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Knowledge for the People



Locating Indigenous Systems of Medicine in Public Health Care in India

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From the ancient time onwards, different healing systems co-existed in India. There were healthy interactions among these systems and were complementary and supportive to each other. However, after the independence the policies that the State formulated had an overemphasis on the notion of “science” and “modernisation”. Until the beginning of the planning period in the 1950s, there was positive perception among policy-makers that the Indigenous Systems of Medicine (ISM) had long been part of the health culture of people of this country that reflected their faith and belief (Banerjee, 2000). Contrary to this it was seen that the development of a health care system was predominantly based on biomedicine. Indian State, under the term AYUSH¹ recognizes various medical systems and this has brought in some importance and credibility to these systems; but the financial allocation to all these systems together constitute only five percent of the total budget allocation. The issues related to ISM have received less scholarly attention and can no longer continue to be a neglected area in public health discourse. This is because not only these systems’ role/ importance in public health care is less recognised but also the epistemological base of these systems are at stake due to commodification and marketisation.

The paper is divided into six sections as follows. The first section is about the term Indigenous Systems of Medicine and the debates around. The second section explains the marginalisation of ISM in its historical and the cultural context of colonial era. The third section is about the State-ISM interaction during the post-independence era and notes down the paradigmatic shifts that occurred during this period. The fourth section briefly explains about infrastructure availability of ISM in the country. The fifth section would highlight the problems and concerns of ISM in the present political and economic context. This is followed with the conclusion.

1.1. Debate over the term Indigenous Systems of Medicine

In India, biomedicine also refers to western medicine, modern medicine and scientific medicine. All other medical systems are collectively represented by the term Indigenous System of Medicine and it leaves an impression that each one of these systems does not have any independent existence. Further, the term “medicine” in “Indigenous Systems of Medicine” seems to be based on the biomedical framework because medical systems like Ayurveda never had terminology “medicine”. Ayurveda, Yoga, Naturopathy etc., are more associated with way of life rather than curative orientation for which the term “medicine” is more appropriate.

Within the term “Indigenous Systems of Medicine” debates and confusions exist among scholars. Terms such as traditional medicine, Indian system of medicine, alternative medicine, and complementary medicine are used interchangeably. Traditional medicine is a sort of antique treatment based on both supernatural and natural cure. It is deeply rooted in the culture, the convictions and the climate of a particular country where it emerged. It is passed from one generation to another through written as well as oral means. Unlike these traditional systems, Indigenous Systems of Medicine in India does not rely upon oral tradition and does not rely upon supernatural powers.

South Asian Medical practices are termed as “Great- traditions” (Leslie, 1972); because they have maintained their individual character although they were in contact with each other. In his co-existence framework Leslie (1972) prefers the term “cosmopolitan medicine” to denote biomedicine rather than “modern medicine” or “scientific medicine”.

Indigenous System of Medicine is a bureaucratic convenient term that includes Ayurveda, Unani, Siddha and Naturopathy (Banerjee, 2000). Indigenous medicine is differentiated from folk medicine as follows; first, these systems have a textual tradition; second it has allowed plurality and; third the development of each system and has been influenced by each other.

Officially the Government of India uses the term “Indian System of Medicine & Homeopathy” to represent Ayurveda, Naturopathy, Siddha, Unani, Yoga and Homeopathy. Recently a new medical system Sowa-Rigpa is also brought in under this umbrella term. As far as the terminology is concerned, in the Government documents one can observe many shifts during the post-independence period. For example in the sixth plan document instead of indigenous system of medicine “traditional medicine” was used. In the eighth plan period the term “Indian System of Medicine” was introduced. In earlier committee reports the term used was Indigenous System of Medicine. Later in 1990s the State started using the term Indian System of Medicine where it projected Unani (which is not of Indian origin) also as a system with Indian origin. Along with the State, the dominant discourse on health locates ISM as unscientific in nature and assigns residual status/ role in the public health system of the country.

1.2. Marginalisation of ISM the Historical and the Cultural Context

Colonial nature of the health care system that was established during the British period marginalized the entire ISM and various political as well as sociological forces played role in this process. Abraham (2005) considers the colonial rule, hegemony of biomedicine and the problems within ISM as various reasons for marginalisation of ISM in the initial periods. The State promoted biomedicine and it developed a new discourse based on “scientific nature” and this ensured that other ISM are not enjoying the State patronage/ support. Gupta (1972) observes

