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Alternative Systems of Health Care and National Health Missions: Treading with Care

(Abstract)

Following the framework of NHP 1983, NRHM has accorded an increased importance to alternative systems of health care. As early as 1995, the Central Government created the Department of ISM&H. NHP 1983 had committed to AYUSH (a new acronym to replace ISM&H) for simpler and gentler therapies. The aim seemed to be laudable. The new approach to AYUSH is expected to lay emphasis on upgradation of standards, quality control, research, and awareness generation. Though with a small budget devoted to this in the Twelfth Plan, inclusion of urban health in the NRHM has further stressed the alternative systems. Yet, there is little scientific, evidence based research on therapeutic aspects of AYUSH and on issues involved in integration of scientific and alternative systems. Some questions are: To what extent are AYUSH effective? What are their contraindications? What training do the AYUSH practitioners require to share responsibilities under NHM? This paper argues that there is a need for exercising caution in adopting AYUSH as these systems are rooted in paradigms quite different from those underlying the scientific medicine. This paper explores the perspective of Ayurveda, one component of AYUSH and its possible dysfunctions in the present mode of service delivery. This paper also critiques the scientific practices which have produced inequality and disempowerment. It is suggested that the social scientists working in the field of health need to be wary of consequences of playing only the supporting role in health policy, requiring a shift from *sociology in medicine* to *sociology of medicine*.

Introduction

Right from its inception National Rural Health Mission, the health project of Government of India has accorded important role to alternative systems of health care. Way back in March, 1995 Ministry of Health and Family Welfare created the Department of Indian Systems of Medicine and Homoeopathy (ISM&H). This was re-named as Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy (AYUSH) in November, 2003. Even earlier, the National Health Policy (NHP) 1983 had committed to AYUSH for ‘simpler and gentler therapies for improving the quality of life and avoiding iatrogenic problems’ ([http://indianmedicine.nic.in/writereaddata/linkimages/7870046089-](http://indianmedicine.nic.in/writereaddata/linkimages/7870046089-Ayush%20%20n%20policy%20ISM%20and%20H%20Homeopathy.pdf)

[Ayush%20%20n%20policy%20ISM%20and%20H%20Homeopathy.pdf](http://indianmedicine.nic.in/writereaddata/linkimages/7870046089-Ayush%20%20n%20policy%20ISM%20and%20H%20Homeopathy.pdf)). The aim was laudable: to provide focused attention to development of education & research in indigenous systems which were still in practice among people of India. The Department is expected to lay emphasis on upgradation of ‘educational standards, quality control and standardization of drugs, improving the availability of medicinal plant material, research and development and awareness generation about the efficacy of the systems domestically and internationally’ (Dept. of AYUSH, 2013). In both Eleventh and Twelfth Plans some (though very small) part of health budget has been allocated to AYUSH. Inclusion of urban health in the National Health Mission has further stressed the alternative systems (Planning Commission, 2013, pp.39-40).

Yet, there has been very little scientific, evidence based research on therapeutic aspects of AYUSH and on managerial issues involved in integration of scientific and alternative systems. The issues are: To what extent Are AYUSH effective in curing diseases some of which are of modern origin? What are their contraindications? What training do the AYUSH practitioners require to share responsibility under NHM? The Twelfth Plan document notes that the medical doctors are wary of AYUSH which are based on traditional belief systems and customary practices. This paper argues that there is a need for exercising caution in adopting AYUSH simply for pragmatic reasons. AYUSH are rooted in paradigms different from that underlying the scientific medicine. In the framework of science, which cannot be abandoned by a secular and progressive nation state, only those medicines need to be promoted which are found to be based on scientific bio-chemical principles; mere clinical support for AYUSH would not be enough for making them part of the National Health Policy. There are several possible dysfunctions of inclusion of AYUSH in the NHP: (a) legitimization of less tested and poor quality health services

among the rural poor and other vulnerable sections of society; (b) permissiveness and often promotion of magic and blind faith in traditional practices doing harm to people in the long run; (c) lending support to religious and superstitious practices; (d) rejection of health inequality hypothesis; and often (e) withdrawal from the remote areas.

