUSH sector is particularly noticeable in Delhi NCR. The region hosts institutions such as the All-India Institute of Ayurveda, which offers tertiary care and acts as a major research centre. Similarly, the National Cancer Institute at the All India Institute of Medical Sciences (AIIMS) Jhajjar and Safdarjung Hospital have also established integrative medicine departments (Ministry of AYUSH, 2025). Further, the capacity was increased with the opening of the National Institute of Homoeopathy (NIH) in Delhi and the National Institute of Unani Medicine (NIUM) in Ghaziabad, serving as the new, cutting-edge satellite centres for AYUSH (Ministry of AYUSH, 2025).

Despite the policy support, infrastructural expansion, and investments made by the government, a paradoxical challenge persists in the form of underutilisation of AYUSH services. Based on statistics from the National Sample Survey (NSS), AYUSH accounts for a mere 6.9 per cent outpatient care in India, which is much less than the 90 per cent that modern medicine receives (Rudra et al., 2017). The problem is particularly pronounced in the urban environment. An urban Delhi study reveals that the Urban Primary Health Centres (UPHCs), which practice modern medicine, offer 83 per cent of outpatient care, which is three to six times higher than that of AYUSH clinics (Garg and Goyanka, 2023). The study also revealed that with the cost-effective exception of homoeopathy (Rs 189), the government spending per outpatient visit was greater for Ayurvedic (Rs 692) and Unani (Rs 1,679) centres than for the UPHCs (Rs 148). This situation raises a basic problem known as the “policy-perception paradox,” which in this case implies a notable discrepancy between the supply of AYUSH services despite policy initiatives and their use by the general public. The paper uses this paradox in a broader sense throughout: an umbrella term for the persistent gap between AYUSH policy support on one hand and its actual utilisation by the public on the other, arising from both supply-side factors and demand-side perceptions, trust, and awareness barriers. Therefore, the study’s primary objective is to analyse the current trends of AYUSH integration within the mainstream healthcare system of Delhi NCR and investigate the reasons for the disparity between high infrastructural development and low level of utilisation.

Research Methodology

This study has adopted a systematic literature review design as its methodology. The purpose of this study is to examine the policy-perception paradox in the Delhi National Capital Region (NCR). We followed the Preferred Reporting Items for Systematic Reviews (PRISMA) guidelines, providing a standard, peer-accepted methodology that uses a guideline checklist, which has been strictly followed in this paper.