that the first two decades of the nineteenth century, did not witness any significant change in the attitude of the British to ISM. The British did not intervene in the matters related to these medical systems and it was very usual to employ ISM practitioners as health workers. According to him, the withdrawal of the support to ayurveda education was a clever British policy to maintain control over the population. The history of colonial rule- ISM interaction according to Gupta (1972) started in 1824 when a Sanskrit college was established in Calcutta. The friendly coexistence of the two medical systems, however, did not last very long. A clear demarcation of British rule against ISM can be traced back to 1835 with the abolition of the Sanskrit College in Calcutta. This was due to the British policy wherein the higher education became orientalist with English as the medium of instruction especially after the introduction of Macaulay's reforms in 1835. In the late 19th century huge funds were earmarked to give scholarships for students of biomedicine and these system's students' had much better job prospectus than their counterparts of ISM. Neglect by the State coupled with humiliation experienced by the practitioners led to the formation of All India Ayurvedic Congress in 1907 (Panikkar, 1992). The Medical Registration Acts of 1912 and 1919 restricted the use of the title "doctor" to biomedical practitioners, and this clearly illustrates the discriminatory colonial policies. According to Kumar (2001) there are evidences that the Bombay Medical Registration Act was not only intended to control quacks but was also to supplant ISM with biomedicine at the "appropriate time". In 1928 when Indian Medical Association was formed, prominent nationalist leaders called for the inclusion of ISM, but General Medical Council in London disagreed to recognize Indian medical degrees (in biomedicine) if ISM is also included within the purview of the Indian Medical Association. By 1930s this position changed and in 1938, indigenous practitioners were registered in Bombay on a separate register.

Loss of British patronage led to the decline of ISM and destruction of village economy and localized commercialisation led to the decline of ISM status (Jeffery, 1988). According to him, one reason for the State tolerance towards ISM was that, the State with biomedicine based health care reached out only to a very small section of the population. The medical bureaucrats continued to be hostile to ISM and most of the administrators even equated ISM with quackery. It was in the later quarter of the nineteenth century, that a few educated Indians started initiatives for the revival of ISM, especially in Ayurveda and Unani. According to the British, Ayurveda and Unani were based on outdated ancient theories but the government allowed the practice as it was impossible to substitute ISM with biomedicine in the whole country because of the financial and other resource constraints. The British though allowed the practice of ISM they were totally against it and were absolutely unwilling to provide any financial assistance/ budgetary allotment for the development of these medical systems. The main reason highlighted was the deductive and speculative nature of ISM which did not have any scientific evidence for the diagnosis and prognosis (Jaggi, 1977). According to Kumar (2001) biomedicine played an important role in colonizing India, where it helped the State to ensure complete domination and later it became a tool of social control.

At the same time, internal problems developed within various ISM which created divide mainly based on epistemological preferences, caste, class and religion of the practitioners. Basham (1972) notes down, earlier the indigenous practitioners' were more professional and they had the ability to incorporate knowledge from other systems. After the formation of All India Ayurvedic Congress in 1907, there emerged two groups within Ayurveda viz. *Shuddha* Ayurveda practitioners and Modernists. *Suddha* Ayurveda practitioners were not ready to incorporate biomedical elements into their practice where as the modernists tried to develop

institutionalised training, research, manufacture and marketing of drugs at par with biomedicine. Panikkar (1992) observes that in Kerala, Ayurveda practice was not the monopoly of the upper castes. Quoting the example of revival movement he shows how class elitism played politics to eliminate lower caste practitioners. According to him the revival movement which was initiated by P S Variar had two objectives viz. one was regaining the old privilege of Ayurveda and the second was abandoning the practice of Ayurveda by the lower caste people. The professionalization efforts of the revival movement declared and deemed the untrained from the lower castes as those who “spoil” Ayurveda. Panikkar (1992) draws attention to the fact that the Ayurveda and other ISM was not only used to develop hegemony of coloniser over the colonized but also used to develop hegemony of different classes. Sivaramakrishnan (2006) about ISM in colonial Punjab observes how the ISM practitioners attempted to develop a self- conscious, corporate identity. In Punjab, she records evidence of language- based interests which produced representations that were divisive. Indigenous practitioners used ISM for political process mainly to protect language interests and to help the process of the development of a Hindu nation. ISM were also facing internal problems in relation to linguistic, theoretical and religious differences (Jeffery, 1988). The medical politics became more communal based in the 1930s when *vaid*s and *hakims* found it difficult to co-operate with each other. Bala (1982) mentions that lowering of scientific- standards of ISM (because of religious- orthodoxy and that unimportance given to empirical demonstration) as the major reason for the degraded status of ISM. According to Kumar (2001), highly divisive caste system which is peculiar to South Asia played an important role in degrading the status of ISM. The caste system separated theory from the practice and mental work from manual work. There were no “how and why” involved in any activity; questioning and enquiry were deemed as negative qualities in the education systems of

the ISM. There was no research and ISM was not tuning itself with the changing social and cultural context and that finally led to the stagnation of ISM.

The practitioners were divided based on caste, linguistic and religious basis. Theoretical orientation was also different which led to development of pure and modernist streams. The confusion whether to make ISM modern or to remain as *Shuddha* practices also persisted. What these internal divisions contributed to ISM is nothing but, made these systems further weak.