However, looked at from the critical and postmodern approaches scientific practices too are magical, inadequate, disempowering and promoting a non-humanistic worldview. The choice between (or combination of) scientific medicine and alternative systems, therefore, goes beyond the instrumental rational choice and raises serious questions about life and living. The social scientists working in the field of health need to be wary of consequences of playing only the supporting role to health policy and to everything that state offers.

Crisis of paradigm

It is now an accepted idea in philosophy of science that during the normal times nobody talks about paradigms because all members of the profession use the same paradigm. However, debate on paradigm starts when the existing paradigm cannot take care of the newly observed anomalies. This idea applies equally to health. For a long time biomedical model of health was the dominant perspective on health: sociologists who worked in the field of health used Durkheimian (or Parsonian) functional perspective. Attempts have been made by Marxists and others to examine class inequalities in health both outside and in India, abandoning the biomedical model of health (Yadavendu, 2001). The challenge to the functional perspective has come from those sociologists and others who stress that the concept of health is socially constructed. In the field of medicine, basic ethical conflicts are reflected in the struggle for control over knowledge, its use or misuse by professionals/healers, and the role of the state in ensuring equity in health (Qader, 2003). Thus the subject of health is contextualized and made subjective. This leads to overlapping and multiple perspectives. To some extent the recent concern about inclusion of AYUSH is the product of the realization of inadequacy, unaffordability, inaccessibility and contradictions of 'scientific medicine'. But this has also a potential for uncritical and disinterested acceptance of AYUSH. In this paper we will explore one of the components of AYUSH – Ayurveda, the indigenous Indian perspective on health and illness in India. This is done on the basis of references to health and illness in the Hindu texts. The ideas developed here require a more systematic examination by experts in religious texts.

There is also a need for empirical examination of beliefs held by people in areas not much touched by modernity. The new ideas require to be situated in the current debate on processes and power in health policy in the developing countries (Walt, 2000).

Why AYUSH?

The development of biopsychosocial model of health has renewed interest in alternative or complementary care approaches. If the goal is to treat the “whole person” the evidence-based scientific medicine may be combined with the alternative approaches including acupressure, acupuncture, massage, chiropractic, herbal therapies, homeopathy, yoga, meditation etc. (Grochowski, 2014). In the West both pull factors and push factors have attracted patients toward alternative systems of medicine. The pull factors include stress on the idea that complementary treatments are “more natural, effective, relaxing, sensible and that one could take an active part in it”. The push factors include “specific failure of orthodox medicine to bring them relief”, “adverse side-effects of orthodox medicine”; and “poor communication between patients and orthodox medicine practitioners”. Easy availability and their cost effectiveness also explain the movement of people from orthodox to alternative therapies (Vincent and Furnham, 2001). Studying the Kung approach to healing in Africa, Katz (2001) avers that most diseases are self-limiting and they heal on their own. In the cultures of developing world people may, however, believe that the traditional healing practices such as dance cure the disease. At the level of patients similar factors may be at work in India. But that does not explain state’s interest in AYUSH. There are two reasons for promotion of AYUSH in India. One reason is the failure of the modern medicine to ensure universal health, and the other is the promise of health by integrating well established traditional practices and the indigenous medical knowledge system. The collective outcome of state, medicine, and business has failed to provide required services to all classes, regions, ethnic groups, men and women. The cost of modern medicine for most people is exorbitant. There are also iatrogenic conditions. There are new afflictions impossible to cure or life style diseases. And the relationship between doctor and patients is very unequal and disempowering to people. In remote areas people are going for medical pluralism due to inadequate facilities of modern medicine. This is the context when people are looking for alternatives. Obviously, the alternatives will not come from the vacuum or from a completely alien world as the alternatives will have to be supported by pre-existing social representations.

