Rationalizing Medical Officer Deployment in Uttar Pradesh

Leveraging e-HRMS for Primary Healthcare Strengthening

INTRODUCTION

Uttar Pradesh (UP), with a population exceeding 235 million, is India's most populous state and operates one of the world's largest government-run public health systems. The state's health infrastructure includes more than 30,000 public health facilities and is supported by approximately 160,000 health personnel, including doctors, nurses, and frontline workers[1]. These figures highlight both the magnitude and complexity of managing healthcare delivery in the state.

Primary Health Centres (PHCs) form the backbone of the healthcare system, particularly in rural areas, as they serve as the mainstay of primary medical services for the rural population. Therefore, PHCs are expected to be staffed with at least one Medical Officer (MO) to deliver essential preventive, promotive, and curative services[2,3]. However, unequal deployment of resources and personnel impedes the effectiveness of PHCs in many regions of the state[4].

To address these gaps, the Directorate of Medical Health in Uttar Pradesh, with technical support from the Uttar Pradesh Technical Support Unit (UPTSU), undertook a comprehensive, data-led exercise to rationalize the deployment of Medical Officers (MOs). By leveraging the Electronic Human Resource Management System (e-HRMS) and field - level validation, surplus MOs were reassigned from overstaffed to MO - deficient PHCs. As a result, the number of vacant PHCs in the state dropped significantly from 1,253 in July 2024 to 446 by March 2025. Notably, this improvement was achieved without any new recruitment, illustrating the effectiveness of optimized workforce allocation guided by robust data.

This document outlines the approach, outcomes, and policy relevance of the rationalization exercise to address workforce distribution challenges in the health sector.

THE CHALLENGE

Rationalizing the deployment of Medical Officers (MOs) in Uttar Pradesh involved addressing two major challenges:

1. **Uneven Distribution of Medical Officers**

   There was a significant mismatch in the deployment of MOs across healthcare facilities, even within the same district or block. Some PHCs had multiple doctors posted, often exceeding the sanctioned norms, while others were underserved. This disparity led to inefficient utilization of available human resources, adversely affecting primary health care delivery.

   The situation was exacerbated by discrepancies between actual field postings and official records in the Electronic Human Resource Management System (e-HRMS). For instance, several doctors physically working at PHCs were officially recorded as being posted at Community Health Centres (CHCs) or Chief Medical Officer (CMO) offices. These mismatches hampered evidence-based decision-making and complicated workforce planning.

2. **High Vacancy Rates at PHCs**

   A substantial number of PHCs across the state had no Medical Officer posted at all, resulting in critical service delivery gaps. These vacancies were particularly prominent in remote or hard-to-reach areas. Despite an overall pool of MOs being available in the system, poor alignment between available human resources and actual facility-level needs led to persistent staffing shortages. These unfilled positions severely restricted access to basic healthcare services for rural populations and undermined the objective of equitable health service delivery at the grassroots level.

OBJECTIVES

The rationalisation exercise aimed to address key challenges in deploying MOs across PHCs in Uttar Pradesh by leveraging accurate data from the e-HRMS system and reducing vacancies at PHCs. The primary focus was to identify and correct discrepancies in MO postings to ensure data integrity and reflect actual field deployment.

Key objectives included:

1. **Identifying Posting Discrepancies:** Detect inconsistencies in e-HRMS records where MOs were listed at incorrect facilities or administrative offices rather than their actual PHC postings.
2. **Developing a Rationalized Deployment Framework:** Design equitable allocation scenarios for MOs that align with staffing norms and population needs across both rural and urban areas.
3. **Ensuring Adequate Medical Officer Availability:** Facilitate the redistribution of surplus MOs from overstaffed or non-clinical locations to vacant or underserved PHCs, improving healthcare access state-wide.