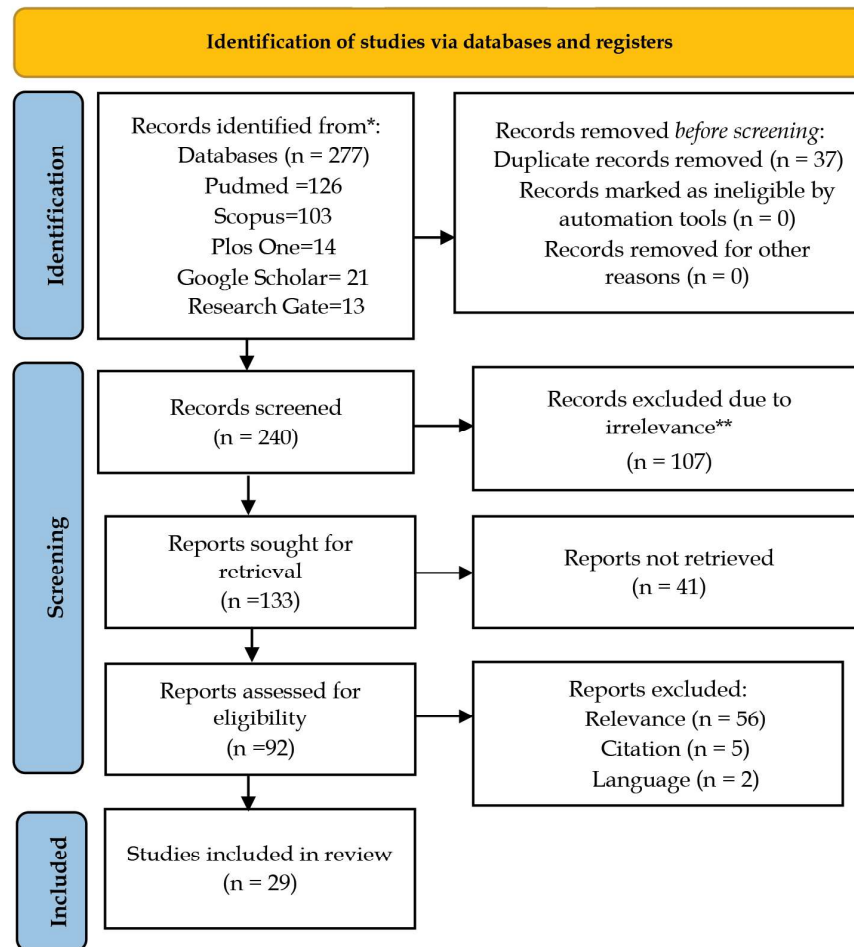


Figure 1: Authors' processes using the PRISMA Framework 2020

The process commenced with defining the research problem and specific questions to analyse this problem. Keywords including 'AYUSH', 'Healthcare facilities', and 'Delhi NCR' were identified to guide the literature search. A total of 277 relevant research papers were identified from Google Scholar, PLOS ONE, PubMed, Scopus and ResearchGate databases. These papers were then processed and reviewed following the PRISMA 2020 framework to ensure a comprehensive and systematic analysis.

Titles and abstracts of the research papers were initially reviewed in order to determine their eligibility to be included in the study. The full text of relevant studies was then reviewed for the final decision. Figure 1 provides a scheme for our methodology. Table 1 provides the full set of articles selected with the research problem, analyses, study area, and major findings.

Table 1: Selected manuscripts for review with areas of research and findings

Sl no.	Citation	Research Problem analysed	Research Questions answered	Study area & period of study	Findings
1	Adhinara yanan & Kathirvel, 2025	The study examines how young adults view traditional medicine – its effectiveness, safety, accessibility, and role in health – but notes that limited research specifically targets young users, despite the system’s ongoing importance in preventive care.	What are the beliefs and perceptions of young adults about traditional medicine? How do young adults experience access to traditional medical systems (accessibility, cost, guidance)? What is the perceived role of traditional medicine compared to modern healthcare (integration, prevention)?	Urban (North and West Chennai) and rural regions (Tiruvallur, Kanchipuram, Chengalpattu) in Tamil Nadu, India	Young adults who use traditional medicine generally trust it for its preventive value and cultural familiarity, appreciate its benefits, but face issues like limited access, lack of guidance, and difficulty combining it with modern care.
2	Chaturvedi et al. (2023)	How India’s pluralistic system (AYUSH + allopathy) can contribute to UHC	Role of AYUSH within India’s health system	India; policy analysis (no fixed period)	AYUSH can strengthen primary care, improve access, and support UHC through integration.
3	Dixit et al. (2025)	How aware people in Gautam Buddha Nagar (NCR) are of the Ayushman Bharat scheme, and how often they use it.	How many urban and rural beneficiaries know about the scheme? How many have actually used it?	Gautam Buddha Nagar district, NCR; 2025.	Only 8.9 per cent of urban and 18.8 per cent of rural beneficiaries were aware of the scheme; only 8 per cent urban and 15.2 per cent rural had actually used it. Lack of awareness was the main reason for non-use.
4	Garg & Goyanka (2023)	Comparative costs of outpatient AYUSH vs allopathic care in Delhi public health facilities	Assesses unit costs for OPD services across systems	Urban Delhi; facility-based cost study (2023)	AYUSH out-patient department (OPD) visits are cheaper than modern-medicine visits, suggesting AYUSH can reduce overall system burden and cost.

