



MEDICAL PLURALISM IN INDIA AND ITS INTEGRATION INTO STATE HEALTH SERVICES SYSTEM

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ABSTRACT

Medical Pluralism is widely practised in India. India has a rich heritage of traditional medicine as both codified and non-codified systems of medicine. The purpose of this review article is to trace the integration of medical pluralism in to state health services system. It starts with British rule in mid nineteenth century. During this period Vaid and Hakims were trained and their network was used to spread the allopathic system of medicine. At the time of independence, various committees gave their recommendations for formulating National Health Service System. These committees also gave recommendations regarding indigenous system of medicine. While Bore Committee termed it as 'Unscientific'; Sakhay Committee proposed training of Vaid and Hakims; and Chopra Committee recommended mutual learning between Allopathy and indigenous system. In 1959, Mudaliar Committee again prioritised modern medicine. National Health policy of 1983 eventually led to creation of department of ISM &H (Indian Systems of Medicine and Homeopathy) in 1995. In 2003, department of AYUSH (Ayurveda, Yoga, Unani, Siddha, and Homeopathy) was created and in 2005 it was integrated in to NRHM. The Sowa-Rigpa system of medicine was included in 2012 and "Ministry of AYUSH" was created in 2014. The paper discussed various issues related to integration of medical pluralism in to state health services system and gave recommendations for the future role of state in "Social Integration" of AYUSH.

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INTRODUCTION

Medical Pluralism can be defined as the employment of more than one medical system or the use of both conventional and complementary and alternative medicine (CAM) for health and illness.^[1] The term was first introduced in mid-1970s when the people resorted to various options for healthcare apart from the government healthcare system which was based on biomedicine.^[2] By the 1990s, complementary and alternate medicine (CAM) was included within the state health administrations of the west and medical pluralism had become state sponsored. Medical Pluralism has become a modern phenomenon and is no longer confined to the deprived societies.

Traditional medicine as defined by WHO, include, "diverse health practices, approaches, knowledge and beliefs incorporating plant, animal and/or mineral based medicines, spiritual therapies, manual techniques and exercises, applied singly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness".^[3] Traditional medicine in India has, codified systems (Ayurveda, Unani, Siddha, Sowa-Rigpa and Homeopathy) as well as non-codified systems (Folk Medicine). In codified system of traditional medicine, "knowledge has been codified, either in the

form of pharmacopoeias or ancient scriptures".^[4] In non-codified system of traditional medicine, "knowledge is transmitted by oral means and is mostly acquired through trial and error approaches".^[5] Non-codified system of medicine was developed according to local needs and resources available to local people. Therefore, the system differs from region to region and is given different names like folklore medicine, little traditions, indigenous medicine, ethnomedicine, bush medicine etc. To preserve the non-codified ancient knowledge, there is a need for proper documentation.

The term, indigenous systems of medicine, is used to emphasize the civilizational origin of a particular system of medicine.^[6] For example, biomedicine, homeopathy and naturopathy have their origins in Europe and so are indigenous systems of Europe. The Ayurveda, Siddha and Unani systems of medicine have their civilizational origins in India.

The term Indian System of Medicine (ISM) was used for, "bureaucratic convenience and included Ayurveda, Unani, Siddha and Naturopathy, all ancient medical systems practiced in India".^[7] ISM is a codified system of medicine that evolved across many historical

periods in terms of knowledge as well as practice. The documentation part verifies this system for its authenticity.

Material and Methods

The paper is a review article. Rigorous literature review was done to extract the information. Thematic analysis was done to generate main themes and sub-themes. The paper was then structured, analysed and concluded at the end.

Medical Pluralism during British India

During 19th century, the biomedicine got well accepted in Europe and America and other systems of medicine were banned. But in India, the cultural ideologies supported indigenous system of medicine and it was not possible to ban these systems of medicine or even regulate them. Some of the very early experiments were done in India in mid-nineteenth century to integrate indigenous system of medicine with western medicine. There were attempts at National Medical Institution in Calcutta. Later on the institution was replaced by a modern medical college. The indigenous practitioners also helped in establishing western medicine in India during 19th century. The Vaid and Hakims were given training during 1860-70s and traditional midwives (dais) were also trained in 1900s. The training was given to them in their vernacular language and the purpose was to implement biomedical measures in rural areas. The colonial system viewed dais as, "unhygienic and dangerous women, the prime cause of maternal and infant deaths in India".^[8] As a consequence, dais refused to get training by British system and more Christian women enrolled in the training who started delivering like doctors. The cleaning up work and postpartum care got in to professional domain of local dais.