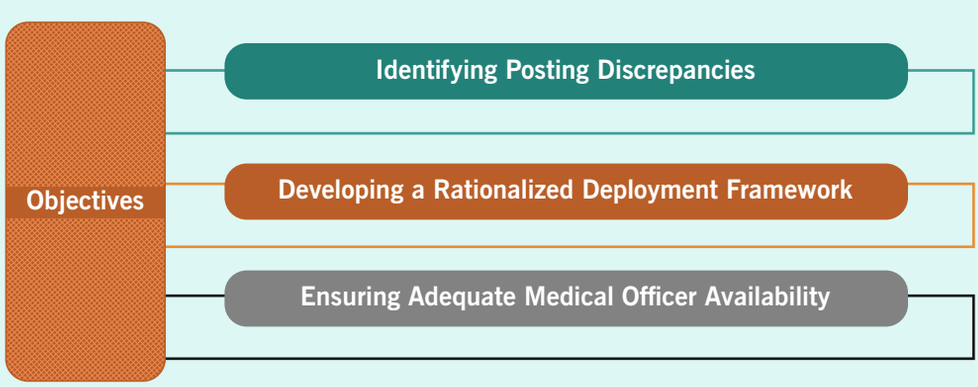

Figure 1: Objective of the Rationalization Process of Medical Officers in Uttar Pradesh

PROCESS OF MEDICAL OFFICER (MO) RATIONALIZATION

To effectively address the gaps in Medical Officer availability, a detailed analysis was conducted to understand the baseline distribution of MOs across PHCs. The findings highlighted significant imbalances, including vacant PHCs, overstaffed facilities, and inaccurate postings, which formed the foundation for the rationalization exercise.

Status of Medical Officers at PHCs Before Rationalization (as of July 2024):

- A total of 3,744 PHCs exist across the state, including 3,043 rural PHCs and 701 urban PHCs.
- Out of the total, 1,253 PHCs were found vacant in July 2024, of which 651 were rural PHCs.
- An analysis of MO distribution revealed that 267 PHCs had more than two MOs posted, totalling 1,244 MOs, including 484 Regular MOs and 760 NHM MOs.
- Among these, 93 PHCs had more than two Regular MOs, with 333 Regular MOs posted at these facilities.
- Additionally, 73 Non-FRU CHCs had more than six Regular MOs, with 554 Regular MOs posted at these CHCs.
- As of August 2024, 160 MO (L1) were posted at CMO offices across the state.

Rationalization Approaches:

Based on the detailed analysis of facility-level deployment data and existing staffing norms, key gaps and surpluses in MO distribution were identified across the state. These insights informed a targeted three-pronged rationalization strategy to optimize the deployment of MOs.

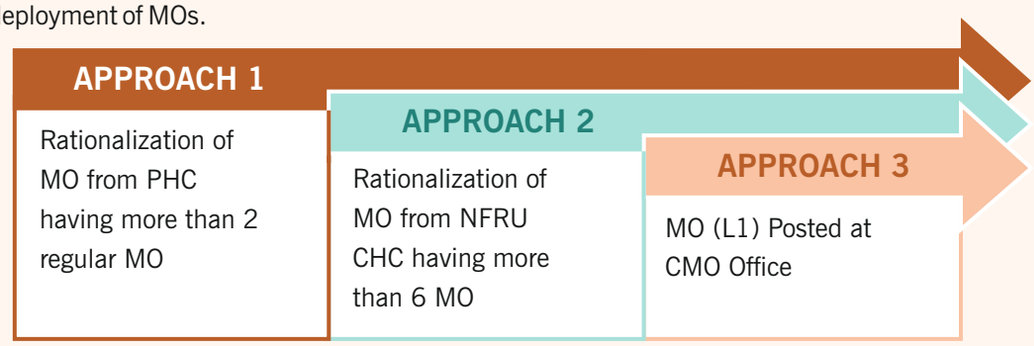

Figure 2: Rationalization Approaches to optimize the deployment of Medical Officers.