Sl no.	Citation	Research Problem analysed	Research Questions answered	Study area & period of study	Findings
5	Hazra et al. (2025)	National understanding of knowledge, attitudes, perceptions, and satisfaction toward Ayurveda vs allopathy	Synthesises existing KAPS studies from across India	India; systematic review of studies up to 2025	Ayurveda is perceived as safe, natural, culturally familiar, high trust and satisfaction; modern medicine preferred for acute care.
6	Khan et al. (2022)	Lack of consolidated evidence on how Unani medicine is perceived and used across India.	Synthesises studies on knowledge, attitudes, utilisation patterns, socio-economic determinants, and barriers.	India; review of studies up to 2022.	Awareness of Unani is moderate; utilisation mainly for chronic illnesses and symptom-specific relief; affordability and cultural lineage drive use; barriers include poor infrastructure, low awareness among youth, and inconsistent quality control.
7	Kumar et al. (2025)	Whether AYUSH-related goals of NHP 2017 have been achieved.	Examines achievements, shortfalls, and implementation barriers affecting AYUSH mainstreaming.	India; policy analysis with data up to 2025.	Progress in AYUSH infrastructure, institutional training, and service delivery; AYUSH integrated into public health programmes; but challenges remain in funding, research evidence, regulatory standards, and field-level implementation.
8	Mallick, 2016	Why Ayurveda struggles to function well inside Delhi's government health system.	What happens when Ayurveda is placed inside a biomedical-style government system? How does this affect doctors and patient care?	Eight public Ayurveda institutions in Delhi; qualitative study, 2016.	Ayurveda doctors had little independence, unclear job roles, and had to follow rules made for modern medicine hospitals that did not suit Ayurveda's own treatment style.

Sl no.	Citation	Research Problem analysed	Research Questions answered	Study area & period of study	Findings
9	Manasi et al. (2016)	How AYUSH programmes work as healthcare interventions in underserved peri-urban regions.	Analyses access, utilisation, service gaps, community perceptions, and programme effectiveness.	Peri-urban Karnataka, 2016; mixed-methods case study.	AYUSH services improve accessibility, reduce out-of-pocket expenditures, and are trusted for preventive/primary care. The community sees AYUSH as culturally aligned, affordable, and safe. However, infrastructure gaps, staff shortages, and limited drug supply affect service quality.
10	Mini & Sreelatha, 2026	Whether AYUSH treatments are covered under India's main public health insurance scheme.	Is AYUSH treatment included under Ayushman Bharat (PMJAY)? What does this mean for patients relying on the scheme?	India; national policy analysis, 2026.	AYUSH treatment remains excluded from Ayushman Bharat-PMJAY, even though a large share of the population depends on this scheme to cover healthcare costs.
11	Muthappan et al. (2022)	Lack of digitisation and standardisation in AYUSH delivery.	Reviews national digital AYUSH platforms (AYUSH Grid, Tele-AYUSH).	India; review up to 2022.	Highlights major digital tools improving record-keeping, telemedicine, drug standards, and accessibility.
12	Muthiah et al. (2019)	Lack of clarity about Siddha "udal tharattu" concepts.	Summarises body-constitution (udal) types described in classical texts.	India; literature review.	Explains Siddha personality/physiology types used in personalised care; strong emphasis on theory.
13	Naaz, 2019	How satisfied patients are with a government AYUSH hospital in Delhi and how they came to use it.	How do patients find out about this AYUSH hospital? Are they satisfied with the doctors, staff, and facilities?	State-level AYUSH hospital, Karol Bagh, Delhi; 2019.	Around 70 per cent of patients came on their own or through friends/family. A modern medicine doctor referred only 8 per cent. Satisfaction with doctor and staff behaviour was only 50 per cent, and 78 per cent of consultations lasted under five minutes.