AYUSH provide a hope. Governments get attracted to AYUSH for a number of reasons: supplementing manpower at the lower levels for services and campaigns, low cost, consistency with the value system of people, and effects of pressure groups (vested interests). Using the distinction made between *sociology of medicine* and *sociology in medicine* by Robert Strauss (Hafferty and Castellani, 2007), it may be said that poor development of *sociology of medicine* in India, which could offer a sociological critique of medical practices making them sociologically more reflective could be another reason. *Sociology in medicine* (though practiced by those working in sociology departments) has remained in supportive role and has not been able to look for reflexive interventions.

The earlier usage for AYUSH was ISM. The National Health Policy, 1983 referred about importance of promoting Indian systems of medicine (ISM), and integrating them with the modern medicines. ISM refers to Ayurveda, Siddha, Yoga, and Yunani systems of medicine. Among them Ayurveda, Siddha, and Yoga are of Indian origin and Yunani system came to India with entry of Islam centuries ago; it too has become part of Indian health practices among both Hindus and Muslims. There are many similarities between Ayurveda and Yunani practices. *National Policy on Indian Systems of Medicine & Homeopathy-2002* is an exhaustive document dealing with all aspects of ISM including infrastructure, research, regulation, industry, pharmacological and pharmacognostical studies, herbal plants, finances and education. It is notable that the National Health Policy (NHP) 1983 committed to AYUSH to provide for the 'simpler and gentler therapies for improving the quality of life and avoiding iatrogenic problems.' To quote:

To quote (<http://indianmedicine.nic.in/writereaddata/linkimages/7870046089-Ayush%20%20n%20policy%20ISM%20and%20H%20Homeopathy.pdf>):

Complementary and Alternative Medicine or Traditional Medicine is rapidly growing worldwide. In India also, there is resurgence of interest in Indian Systems of Medicine. People are becoming concerned about the adverse effects of chemical based drugs and the escalating costs of conventional health care. Longer life expectancy and life style related problems have brought with them an increased risk of developing chronic, debilitating diseases such as heart disease, cancer, diabetes and mental disorders. Although new treatments and technologies for dealing with them are plentiful, nonetheless more and more patients are now looking for simpler, gentler therapies for improving the quality of life and avoiding iatrogenic problems

In 1999 the Central Council for Health and Family Welfare recommended that there should be at least one practitioner of ISM at every health centre. The policy on Aurveda goes further and includes in its ambit promotion of medical tourism. To quote from the policy:

Medical tourism will be propagated by establishing facilities, specialized treatment therapies of Ayurveda like Panchakarma & Yoga in tourist hotels and resorts so as to attract domestic and foreign tourists who, particularly travel to various places for seeking treatment facilities of traditional medicine. These therapies mainly play a significant role in providing rejuvenation and psychophysical relaxation. Such centers will be established at tourist places so that tourist may have dual benefit of site seeing and availing health promotive procedures at the same time and same place. The objective is to exploit the popularity of Ayurveda and Yoga for propagating tourism.

Centre for Research Planning and Action (CERPA), New Delhi, Institute for Research in Medical Statistics (IRMS), Indian Council of Medical Research (ICMR) and ORG-MARG have conducted studies of demand for ISM&H services and results are favourable to promotion of indigenous systems. Central Council for Research in Yoga and Naturopathy organized a 'National Workshop on Management of Diabetes and Hypertension' on 29th and 30th of April 2002 in New Delhi. Efforts are also made to draw attention of the world to importance of ISM&H. Department of ISM&H organized a presentation-cum-exhibition on Ayurveda and Yoga on 15th May 2002 for delegates to World Health Assembly in Geneva. At several institutes and colleges medical researchers are conducting research on chemical structures of herbal compounds and screening of herbs for their claimed activities.

Looking at the vast potential for ISM products industry has also taken a keen interest in producing and distributing Indian medicines. However, the revival of ISM&H is selective: it accepts and promotes the magical aspects of curative health practices but stigmatizes the basic principles on which Indian systems are based. Adams (2002) has highlighted the same plight of Tibetan medicine. There is no taker of the philosophical framework in which ISM is rooted. Sociologists should ponder on the need to understand and preserve the philosophy of health as part of the indigenous knowledge.