Towards the end of nineteenth century, ISM was informally an integral part of medical services. When the dispensaries used to run out of medicines, they relied on Indian medicines. The surgical instruments were similar to the one mentioned by Sushruta. The use of chloroform and morphine to perform surgeries was a method adopted from the teachings of Sushruta. The indigenous practitioners and dais were regularly used to assist hospital staff and were a part of routine work of western medicine.

By the start of 20th century, there started a colonial discourse against indigenous system. The medical registration was denied to ISM practitioners and the allopathic doctors were deregistered for being associated with ISM institutions. There were protests across the country against such British policies which abhorred indigenous system of medicine. The continued support was extended by some wealthy patrons and it led to the establishment of many ISM training institutions across country.

The Conflict during Independence and recommendations of Various Committees

After Independence, there were different perspectives and ideologies regarding the development of indigenous system of medicine. There was Nehru – Gandhi debate. Overall, "there was a positive perception about the Indian Systems among policy makers".^[9] The various merits of ISM recognized by policy makers were; a) the people of country had faith and belief in these systems, b) the country had rich biodiversity to provide for traditional medicines, c) the emphasis of ISM was on ensuring prevention of diseases and adopting healthy lifestyles. For the above stated reasons, the ISM was considered a potential support for public health in the country.

For planning health services in independent India, two committees were set up. The British colonial authorities in India set up the "Health Survey and Development Committee (Bhore Committee) in 1943. The Bhore Committee showed a contemptuous attitude towards indigenous system of medicine and termed it as 'unscientific'.^[10] The Bhore committee was not having even a single representative of these indigenous systems on its board. In contradiction to the recommendations of Bhore committee regarding Indigenous systems of medicine, Sokhey committee (National Planning Committee) gave due recognition to the Vaid and Hakims, and proposed their training to mainstream them with the physicians or surgeons or gynaecologists and obstetricians.^[11] But regarding the type of training, the committee recommended, "the best scientific training in medicine in schools of a university standard".^[12]

One more committee called Chopra Committee was set up in 1946 to plan for ISM in independent India. The committee recommended, "mutual learning between allopathy and the indigenous systems, some practitioners of each being given education in the other so that all systems could be enriched and evolve in to one integrated knowledge system".^[13]

The Mudaliar Committee (Health Survey and Planning Committee) was set up at the end of second five year plan in 1959 to survey the progress made in health services since the submission of Bhore committee report and to make recommendations for future development and expansion of health services. Just like Sokhey committee, the mudaliar committee emphasized the need for giving a degree qualification in modern medicine to the students qualified in Ayurveda.^[14] The committee, like earlier committees, prioritised the modern medicine by asserting that national health services should be based on modern medicine and its persons should be adequately trained in modern medicine to be comparable to international standards.^[15]

Emergence of ISM&H (Indian Systems of Medicine & Homeopathy)

As a consequence of recommendations made by above mentioned committees, there emerged a "compromise" between Allopathy and the indigenous

system of medicine.^[16] The prime focus was given to modern medicine in a hierarchical order, at the same time making the pluralism “official”. The ISM was marginalised in terms of budget allocation also. The Alma-Ata declaration of 1978 led to adoption of Primary Health Care approach with its principles being community participation, appropriate technology, comprehensive healthcare, and universal accessibility.^[17] The Alma-Ata recognised traditional medical practitioners as important allies and recommended their training and engagement in primary health care.^[18] Followed by this paradigm shift came National Health Policy of 1983 which referred to ISM as, “our rich, centuries old heritage of medical and health sciences”.^[19] The policy recommended integration of indigenous systems and their services to the overall healthcare delivery system at various levels.^[20] The department of ISM&H (Indian Systems of Medicine and Homeopathy) was created in March 1995. The department was renamed as AYUSH (Ayurveda, Yoga, Unani, Siddha and Homeopathy) in November 2003. The Central Council of Indian Medicine was set up under Indian Medicine Central Council Act 1970. The council was framing and implementing various regulations related to ISM including the curricula and syllabi of ISM institutions. The Sowa-Rigpa system of medicine is included in the central council of Indian medicine from the year 2012. The Sowa-Rigpa is a centuries old traditional medical system originated from Tibetan medicine and employs complex approach for diagnosing patients. The system incorporates techniques such as pulse-analysis and urinalysis. It uses behaviour and dietary modification techniques and uses natural materials (e.g. herbs and minerals) and physical therapies to treat illness.^[21]