Sl no.	Citation	Research Problem analysed	Research Questions answered	Study area & period of study	Findings
14	Patel et al. (2023)	Why traditional medicine integration succeeds or fails in the Indian public health system.	Identifies contextual, institutional, and political factors shaping integration	India; qualitative interviews (2023).	Integration depends on local politics, professional hierarchies, facility-level coordination, and resource allocation.
15	Patel et al. (2026)	Why AYUSH doctors working inside government health centres struggle to practise AYUSH fully.	How are AYUSH doctors treated within India's biomedicine-led health system? What happens when AYUSH medicine stocks run out?	Primary health centres in India (not Delhi-specific); qualitative fieldwork, 2026.	AYUSH doctors often work on short-term, low-paid contracts and are pushed to practise biomedicine or refer patients elsewhere when AYUSH medicines are unavailable.
16	Roberti di Sarsina & Tassinari (2015)	Need for aligning biomedical research with Ayurveda & yoga.	Examines conceptual integration frameworks.	Global/India; conceptual essay.	Advocates for integrative health models combining evidence-based AYUSH and biomedicine.
17	Roy et al. (2015)	Understanding CAM perception among doctors & patients.	Attitude, usage, trust, and perceived effectiveness of CAM.	Tertiary hospital in India; 2015.	Mixed trust levels; CAM used for chronic issues; doctors show cautious support; patients rely on traditional practices culturally.
18	Rudra et al. (2017)	Lack of national data on AYUSH service use.	Analyses NSS 2014 healthcare survey.	India, national dataset.	AYUSH utilisation is low but significant in chronic illness; higher among rural, poorer groups; affordability a key factor.
19	Sahoo & Manchikanti, 2013	Quality and regulation problems in India's AYUSH/herbal drug manufacturing industry.	How well-regulated is the AYUSH drug manufacturing sector? What quality-control issues exist?	India; industry-wide survey, 2013.	Regulatory guidelines were inconsistent, manufacturing practices were weakly enforced, and raw material quality varied across manufacturers.

Sl no.	Citation	Research Problem analysed	Research Questions answered	Study area & period of study	Findings
20	Saxena et al. (2024)	Scope of AYUSH in public-health prevention.	Reviews preventive roles of Ayurveda, Yoga, Unani etc.	India; review 2024.	AYUSH effective for lifestyle diseases, stress management; suggests strengthening AYUSH in primary care.
21	Seelamantula et al. (2025)	Limited insight into why urban residents choose AYUSH.	Provider views on patient choices in urban Puducherry.	Puducherry, 2025; mixed-methods.	Patients choose AYUSH for chronic disease relief, affordability, and cultural trust. Barriers include stigma & systems-level gaps.
22	Singhal & Roy (2018)	Lack of understanding of allopathic doctors' views on AYUSH inclusion.	Awareness, practice, acceptance of AYUSH among allopathic doctors.	New Delhi; hospital-based; 2018.	Doctors have moderate awareness; mixed attitudes toward integration; training exposure low.
23	Singh (2010)	Need for improving methodological quality in Ayurveda research.	Reviews limitations in clinical trial design and documentation.	Conceptual; India.	Highlights need for standardised protocols, documentation reforms, evidence generation.
24	Singh, Patra, & Khan, 2022	How elderly people in a Delhi resettlement colony use healthcare services.	What type of healthcare do elderly residents prefer? Why do they choose private over public facilities?	Urban resettlement colony, East Delhi; 2022.	Around 90 per cent had used some healthcare in the previous 15 days; most preferred private, licensed practitioners over public facilities, citing greater trust, convenience, and shorter waiting times.
25	Sudan et al. (2023)	Teenagers' awareness and use of AYUSH is under-studied.	Knowledge, usage, trust, and reasons for AYUSH use among adolescents.	India; adolescents in schools; 2023.	Moderate awareness; usage driven by family influence and affordability; concerns about slow results
26	Thamizhoviya (2025)	Need for global frameworks for integrating TM & modern medicine	Policy, regulation, global clinical integration models.	Global policy review.	Highlights WHO strategies, national integration models, regulatory requirements, and clinical collaboration.

Sl no.	Citation	Research Problem analysed	Research Questions answered	Study area & period of study	Findings
27	Thyagarajan (2022)	Challenges in mainstreaming AYUSH nationwide.	Examines barriers to national integration in clinical settings.	India; policy viewpoint.	Identifies regulatory gaps, workforce shortages, and need for stronger evidence & coordination.
28	Tripathi et al. (2024)	Role of homoeopathy in human-animal-environment health link.	One Health model integration via homoeopathy	Conceptual; India-oriented.	Proposes using homoeopathy in zoonotic disease management, public health resilience.
29	Varanasi et al. (2023)	Lack of data on multimorbidity patterns in AYUSH OPDs.	Prevalence & correlates among AYUSH patients.	Delhi NCR, 2023.	High multimorbidity burden; AYUSH OPDs cater predominantly to chronic disease patients; socio-demographic variations found.