1.3. State and ISM during the post-independence

The neglect of ISM by the state which began during the colonial times did not significantly change after the independence (Abraham, 2005). After the analysis of various committee reports and parliamentary debates it is clear that the marginalisation and neglect was not a homogenous process through out the last six decades. During the period 1940s-1960s the approach was neglect coupled with biomedical modelingⁱⁱ. Terms like scientific nature, setting standards etc., was used to propagate this biomedical modeling trend. The minimal support extended by the State provided some credibility for the existence of these systems; yet the State wanted modernisation/ biomedicine base standardization of education of these systems, if they wanted to exist at least at the periphery of the health care system.

The first paradigmatic shift occurred in the 1960s where the State, seemingly abruptly, recognised the importance of ISM and set up research and educational institutions for the development of *Shuddha* ISM practices. Budgetary allocations and programmes rose during this period.ⁱⁱⁱ During this period, the “integrated approach” was buried and committees focused on the educational aspects of *Shuddha* practices. There is a shift in the policy directions the State gave to these committees. The recommendations reflect these changed political contexts. The 1962

Health Survey and Planning Committee, chaired by L. S. Mudaliar, recommended the abolition of the integrated approach of ISM education. The Abdul Hameed Committee, tasked in 1963–64 with developing a curriculum for *Shuddha* Unani Education, strongly criticised the State's prior policies where ISM was equated with Ayurveda. In the case of Ayurveda, the M. Vyas (1962) Committee favoured development of a *Shuddha* system based on an intense study of the classical medical literature. Yoga was taken up for the first time since independence, with the setting up of the Committee on Evaluation of Therapeutical Claims of Yogic Practices in 1961.

In the 1970s, the emphasis moved from education and curriculum to drug research and institutionalisation. The Drug and Cosmetic Act of 1940 was amended in 1964 to include substances and medicines prepared as per Ayurveda/Unani system of medicine, with provisions that ingredients and production be listed out^{iv}. What is noteworthy is that the State's policies during the period did little to increase the role of ISM in the health-care system or strengthen their epistemic bases. The enthusiasm it exhibited in standardising ISM drugs and protecting the interests of marketing firms did not carry over to make ISM education curricula uniform throughout the country or to protect the interests of ISM practitioners.

Parallel to these, the government established apex bodies and research institutions for ISM^v to initiate and develop scientific research. Drug standardisation was given prime importance. Development of agro-techniques for cultivation of Unani medicinal plants was also highlighted.

Abraham (2005) documents the history of establishment of various institutions for promotion of research. This includes Rashtriya Ayurvedic Vidyapeeth, Delhi (1988), National Institute of Ayurveda, Jaipur (1978), National Institute of Homeopathy, Calcutta (now Kolkata) (1975), National Institute of Unani Medicine, Bangalore (now Bengaluru) (1987), National

Institute of Naturopathy, Pune (1987), Gujarat Ayurveda University and Banaras Hindu University College, Varanasi. Similarly, the National Institute of Research in Yoga was established in Delhi.

The National Health Policy of 1983 pointed out the under-utilisation of the available infrastructure of ISM and mentioned that ISM can be optimally used to address public health issues. The policy suggested that it was necessary to initiate measures to enable each of the systems of medicine to develop in accordance with its genius.

The second paradigm shift in the State's policies can be observed from 1990s onwards where the focus is on biomedical modelling for commercialisation of ISM .In 1995, the State established a separate department named AYUSH for ISM. Banerjee (2000) argues that this occurred not because the State identified the intrinsic value of ISM but because it identified the market opportunity of ISM, especially of Ayurvedic drugs and yogic practices, in the international market. The 2002 National Policy on Indian Systems of Medicine and Homeopathy is also focused upon exploring the exporting possibilities of ISM due to the growth of international interest in complementary and alternative medicine. It speaks of ISM as an industry and the need for Intellectual Property Rights. Medical tourism based on ISM is projected as a good opportunity to earn foreign exchange. The policy endorses the evidence of safety and efficacy as demanded by consumers and these safeties and efficacy should be in comparison to biomedicine standards.

1.4. ISM Infrastructure

In the case of ISM infrastructure, the State funded health care infrastructure co-exists with a vast infrastructure developed by the private sector. Availability of data about this formal as well as informal private sector is limited because the documentation is restricted mainly to the State funded sector. In States like Kerala, Karnataka and Maharashtra ISM health care facilities co-exist with a vast spread network of biomedicine based health care facilities.

Hospitals, Dispensaries and Beds^{vi}

Under the Department of AYUSH, the Government of India has established network of health care facilities in ISM. The data available from the government documents show that amongst ISM, there is a preponderance of Ayurveda hospitals, as 75.8% hospitals and 75.0% beds pertain to this system exclusively.