Government is using AYUSH to meet the unmet needs in different fields of medical services: To quote from the Twelfth Five Year Plan (Planning Commission, 2013, p.30):

AYUSH doctors, wherever feasible, would to be given SBA, RCH and IMNCI training and their services will be used in meeting unmet needs. This will increase the availability of trained human resource for better outreach of child and maternal health services.

This is true that many AYUSH doctors can be trained and used in various medical campaigns but same is the case with graduates in bio-sciences and unregistered practitioners. Can we not involve the unregistered medical practitioners in the programme? They have the trust of people and they are anyway approached first for health services. The following long quote reveals the government thinking on the matter (Planning Commission, 2013, p.38).

There are two pre-requisites before this can be done—first by amendment of the legal framework to authorise the practice of modern medicine for primary care by practitioners of Indian Systems of Medicine; and secondly by supplementing skills of AYUSH graduates by imparting training in modern Medicine through bridge courses. High professional standards of eligibility for, and qualifying in the bridge courses should be laid down so that the quality of such primary care integrated physicians remains high. States like Tamil Nadu and recently Maharashtra have shown the lead in this regard. Associations of allopathic practitioners are generally opposed to AYUSH practitioners being allowed to prescribe allopathic medicines; they will have to be persuaded to yield in the national interest of serving the masses, particularly the rural population and the urban poor. Suitably trained, AYUSH graduates can provide primary health care, and help fill in the human resource gaps in rural areas.

AYUSH is also supported for its role in geriatrics. The Twelfth Plan says that geriatrics and therapies in restoration and rejuvenation in old age, and metabolic and life style diseases like diabetes and hypertension, and treatment for drug-abuse (deaddiction) can benefit from AYUSH (Planning Commission, 2013, pp. 40-41).

Concept of health in Ayurveda

In the mainstream literature health is defined in terms of indicators of health such as morbidity and mortality rates. When sociologists, demographers, or public health experts deal with health issues they are looking for data on birth weights, crude death rate, infant mortality rate, maternal mortality ratio, life expectancy, knowledge of HIV/AIDS, institutional deliveries, couple protection rate, etc (IIPS, 2001). There is seldom an attempt to define health as such. To them

health is basically a state of absence of illness. In this perspective even when public health experts show interest in indigenous knowledge it is only to counter superstitions, intervene in current practices or evolve an optimum strategy for health delivery. However, now a debate has started on defining the social dimensions of health which entails exploring the subjective meanings attached to health, and social representations (CBCS, 2003).

There is now more research on mapping of local knowledge, differential rationalities involved in treatment, pattern of communication between providers and community, nature of community participation and relationship between culture and needs and resources of the community. It points out towards the process of de-differentiation and a conceptual link between medical and health terminologies and people's concepts (used for reasoning, diagnosis and treatment). Frank (1995) says that ill people recognize that 'more is involved in their experiences than the medical story can tell'. Sushma Swaraj, when she was the Health and Family Welfare Minister, enunciated need for promoting marital fidelity as part of holistic approach to fight AIDS and gave the slogans of restraint and abstinence (Gupta, 2003; Jain, 2003). The WHO too defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. In the new context of ageing the indicators of health include ability to perform all the daily activities without difficulty (Ogawa et al., 2003). This approach warns against the biomedical model of health that defines health in a purely physical sense and assumes that promotion of health is a matter that requires understanding and use of science of body.

Ayurveda is one of the oldest systems of medicine developed in India. Vedas and Vedic literature provide several references to illness and medicines. Rik Veda contains verses on the nature of health and disease and discusses the concept of the three doshas (Vata, Pitta, and Kapha). The verses of Sama Veda pray Somadeva and Somarasa. Somarasa was some sacred extract obtained from plants and herbs. The singers of Sama prayed Soma to get food, physical strength, long life, progeny, welfare, victory and bliss (Acharya, 1996). It was called the soul of Yajna (sacrifice). Without Soma sacrifice is not possible, says Veda. Soma makes one fearless. It is present in all living beings, air and earth. In Samaveda the term medicine (aushadhi) is used for invigorating principle of vegetation. It was equally available to all social divisions. Another text, called the Atharva Veda, lists the eight divisions of Ayurveda: internal medicine, surgery of head and neck, ophthalmology and otorinolaryngology, surgery, toxicology, psychiatry, pediatrics, gerontology or science of rejuvenation, and the science of fertility. Sushruta and

Charaka Samhitas are two famous medical textbooks which are compilations and interpretations of Vedic texts. The Sushruta Samhita provides a good outline of surgical techniques, the Charaka Samhita of internal medicine.