The selection of the research papers to review was conducted in three rounds. The first round involved the screening of the titles and abstracts. The second round was the analysis of the research papers. The selection criteria were established according to the research question and the results (Table 1). While the study's geographic focus is Delhi NCR, the review also draws on studies conducted in other Indian regions (e.g. peri-urban Karnataka, Puducherry) and at the national level (e.g. studies using the national sample surveys). These studies were retained not for their regional specificity, but because they document generalizable patterns of AYUSH utilisation, cost structures, and demand-side perception and trust barriers that inform the interpretation of the Delhi NCR-specific evidence. Findings drawn from outside Delhi NCR are treated as supporting and comparative literature rather than as direct evidence about the study region.

The search involved using keywords as mentioned before, which yielded a total of 277 articles. After removal of 37 duplicate records, 240 records were screened. Among these studies, the author eliminated around 107 records due to their irrelevance. Further, 41 records were removed due to their unavailability and irrelevance, resulting in 92 studies which were assessed for eligibility, out of which finally 29 studies were included.

Findings and Discussion

After reviewing the final selected research papers, we classified the findings from the articles into the following themes: the Indian blueprint for mainstreaming AYUSH, the role of tertiary centres in AYUSH, digital integration, and the policy-perception paradox.

The Indian Blueprint: Mainstreaming AYUSH

Since ancient times, the traditional systems of medicine have been deeply ingrained in our society, offering comprehensive care for centuries. Among them, the AYUSH system, which was once disregarded, has gained a lot of attention in recent decades. The National Health Policy (NHP) 2017 was viewed as the primary driver behind the AYUSH system's continued growth, which eventually led to its incorporation into the mainstream system (Kumar et al., 2025; Chaturvedi et al., 2023). Following its institutionalisation, the sector saw a diversified expansion, especially in the last decade, as demonstrated by the five-fold increase in budgetary allocation from Rs 690 crore to Rs 3647 crore and a 17 per cent growth in market size of AYUSH between 2014-2020 to a turnover of USD 18.1 billion (approximately Rs 1.5 lakh crore), with estimates topping USD 70 billion by 2025 (approximately Rs 5.8 lakh crore) (IBEF, 2025).

Infrastructure was given a significant push by the launch of various policies, resulting in the upgradation of dispensaries and hospitals and the establishment of Ayushman Arogya Mandirs (AAMs). (Kumar et al., 2025). One such initiative that worked towards the operationalisation of the National Health Policy's vision of pluralism and co-location of AYUSH services within public health facilities was the National AYUSH Mission (NAM). It is a flagship scheme that works towards strengthening service delivery, educational institutions, and the medicinal plant sector. Furthermore, the government worked towards the promotion of primary-level co-location of AYUSH services with modern medicine PHCs, Community Health Centres (CHCs), and District Hospitals (DHs), offering patients a choice of system under one roof (Ministry of AYUSH, 2021). A vast network of institutions formed by the local municipal corporations, which includes the North Delhi Municipal Council (NDMC), alone runs about 42 AYUSH facilities. This involves about 12 Ayurvedic, 14 Homoeopathic, 2 Unani, and 2 Yoga & Naturopathy centres and 1 Siddha dispensary. Apart from this, NDMC operates 32 dispensaries for regular outpatient care, further illustrating the decentralisation of infrastructure (New Delhi Municipal Council, 2022). The establishment of AAMs, which currently number over 178,000 nationwide and comprise a decentralised system for primary AYUSH treatment, was further expedited by the Ayushman Bharat initiative (MoHFW, 2025).

Tertiary care and Specialised Care: National Institutes and Integrative Centres of Excellence

The National Institute of Homoeopathy (NIH) in Delhi, the National Cancer Institute at AIIMS Jhajjar, the All-India Institute of Ayurveda (AIIA), the National Institute of Unani Medicine (NIUM) in Ghaziabad, and the Morarji Desai National Institute of Yoga are all located in Delhi NCR, specialising in

tertiary AYUSH care (MoA, 2024). Furthermore, among other locations, the MoA has opened a new satellite national institute in Delhi and Ghaziabad, providing top-notch education and health facilities (Kumar et al., 2025). The specialisation and diversification of AYUSH services has been another significant trend in infrastructure development. For instance, patients can obtain all AYUSH therapies, including *Panchkarma* and Cupping Therapy (*Hijama*), at the specialist AYUSH Wellness Centre at Charak Palika Hospital in Moti Bagh, New Delhi. This shows how patients are now receiving advanced treatments instead of only basic consultation (New Delhi Municipal Council, 2022).