Out of 24392 ISM dispensaries 61.8% dispensaries provide Ayurveda system based services whereas, 4.7%, 3.4%, 0.5%, 0.4%, 28.8% and 0.4% dispensaries belonged to Unani, Siddha, Yoga, Naturopathy, Homoeopathy and Sowa-Rigpa respectively. If we desegregate the data on dispensaries state-wise then Rajasthan has 19% of them followed by Uttar Pradesh (10%) where as states like Mizoram has only one dispensary of Ayurveda.

The facilities are unevenly distributed through out the country for example the state of Uttar Pradesh has more than three fourth of Ayurveda hospitals. States like Manipur, Mizoram, Nagaland and Sikkim are devoid of any Ayurveda hospitals. More than 28% of Homeopathy hospitals are in the state of Maharashtra. Similarly Siddha hospitals are predominantly located in Tamil Nadu where as Unani hospitals are maximum in the state of Uttar Pradesh. The existing health culture, practice of traditional/ folk medicine, demand for one system over the other and long tradition of absence of these medical systems may be the reasons for such wide inequality in

the distribution of facilities. In many states like Kerala, Karnataka ISM health care facilities co-exist along with the biomedicine based health care facilities and this is reflecting the medical pluralism and health culture of these states.

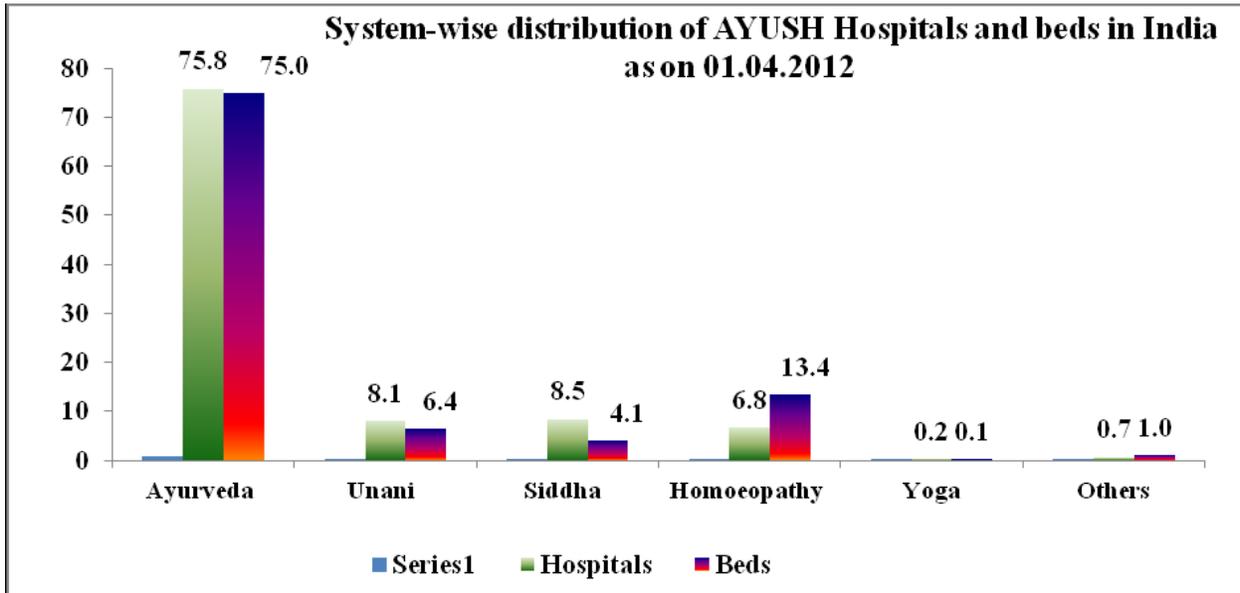


Diagram No 1. Source: Adopted from Government of India (2012), Ministry of Health and Family Welfare, Report “AYUSH in India 2012”