The Central Council for Health and Family Welfare in 1999 recommended the posting of one ISM&H physician at every primary health centre and vacant posts of allopathic doctors to be filled by ISM&H physicians. The council also recommended establishing specialised ISM&H treatment centres in rural areas and a separate wing of ISM&H in government hospitals. In 2002, the World Health Organisation came up with its strategy on traditional medicine and concurrently the, “National Policy on ISM and H” emerged. As a result, ISM&H experienced an enormous growth in institutions and their pass-out registered practitioners. In 2007, there were 485 colleges of AYUSH (Ayurveda, Yoga, Unani, Sidha and Homeopathy) and 5,06,229 institutionally qualified registered AYUSH practitioners.^[22] At the same time budget allocation to AYUSH was only a small fraction of the total health budget. During tenth plan (2002-07), the budget allocated to AYUSH was only 1.32% of total health budget and during eleventh plan (2007-12), the budget allocated to AYUSH raised to 2.7% of the total health budget.^[23]

NRHM (National Rural Health Mission) and AYUSH (Ayurveda, Yoga, Unani, Siddha, Sowa-Rigpa, and Homeopathy)

In 2005, National Rural Health Mission (NRHM) was launched, “to provide accessible, affordable and quality healthcare to the rural population, especially to vulnerable groups” (nrhm.gov.in). The strategy of NRHM was to “mainstream” AYUSH in the health service system and to “revitalise” it.^[24] Under NRHM, one AYUSH doctor was to be posted at primary health centre (PHC) and two at community health centre (CHC). The separate department of AYUSH was created in ministry.^[25] At the level of CHC, separate room was allocated to AYUSH doctors with separate paramedical personnel and AYUSH medicines.^[26] The purpose of mainstreaming were, one to give choice of treatment to patients and second was to strengthen public health services system by providing human resource in the form of AYUSH doctors. The additional work of implementing National Health Programmes was also given to AYUSH doctors. AYUSH medicines were included in ASHA (Accredit Social Health Activist) drug kit. The RCH (Reproductive and Child Health) programme also include seven Ayurvedic and five Unani medicines.^[31] These strategies of NRHM created a huge demand for AYUSH doctors and paramedics, and they were recruited on contractual basis. By the end of 2010, there were 9,578 AYUSH doctors and 3,911 AYUSH paramedics on contractual basis.^[27] Some states had created a paramedical council for training AYUSH paramedics and some had started AYUSH speciality hospitals and AYUSH monitoring and management cells.

There were several issues concerning AYUSH department under NRHM. There was an inequality regarding salary structure of AYUSH doctors as compared to allopathic doctors. The AYUSH doctor was considered secondary to allopathic doctor and as a substitute of allopathic doctors who were not willing to work in rural areas.^[28] There were no inter linkages and interface between AYUSH department and Allopathy. Although biomedical knowledge was integrated in to AYUSH training as per recommendations of Chopra committee but no learning of AYUSH systems was incorporated into allopathy. IPHS (Indian Public Health Standards) provide for herbal medicine gardens at primary care centres (PHC and sub-centre) but practically they are absent.