The service delivery mechanism in Delhi NCR has revealed that the government is striving towards the co-location model, in which modern medicine physicians and AYUSH practitioners work in shared facilities. In addition to giving the AYUSH doctors more career opportunities, this model's goal is to expand patients' access to traditional medicines (Patel et al., 2023). However, the main issue this research found was the ambiguous accountability between AYUSH and health directorates, which frequently resulted in medication supply shortages. As previously stated, Delhi NCR has dedicated tertiary care units providing specialised patient care like the All-India Institute of Ayurveda (AIIA) and the National Institute of Unani Medicine (NIUM) (MoA, 2025). The MoA recently embraced digital technologies for AYUSH development, teaching, and research. This use of digital technologies is acknowledged as one of the necessary elements to get improved health care services.

The Digital Integration: AYUSH Grid and COVID-19 Tele-response

In line with Digital India, MoA unveiled the AYUSH Grid project in 2019, an ambitious IT infrastructure that served all spheres of the AYUSH sector (Muthappan et al., 2022). AYUSH-hospital management information system (A-HMIS), AYUSH Suraksha, e-Aushadi, e-Charak, National AYUSH Morbidity and Standardised Terminologies Electronic Portal (NAMASTE), *Triskandha Kosha*, and SiddAR App are a few examples of digital health information systems initiatives (Muthappan et al., 2022). During the COVID-19 pandemic, the government came up with the AYUSH Sanjivani App to collect information from millions of users, highlighting the sector's responsiveness to emerging health challenges (Muthappan et al., 2022). The government's decision to digitise the AYUSH industry is a strategic move to modernise and make it more accessible, particularly to a tech-savvy populace.

The COVID-19 pandemic acted as a catalyst for AYUSH healthcare as well as a testing ground in Delhi NCR. According to NITI Aayog (2022),

the government of Delhi worked towards the establishment of “dedicated AYUSH Covid Healthcare Centres at teaching hospitals of AYUSH Government Institutes,” including facilities like Ayurvedic and Unani Tibbia College and Hospital, Nehru Homoeopathic Medical College and Hospital, and Chaudhary Brahm Prakash Ayurveda Charak Sansthan, to increase the sector’s capacity for rapid integration and adaptation during public health emergencies.

The pandemic further hastened the adoption of telemedicine, with the MoA running its National Teleconsultation Service from 2020 to 2023. PIB (2021) reported that nearly 575,058 COVID-19 patients were provided with teleconsultation under the National Teleconsultation Service. In addition, 135 Ayush Medical Officers and a group of five Senior Ayush Consultants received specialised training for this role. All these initiatives represent that there was a great emphasis on capacity building, which improved these AYUSH workers’ ability to respond to emergencies. The pandemic revealed interesting trends about the public perception and usage patterns of AYUSH. According to Kumar et al. (2025), the large-scale promotion of immunity-building protocols through digital platforms and the distribution of AYUSH prophylactic kits significantly raised the acceptability and visibility of the traditional systems, but this did not necessarily translate into ongoing usage of official AYUSH services.

The Policy-Perception Paradox: Infrastructure Growth versus Low Patient Footfall

Even if there is a greater push for infrastructure development and investment, the utilisation patterns of AYUSH services in Delhi NCR present a completely different picture. According to an economic analysis of the use of these public facilities in urban Delhi conducted by Garg and Goyanka (2023), an economic dilemma is revealed. Their research stated that the modern-medicine UPHCs accounted for 83 per cent of outpatient care, which is nearly five times the patient load as compared to total visits for Ayurveda, three times as compared to Homoeopathy, and nearly six times that compared to Unani. Another study reveals that AYUSH accounts for only 6.9 per cent of all outpatient care in India, while modern medicine covers over 90 per cent (Rudra et al., 2017). This presents an acute problem, especially in the urban environment.