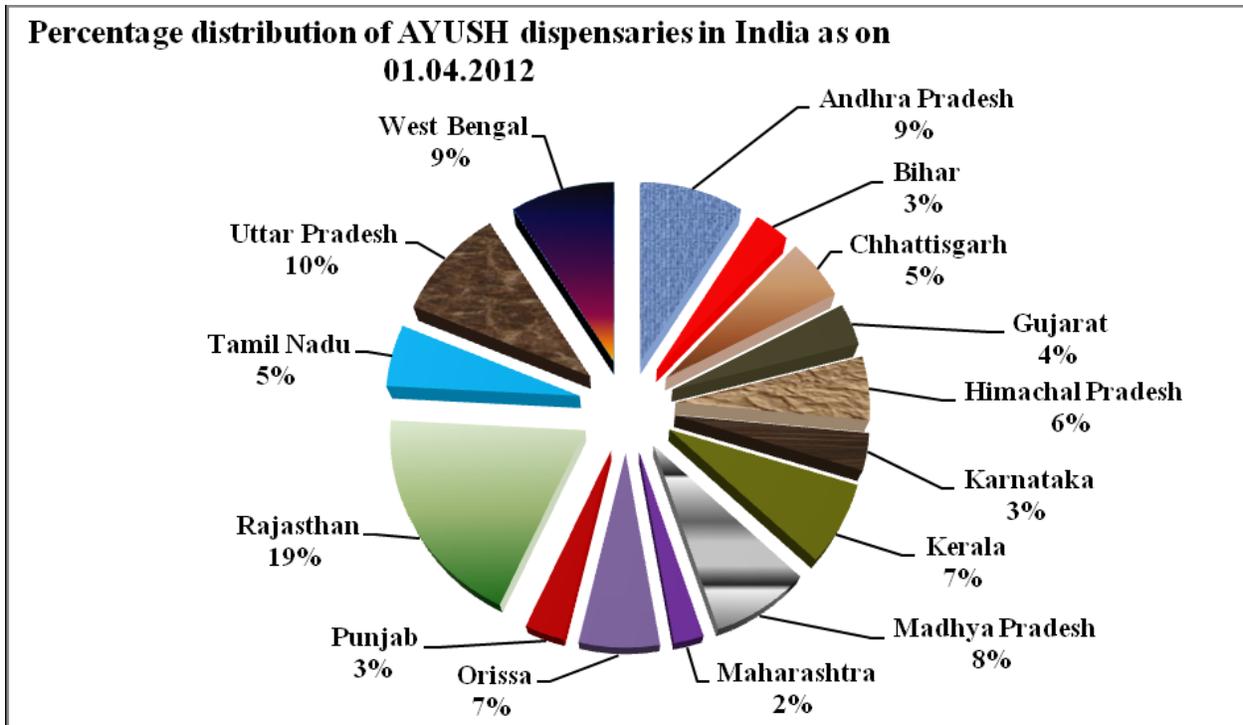


Diagram No 2. Source: Adopted from Government of India (2012), Ministry of Health and Family Welfare, Report “AYUSH in India 2012”

Practitioners^{vii}

As per 2012 data of the AYUSH department, there are 720937 registered AYUSH doctors/ practitioners in India. Out of this, 60.9% belong to Ayurveda, 31.1% and 6.8% belong to, Homoeopathy & Unani Systems respectively. Only 1.1% and 0.2% doctors belong to Siddha and Naturopathy Systems respectively. Significant variation can be observed in the distribution of doctors in various states of the country. More than 60% of the practitioners are registered in the states of Bihar, Maharashtra, Uttar Pradesh, Madhya Pradesh and Karnataka. No ISM doctors are registered in the State of Mizoram and Manipur. At present 5877 ISM practitioners are available to serve one crore population in this country. If we analyse the data between 1980-2012 on the availability of ISM doctor per crore of population, then in 1980 it was 5582 practitioners

per crore of population and in 2012 it is 5877 practitioners per crore of population. That mean availability of doctors has shown only marginal increase during the last three decades.