Approach 1: Redeployment of Regular MOs from Overstaffed PHCs to Vacant Rural PHCs (Within District)

- In July 2024, 93 PHCs had more than two regular MOs posted, with a total of 333 regular MOs at these locations. As per staffing norms, each PHC should ideally have only one regular MO. Therefore, 240 surplus MOs from these overstaffed PHCs were reallocated to PHCs that were entirely vacant.
- This exercise not only helped reduce the number of vacant PHCs but also brought down the number of PHCs with more than two regular MOs. As a result, the overall number of PHCs with at least one regular MO increased.
- Through this rationalization, the number of PHCs with more than two regular MOs dropped from 93 to 33, while the number of vacant PHCs reduced to 446.

Approach 2: Redistribution of MOs from NFRU CHCs with Surplus Staff (Within District)

- CHCs were classified as either FRU (First Referral Unit) or NFRU (Non-FRU). Given the critical services offered at FRU CHCs, MOs posted there were excluded from the rationalisation.
- In July 2024, 73 NFRU CHCs had more than six MOs posted, with a total of 554 regular MOs across these facilities. Nearly 60 surplus MOs from these overstaffed CHCs were reallocated to vacant rural PHCs, reducing the number of overstaffed CHCs to 59.

Approach 3: Reassignment of MO (L1) Posted at CMO Offices

- As part of the rationalization process, Medical Officers (L1) posted at CMO offices were reviewed for reassignment. As of August 2024, 160 such MOs were stationed at district-level administrative offices. Of these, nearly 80 MOs were redeployed to vacant PHCs, given that the primary role of Medical Officers is to deliver clinical services.
- The Directorate initiated a systematic review to identify and reassign eligible L1-level doctors from CMO offices to PHCs, aligning their deployment with service delivery priorities.

OUTCOME OF RATIONALIZATION

Strategic Rationalization of MOs Reduces PHC Vacancies Statewide

Between July 2024 and March 2025, the rationalization exercise resulted in a substantial 64% reduction in the number of PHCs without MOs in Uttar Pradesh, bringing the figure down from 1,253 to 446. This improvement was driven by the strategic redistribution of surplus MOs from overstaffed PHCs, NFRU CHCs and CMO offices to underserved facilities. Notably, this data-driven approach optimized existing human resources without the need for fresh recruitment, enabling the deployment of Medical Officers to 807 previously unstaffed PHCs and significantly strengthening the delivery of primary healthcare services across the state.

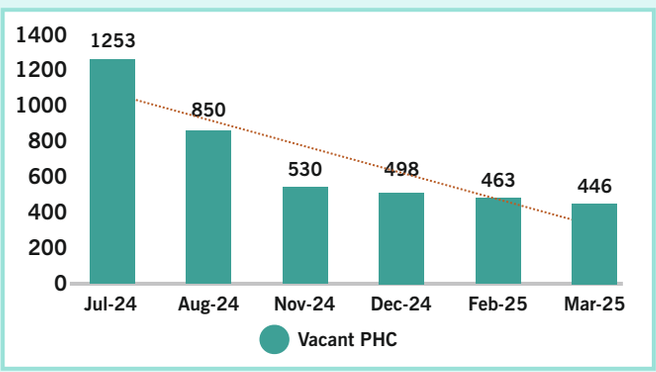

Figure 3: Declining trend in the number of vacant PHCs following MO rationalization (July 2024 – March 2025)

Improved OPD Footfall Reflects Increased Service Utilization at Previously Vacant PHCs

The rationalization exercise demonstrated a clear impact, as MOs were systematically placed in previously vacant PHCs. As a result, overall OPD footfall at these facilities increased steadily from approximately 1.26 lakh in August 2024 to 5.71 lakh in March 2025, reflecting a 350% increase over seven months. The data underscores that even without new recruitment, the strategic redistribution of existing human resources can significantly strengthen service delivery at the last mile.