Part of this low footfall may show the supply-side constraints rather than low demand alone. A performance audit of the Directorate of AYUSH, Government of NCT of Delhi, found that, as of March 2017, a total of 28 of the 163 sanctioned doctor posts and 61 of the 155 sanctioned pharmacist posts were vacant across AYUSH dispensaries. It was also noted that only 24 of the 103 homoeopathic dispensaries had all sanctioned staff in

position, highlighting a widespread staffing shortage (Comptroller and Auditor General of India, 2018). This suggests that a portion of Delhi NCR's recorded AYUSH infrastructure is not fully functional on the ground, which complicates any reading of "low utilisation" as reflecting patient choice alone.

The study by Garg and Goyanka (2023) also revealed that the government expenditure per outpatient visit remained higher for all AYUSH dispensaries when compared with UPHCs despite having a lower facility cost for a few AYUSH units. Their calculation revealed that the Unani (Rs 1679) and Ayurveda (Rs 692) dispensaries, among others, have high costs per visit, including the out-of-pocket expenditures, as compared to Rs 325 for the UPHCs. Homoeopathy emerged as the only exception, with a Rs 189 per visit cost, making it an economically efficient option among others. Therefore, the study comes to the conclusion that expanding the public's utilisation of AYUSH care at a reduced cost is the key component to the success of the government policy for mainstreaming it, highlighting this as a major challenge faced by the policymakers (Garg and Goyanka, 2023).

When the usage of AYUSH services is examined beyond the economic criteria, it reveals how complicated usage patterns are based on demographics and health problems for AYUSH facilities. A study found that AYUSH facilities primarily attract patients with chronic conditions, mainly cardiac and metabolic diseases (25.8 per cent), which was found to be the highest among others, followed by skin diseases, nearly accounting for 13.1 per cent (Varanasi et al., 2023). This research concluded that the system of AYUSH was predominantly being sought out for severe long-term health problems rather than for providing emergency care (Varanasi et al., 2023). However, it is important to delve deeply into the demand-side drivers, including their perceptions and barriers to adoption, in order to comprehend this policy-perception paradox. The supply-side gaps are compounded by structural challenges within AYUSH bureaucracy.

Based on an institutional analysis of Ayurvedic practice in government health facilities in Delhi, Mallick (2016) found that once Ayurveda was absorbed into a bureaucratic and biomedicine-oriented administrative structure, its practitioners faced constrained professional autonomy, ambiguous standing, and administrative practices that did not align with Ayurveda's own therapeutic principles. Such institutional constraints could have influenced the quality as well as accessibility of services, ultimately affecting the extent to which patients utilised government AYUSH facilities. AYUSH is predominantly used for chronic and lifestyle-related conditions. Numerous studies suggest that AYUSH is safer, more natural, and an effective long-term therapy for conditions such as arthritis and diabetes. (Hazra et al., 2025). People often rely on AYUSH due to "the fear of side

effects” from modern medicines (Varanasi et al., 2023). However, this trust is accompanied by doubt, particularly among educated urban youth who see the lack of scientific validation as a major barrier. According to a study of modern-medicine doctors in a Delhi tertiary care setting conducted by Singhal and Roy (2018), 73.3 per cent cited the absence of scientific evidence as a primary barrier towards the adoption of AYUSH, while lack of trained professionals accounted for 46.3 per cent, and 43.5 per cent was attributed to having a negative attitude towards traditional medications. Additionally, this feeling permeates the patients whom these doctors advise. Another issue highlighted in the studies is the communication gaps between AYUSH users and the modern-medicine doctors, as only 19 per cent of patients voluntarily revealed their usage of AYUSH to their modern-medicine doctors, which raised the possibility of medication interaction and inconsistent treatment approaches (Roy et al., 2015).

Even the AYUSH facilities present in Delhi exhibit this weakness in the cross-referral channel. A descriptive cross-sectional study of patients attending a state-level AYUSH hospital in Karol Bagh, Delhi, found that 70 per cent of them had sought AYUSH care either on their own initiative or on the recommendation given by friends or relatives, while only 8 per cent had been referred by a modern-medicine doctor (Naaz, 2019). As per the same survey, around 78 per cent of the patients had consultations that lasted less than five minutes; even though the majority of the patients were happy with the general care, just 50 per cent were satisfied with the behaviour of physicians and personnel. This shows that patients who do not visit Delhi’s AYUSH institutions are not routinely incorporated into the system via the biomedical referral and that the service-quality shortfalls within the AYUSH facilities themselves may act as a hindrance and restrict recurring visits and word-of-mouth recommendations.