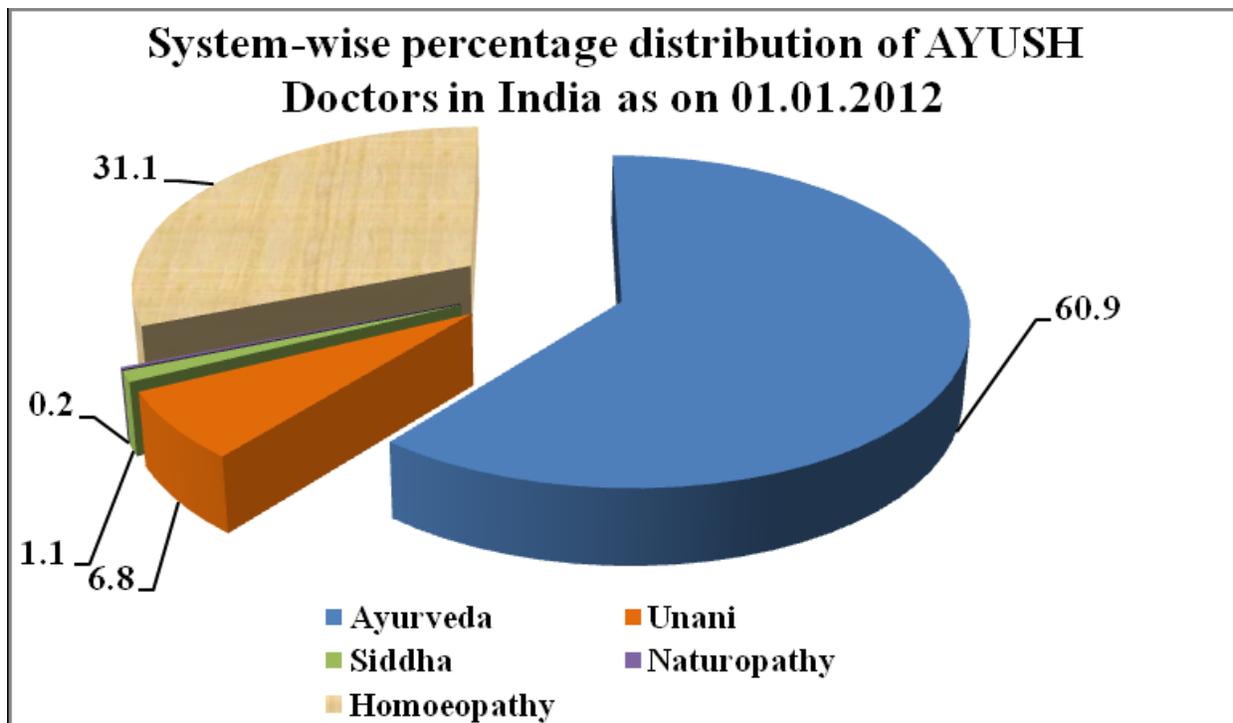


Diagram No 3 Source: Adopted from Government of India (2012), Ministry of Health and Family Welfare, Report “AYUSH in India 2012”

Table No 1 showing trends in the availability of ISM doctors for one crore population between the period 1982-2012

Year	Availability of ISM doctors per crore population
1982	5655
1983	5442
1992	6528
1993	6470
1999	6173
2000	6774
2008	6611
2009	6733
2012	5877

Table No 1. Source: Data Extracted from Government of India (2012), Ministry of Health and Family Welfare, Report “AYUSH in India 2012”

***Medical Education*^{viii}**

ISM practitioners have made tremendous efforts to modernize and institutionalize education, so as to gain more credibility and popularity in the country. This was also influenced by various political and economic factors (Abraham, 2005). Thus traditional methods of teaching are replaced by modern colleges and apex bodies are established to lay down standards on medical education of ISM.

As per 2012 data of AYUSH department, there are 508 colleges conducting undergraduate ISM education with an admission capacity of 25586 students in India. Out of which, 21.1% of the total colleges with 17.3% intake capacity belong to Government Sector. Amongst these, 51% of the colleges are Ayurveda colleges, followed by 36.4 % Homeopathy colleges. The State of Maharashtra had a lead over other states for having the maximum number of ISM colleges (22.8%) and also having maximum number of Ayurveda (23.8%) and Homoeopathy (25.9%) colleges in the country. There is dearth of ISM colleges in the North-East States and many Union Territories. For conducting Para-medical education under various systems of ISM, there are 66 institutions with admission capacity of 2505 students (2012 data). 50% institutions with 47.9% admission capacity belong to Government sector, whereas, 3% institutions with 2.8% admission capacity were owned by local bodies and 47% institutions with 49.3% admission capacity being managed by private sector.

1.5. ISM Concerns and Challenges

Unlike biomedicine ISM is much more heterogeneous in terms of their principle, philosophy, and treatment-diagnostic modalities. The state has not only played its role as a monitor in setting up standards for ISM , but has also equally promoted biomedical modelling

and is actively involved in commercialising these systems. The State's commitment towards modernizing and institutionalizing these ISMS has both strengthened and weakened these systems in different ways. For example, as far as institutionalised education is concerned on one hand it helped in regulating the practice, where as on the other hand biomedical model based institutionalizing has weakened the epistemic base of these systems. The availability and accessibility of ISM services across the country remains a major issue. As explained earlier, ISM hospitals, dispensaries, educational institutions and practitioners are unevenly spread across the country. If the State aspires to promote medical pluralism and want to give people a choice to exercise and allow them to decide which medical system based care they prefer for different health problems then this disparity in access and availability need to be addressed at the earliest.

Maintaining standards of ISM education, without modelling it on biomedical standards is another concern that needs immediate attention. People's ignorance coupled with the State's apathy led to the development of these systems in less controlled and monitored manner. This has led to a situation where a lot of bogus degrees, titles and practices have developed within ISM. ISM practitioners receive their education from formal educational institutions, informal institutions and sometimes folk medicine practitioners are also confused as ISM practitioners. The titles, degrees vary in terms of region, language etc., and it is difficult for the service seeker to identify who is trained/ qualified and who is not. To worsen the situation, ISM practitioners some time couple their practice with prescribing biomedicine based drugs, for which they are not having the expertise/ legal sanction. The state's focus and attempts to control such practices is now non-existing and this leads to a situation where qualified ISM practitioners also start getting

identified as quacks. The lack of uniform standards in training, curriculum and qualification degrade the status of ISM practitioners as professionals.