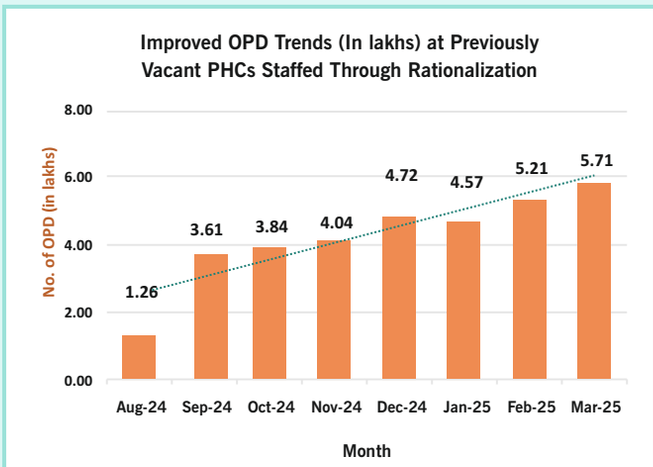

Figure 4: Increasing trend in the total OPDs in the previously vacant PHCs following MO rationalization (August 2024 – March 2025)

LIMITATIONS AND CONCLUSION

While the rationalization exercise has significantly reduced the number of vacant PHCs and improved service coverage, certain structural constraints have limited complete redeployment. The analysis included MOs from MBBS, AYUSH, and Dental cadres; however, MOs on prolonged leave, study leave, or those marked as long-term absent were excluded from the process [5]. Additionally, NHM MOs deployed under the RBSK program were not considered, as they function as part of mobile health teams conducting outreach across blocks[6]. Some PHCs function as block-level facilities and require more than one Medical Officer, making further redistribution from these centres impractical. Additionally, CHC-FRUs, being critical for MNCH services, were excluded from the rationalization pool. The availability of doctors also varied across districts, with some facing acute shortages, restricting reallocation options. Furthermore, addressing vacancies in urban PHCs remains contingent on the timely recruitment of NHM contractual doctors through walk-in processes. In conclusion, the rationalization process has laid the groundwork for long-term workforce planning by highlighting systemic gaps and establishing mechanisms for evidence-based decision-making in human resource deployment.

REFERENCES

1. Government of Uttar Pradesh. (2024). Electronic Human Resource Management System (eHRMS) – Uttar Pradesh. Department of Medical Health and Family Welfare. Retrieved from https://ehrms.upsdc.gov.in/
2. Ministry of Health and Family Welfare. (2012). Indian Public Health Standards (IPHS) Guidelines for Primary Health Centres: Revised 2012. Government of India. Retrieved from https://nhm.gov.in/images/pdf/guidelines/iphs/iphs-revised-guidlines-2012/primay-health-centres.pdf
3. Government of Uttar Pradesh. (2020). The Uttar Pradesh Medical and Health Service Rules, 2020. Retrieved from https://shasanadesh.up.gov.in/GO/ViewGOPDF_list_user.aspx?id1=MjUjMjAxIzIjMjAyMA==
4. Ministry Ministry of Health and Family Welfare, Government of India. (2021). Rural Health Statistics 2020–21: State Profile – Uttar Pradesh. Retrieved from https://mohfw.gov.in/sites/default/files/rhs20-21_2.pdf
5. Ministry of AYUSH. (2012–2013). NHM Mainstreaming of AYUSH Guidelines. National Health Mission, Government of India. Retrieved from https://upnrhm.gov.in/assets/site-files/gogl/ayush_guidelines.pdf
6. Ministry of Health and Family Welfare. (2014). Child Health Screening and Early Intervention Services: Rashtriya Bal Swasthya Karyakram (RBSK) Guidelines. National Rural Health Mission, Government of India. Retrieved from https://nhm.gov.in/images/pdf/programmes/RBSK/Resource_Documents/RBSK_Job_Aids.pdf