This trust deficit, however, is not confined to modern-medicine doctors’ perceptions of AYUSH. It is echoed by the Delhi public. A community-based study among the elderly in a resettlement colony of East Delhi presents that although 90 per cent had used some form of healthcare in the preceding 15 days, most of them still preferred licensed private practitioners over public facilities, indicating greater trust, more convenient timings, and shorter waiting times as reasons (Singh et al., 2022). This highlights that even where a public AYUSH facility is geographically accessible to all, it must still compete with a general public preference for private, trusted providers, a preference that is unlikely to be satisfied by merely expanding infrastructure alone.

Another important, yet overlooked barrier is the financial cost. AYUSH treatment is not included under the national Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), India’s flagship program that

publicly funds a health insurance scheme, even as AYUSH dispensaries under the separate Central Government Health Scheme (CGHS) continue to operate across Delhi NCR for government employees (Mini & Sreelatha, 2026). The exclusion of AYUSH from AB-PMJAY, which acts as a primary safety net for many economically weaker sections nationally, creates a disincentive to choose AYUSH over an insured modern medicine alternative, regardless of how many AYUSH facilities might exist nearby. The low awareness and uptake of AB-PMJAY within NCR itself exacerbates this financial disincentive.

Because AB-PMJAY is the primary financial safety net for economically weaker groups nationally, its exclusion of AYUSH creates a disincentive to choose AYUSH over an insured modern-medicine alternative, independent of how many AYUSH facilities exist nearby. This financial disincentive is compounded by low awareness and uptake of AB-PMJAY within Delhi NCR: a comparative study of beneficiaries in Gautam Buddha Nagar found that only 8.9 per cent of urban and 18.8 per cent of rural beneficiaries were aware of the benefits under AB-PMJAY and that just 8 per cent of urban and 15.2 per cent of rural beneficiaries had actually used it, with lack of awareness cited as the main reason for non-utilisation (Dixit et al., 2025). If the region's own population engages only marginally with its principal public health insurance scheme, this limits the practical relevance of AB-PMJAY's AYUSH exclusion as a standalone barrier, but also signals a broader information and outreach gap that likely affects awareness of AYUSH services. Similar dynamics have been reported elsewhere in India, where AYUSH doctors working in primary healthcare dominated by biomedicine have unstable contracts and are periodically moved towards biomedical tasks when supplies of AYUSH medications run low (Patel et al., 2026), while quality-control gaps within the AYUSH pharmaceutical manufacturing sector have also been shown to shape public confidence in AYUSH products nationally (Sahoo & Manchikanti, 2013).

Conclusion

Despite the development of infrastructure, including primary, secondary, and tertiary care services, the infrastructure of innovative delivery mechanisms, such as co-location of AYUSH centres with modern medicine centres and digitalisation, capacity expansion for emergency response, particularly during the COVID-19 pandemic, significant policy support, and increased budgetary allocation, AYUSH healthcare in Delhi NCR continues to face persistent underutilisation. This study finds that the resulting policy-perception paradox cannot be explained by patient load, expenditure, or use-pattern data alone. It shows how several different mechanisms on both supply and demand sides are layered. On the supply side, the underutilisation of the infrastructure is demonstrated by the vacancy for doctors' and

pharmacists' posts and the constraints faced by the practitioners. While on the demand side, low cross-referral from modern-medicine doctors, modest patient satisfaction with consultation quality, and a continuing trust deficit around the scientific validation of AYUSH therapies limit conversion of infrastructural access into sustained utilisation. This policy-perception paradox requires more than continued infrastructure expansion. It mandates addressing workforce vacancies within existing AYUSH facilities, strengthening the institutional standing of AYUSH practitioners within public health administration, building structured referral pathways between modern medicine and AYUSH providers, and reconsidering AYUSH's exclusion from public health insurance. As this review draws primarily on secondary literature, future research using primary, facility-level data from Delhi NCR would help establish how these mechanisms interact and which carries the greatest weight in shaping patient utilisation.

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