Various professional bodies of ISM are having confusions whether to remain as *Shuddha* practices or to modernise it as per the present day requirements. Similarly, research is also limited and the formal sector of each of ISM is located in the urban areas and this is widening the divide between practitioners.

Inadequate funding and support by the State is another major concern for ISM sector. As discussed earlier the State policies, programmes are not intended at integrating ISM into the public health system of India; but is according ISM a subordinate status and utilizing them to reach out to people where biomedicine based health care is not well established. As mentioned earlier, only 5% of the total health budget is allotted to this entire ISM together. Because of inadequate funding and support, formally trained, qualified practitioners are providing their services mainly in the urban areas leaving apart the vulnerable rural population in the hands of untrained, semi-trained practitioners. Presently, government's support provided to ISM is mainly to develop legitimacy and credibility to these systems so that their value in international market can be tapped properly.

Commercialisation of ISM in international market is also another problem, as far as ISM is concerned. Bagchi (1994) explains that what is happening to ISM especially to Ayurveda in the context of globalisation. As per the patenting laws, process or product or both are patentable. With the huge potential of capital, research and development facilities, the transnational companies are patenting faster than Indian firms and thus our knowledge and our medicinal plants are becoming alien to us and drugs are becoming more expensive. Small manufacturers are being eliminated from the market and the companies with huge capital potential are gaining

total control of the market .Therefore ISM from a medical system is being converted completely as food supplements and cosmetic products provider.

Banerjee (2004, 2002) gives another interesting observation about ISM in the context of globalisation. With the neo-liberal policies when the State withdrew from almost all social sectors, ISM faced an opposite trend. Till this time ISM had a lower budgetary allocation. With the globalisation this budget increased. She further argued that this increased support is to exploit the market opportunities associated with ISM products with focus on Ayurveda. Abraham (2005) notes down that according to WHO projection global herbal market projection is US \$ 62 billion which will become US \$ 5 trillion by 2050. Both market and the Government of India have identified medicinal plants as potential area of export.

It is evident that in UK, USA and other countries of EU, there is a positive attitude towards Complementary and Alternative Medicines (John, 2007). This opportunity is identified by the pharmaceutical giants and thus they have pressurised the Governments of those countries to develop policies which support them in two ways- first is to retain superiority of biomedicine and second is to develop ISM drugs in line with biomedicine standards. This second attempt is to make the market entry easier. Consumers belong to “modern” group who are the clients of biomedicine practitioners. It was these radical changes in the west which transformed the status of ISM even in India but this transformation was also to degrade its status further.

1.6. Conclusion

In India, various medical systems are arranged in a hierarchical manner to provide health care services to various sections of population. Health culture of this country is pluralistic in nature and this is a historical reality. The colonial governments’ initiatives of marginalizing and

subordinating ISM to biomedicine are continued after the post-independence as well. At the same time, various internal problems that developed amongst ISM practitioners also accelerated the phase at which degrading of these systems occurred. The recent initiatives of the State to promote ISM reflect not a strong concern to revive these systems but are attempts to use these systems' potential to harness international market opportunities. This has further changed the status of ISM from alternate health care provider to cosmetic care supplier. Resources are available within ISM and they are of varied nature and offer treatment to variety of diseases for which biomedicine does not offer complete cure. If the State aims to provide basic, affordable health care to whole of its population then mobilizing ISM resources will be a wiser strategy because ISM practice is much close to the pluralistic health culture of this country. This has to be done with maintaining distinct epistemological identity of each of ISM and integrate these systems into public health care system so that the goal of universal health care can be achieved.

End Notes and References

ⁱ AYUSH is the department established under the Ministry of Health for the promotion of various Indigenous Systems of Medicine. AYUSH stands for Ayurveda, Yoga, Unani, Siddha and Homeopathy. Recently a new medical system is added viz. Sowa-Rigpa (Amchi).

ⁱⁱ For example Bhole Committee (1948) mentioned that if ISM was to play any role in public health care then it need to be modernise and mould itself through the biomedical standards. Similarly Sokhey Committee (1946) suggested that ISM practitioners can be health workers after properly training them with biomedicine based first aid requirements. Col. Ramanath Chopra Committee (1948) began the move towards biomedical modeling of ISM, where as Swift Committee (1954) suggested that ISM education should include all the basic papers and principles of biomedicine. The push towards biomedicine continued with the Dave committee, 1954, which called for including science training as part of the ISM curriculum; and the Borkar Committee, 1961, which recommended that Ayurveda and Unani be reduced to specialisations in the undergraduate bio medical training programme

ⁱⁱⁱ The Third Five-year Plan document acknowledged the failure of the integrated approach. For ISM plan allocation was Rs. 9.8 crores, whereas the total budget for health was Rs. 225.9 crores. (Government of India, 1961, Third Five-year Plan document, Planning Commission of India, New Delhi, Chapter on Health). In the Fourth Five-year Plan document, the classification of Indian medicinal plants was a thrust area. Clinical research was the focus where it was directed to get scientific evidence for the chemical and pharmacological properties of medicinal plants. (Government of India, 1969, Fourth Five-year Plan document, Planning Commission of India, New Delhi, Chapter on Health).