Ministry of AYUSH

On 9 November 2014, the department of AYUSH has been upgraded as “Ministry of AYUSH”. The vision of ministry of AYUSH is, “to position AYUSH systems as the preferred systems of living and practice for attaining a healthy India”. “National AYUSH Mission” (NAM) was launched on 29 September 2014. The mission aims to address gaps in access to healthcare services in the country. Under NAM increased number of AYUSH services and education will be provided especially in remote or far flung areas.^[31] A resolution was adopted by the UN General Assembly for celebrating International

Day of Yoga on 21 June 2015. The event took place at Rajpath and established two Guinness World Records. One was to organise largest Yoga class of 35,985 people and second was of maximum participating nationalities (84 Nations). During 2014-15, although there were budgetary cuts by central government regarding health budget, but there was a hike in AYUSH budget by 36% as compared to 2013-14. A sum of Rs 1,272 Crore was allocated to AYUSH as compared to Rs 936 Crore in 2013-14.^[29]

Draft National Health Policy 2015 and AYUSH^[31]

The draft National Health Policy 2015 recognizes the importance of traditional systems of medicine in India. The draft policy emphasizes on the integration of private providers and non-governmental organisations in to AYUSH. The draft policy seems to be greatly impressed by the performance of private sector in both allopathy as well as AYUSH systems of medicine. The draft policy advocates increased investments in making AYUSH drugs and a regulatory system to validate quality, safety and efficacy of AYUSH drugs and therapies. The draft also proposes trainings of both Allopathic and AYUSH practitioners to know strengths of each other's' system of medicine. So that cross-referrals could be done effectively. The draft policy also recommends strengthening of farming of herbal medicinal plants. The draft also suggest introduction of Yoga in schools and work-places.

Rashtriya Bal Swasthya Karyakram (RBSK) and AYUSH^[32]

In 2015 the ministry of health and family welfare has started, Rashtriya Bal Swasthya Karyakram for early identification and intervention to children from birth to 18 years. It will cover 4 D,s which are Defects at birth, Deficiency disease, Developmental Delays and Disability. District Early Intervention Centres (DEIC) will manage children of 0-6 years age group and 6-18 year age group children will be managed by existing public health facilities. Outreach screening of children will be done by mobile health teams consisting of two AYUSH doctors (one male and one female) along with one ANM/staff nurse and one pharmacist. The mobile health teams will also be provided with laptops for data entry and data management. The children with defects, deficiencies, diseases and developmental delays will be referred to District Early Intervention Centre (DEIC) and other public health facilities.^[32]

Timeline/ Conclusion

The process of integration of Medical Pluralism in to State Health Services System has been concluded in the figure 1. (visit page number 314)

Recommendations for the future

The integration of Indigenous Systems of Medicine in to State Health Services System has been done more or less at the level of Infrastructure only, forgetting the Social Science aspects of this integration. Mere providing infrastructure for AYUSH practitioners

and hiring them on contractual basis will not suffice. There should be a congruence of Allopathy and AYUSH. MBBS doctors should welcome and respect AYUSH doctors and there should be a two-way referral of patients between them for expert opinion or specialised treatments. The two departments at health centres should talk to each other and patients should be benefitted by this relationship. The AYUSH doctors at health centres are regularly assigned night duties or emergency duties. This arrangement makes it imperative to train them in life saving measures to be competent enough to deal with emergency situations.

The AYUSH drugs are generally found in short supply at PHCs. Logistic arrangements should be made for an uninterrupted supply of drugs. The commercialisation of AYUSH pharmaceutical preparations is an important issue here, in which state should intervene and regulate the market by applying Ceiling laws.

The work done by AYUSH practitioners is generally undermined and the whole department is looked upon as secondary to Allopathy. The therapeutic potential of AYUSH systems of medicine should never be under-estimated. A patient suffering from Piles or Fistula may undergo well known Ayurvedic treatment called "Ksharasutra" instead of going for an invasive procedure. Similarly Unani medicine has an expertise in treating Vitiligo and Siddha medicine in South is very well known for the treatment of Psoriasis.^[30]

Along with the interaction between doctors of two systems, there is also a need to orient and sensitize paramedical and auxiliary staff towards the importance of AYUSH systems of medicine. The interaction should also be there within AYUSH systems. The research staff at the councils should constantly interact with peripheral systems, for sound evidences as basis of their research and both of them in turn, should interact with policy makers to help formulating policies considering "evidence based research".

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Figure 1: Flow Diagram showing integration of Medical Pluralism in to State Health Services System