^{iv} Banerjee (2002) argued that such amendment of the Act intended to get hold in local as well as international markets.

^v The Central Council for Research in Indian Medicine and Homeopathy came up in 1969. The Central Council for Research in Ayurveda and Siddha and the Central Council for Research in Yoga and Naturopathy were set up in 1978. The Central Council for Research in Unani Medicine was established in 1979.

^{vi} The data of this section is mainly from AYUSH in India 2012 Report.

^{vii} The data of this section is mainly from AYUSH in India 2012 Report

^{viii} The data of this section is mainly from AYUSH in India 2012 Report

References

- Abraham, Leena (2005): *Indian System of Medicine and Public health care in India*, in Gangolli, Leena et.al. (ed.) *Review of Health Care in India*, CEHAT, Mumbai
- Bagchi, Amiya Kumar (1994): *Globalising India: The Fantasy and The Reality*, Social Scientist, Vol 22, No 7-8 July-Aug, pp. 343-354
- Bala , Poonam (1982): *The State And Indigenous medicine: Some explorations on the Interaction between Ayurveda and the Indian State*, M Phil Dissertation, Unpublished, JNU, New Delhi
- Banerjee, Madulika (2004): *Local Knowledge for world market- globalising Ayurveda*, Economic and Political Weekly, Jan 3.
- Banerjee , Madulika (2002): *Public Policy and Ayurveda- modernising a great tradition*, Economic and Political weekly , March.
- Banerjee, Madulika (2000): *Whither Indigenous Medicine*, Economic and Political Weekly, July
- Basham, A L (1972): *Practice of Medicine in Ancient and Medieval India* in Leslie, Charles (ed) *Asian Medical Systems: A Comparative Study*, University of California Press, London
- Government of India (2012), Ministry of Health and Family Welfare, Report “*AYUSH in India 2012*”
- Government of India (1969) : *Fourth Five Year Plan Document*, Planning Commission of India, New Delhi, Chapter on Health
- Government of India (1962) : *Report of the Health Survey and Planning Committee*, (Chairman L Mudaliar) , Ministry of Health, New Delhi
- Government of India (1962) : *Report of Curriculum And Syllabus For Ayurvedic Education formulated by The Central Council of Ayurvedic Research*, (Chairman M Vyas) Ministry of Health, New Delhi
- Government of India (1961) : *Third Five Year Plan Document*, Planning Commission of India, New Delhi, Chapter on Health
- Government of India (1956) : *Report of the Committee appointed by Government of India to Study the Type of Training In pharmacology imparted in different parts of the country to students undergoing the training of 4 and ½ years in Ayurvedic and Unani Colleges* , (Chairman Dr. H B N Swift), Ministry of Health , New Delhi

Government of India (1956): *Interim Report of the Committee Appointed by the Government of India To Study and Report on the Question of Establishing Uniform Standards in respect of Education & Practice of Vaidyas, Hakims and Homeopaths*, (Chairman D T Dave), Ministry of Health, New Delhi

Report on Health Sokhey Committee Report (1946)

Government of India (1948): *Report of Health Survey and Development Committee*, (Chairman Sir Joseph Bhore), New Delhi, pp. 455- 457

Gupta, Brahmananda (1972): *Indigenous Medicine in Nineteenth and Twentieth Century Bengal* in Leslie, Charles (ed) *Asian Medical Systems: A Comparative Study*, University of California Press, London

Jaggi, O P (1977) : *Medicine in India : Modern Period* in Chattopadhyaya, D P (ed.) *History of Science - Philosophy and culture in Indian Civilisation* , Oxford University Press, pp. 311-344

John, Hari M (2007): *Politics of Knowledge*, written for CETIM, Geneva, accessed online as <http://cetim.title/tvw/kk34> on 23.02.08

Jeffery , Roger(1988) : *The Politics of Health in India*, University of California Press, London

Kennett and Jalota (2005)

Kumar , Deepak (2001): “*Introduction* ” in Kumar, Deepak(ed.) *Disease and Medicine in India A historical Overview*, Indian History Congress, Tulika

Leslie ,Charles (ed.) (1972) : *Asian Medical Systems: A Comparative Study* University of California Press, London.

Panikkar, K N (1992) : *Indigenous medicine and cultural hegemony- a study of the revitalization movement of Keralam*, in book *Studies in History*, Sage Publication , New Delhi, 1992 , P.No 282-308

Sivaramakrishnan, Kavita (2006): *Old Potions, New Bottles- Recasting Indigenous Medicine in Colonial Punjab1850-1945*, Orient Longman, New Delhi

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