The meaning of Ayurveda is as follows (Ayurvedweblne, 2003):

1. By which liveliness is present.
2. By which one can get long life (Ayu).
3. By which one can get knowledge of life.
4. It generates attitude to think on Ayu (life).

Ayurveda is divided into eight branches

1. Shalya
2. Shalakya
3. Kay Chikitsa
4. Bhootvidya
5. Kaumarbhrutya
6. Agadatantra
7. Rosayantantra
8. Vajikarantantra

As per the request of students Sushrut described Surgery (Shalya) related Ayurveda. Ayurveda is meant for two main purposes: rescue from disease; and to maintain good health.

In India the traditional slogan '*dharmarthakamamokshanamarogyam mulamuttamam*' shows that in health is the root of all ends of life, *dharm*, *artha*, *kama* and *moksha*.

In the first chapter of *Chhandogyopnishad* the story of Ushashti who accepts used *urad* from an elephant raiser but not water, illustrates that to save life even deviance from norms is permitted.

In the fourth part of *Taittiriyanishad* also there is a prayer for body.

In Chapter 12 of *Atharvaveda* there are prayers for *aushadhis* (medicines). Here medicines are seen as mother and are believed to be responsible for removing thirst, hunger and diseases (Book Ten of *Srimad Bhagavata Mahapurana* enumerates six waves of existence, viz. hunger and thirst, grief and delusions, old age and death). These medicines are meant for countering bodily diseases which are caused by various factors such as sins associated with oath, playing in water, sin against Yama, curse of gods, etc. In the Vedic tradition medicines are believed to be living in heaven. When they come to earth; the person in whose body they mix cannot be destroyed and

diseases do not attack him. In seventy fourth *Sarg* of *Ramayana* (*Yudh Kand*) there are direct references to four medicines: *mrit sanjivini*, *vishalya karani*, *suvarnakarni*, and *sandhani*. Their smell gave a new lease of life to warriors who were injured in the war including Ram and Laxman. They lived on the hill Rishabh in Himalayas. It may be noted that on the one hand *Ramayana* talks about force that Hanuman applied on them to bring them to the battlefield near Lanka for the benefit of people, and on the other hand they were returned back to their abode in Himalaya with respect. No contradiction is seen between force used to bring them to earth for the treatment of people and respect for them and their place. Written in Hindi *Ramacharitmanas* is less mythical about medicines; it accepts the importance of medicines for body but stresses that one can be happy only through cleaning of mind.

What is interesting is that medicines were worshipped not only because they eliminated diseases but because they also turned long time enemies into followers. The aim of the Vedic prayer was to make all cells of the body blissful and this included fortune, morality, and existence with subjects (Chapter 20). Those who followed *Vedas* had a holistic thinking.

In *Durgasaptashati* the devotee asks for *saubhagyam*, *arogyam* and *param sukham* (fortune, health and extreme happiness). *Shrimadbhagavadgita* uses six words for health (Das, 2001; Prabhupada, 1987), viz. *aayu*, *satva*, *bala*, *arogyam*, *sukh*, and *priti* which mean continuity of life, patience of mind, physical strength, absence of diseases, happiness, and love. They depend on *swabhava*, i.e., natural inclinations of self (which are classified into *satviki*, *rajasi* and *tamasi*) and food. In the Indian system of thought *swasthya* (*health*) means staying in *atma* (which in itself is a state of happiness) and ill health means living under control of a certain disease.

Anything that produces pain is a disease. It may be physical, mental, accidental or natural (such as hunger and thirst that are experienced daily). This system classifies all causes of diseases into three classes, namely *karmaj*, *doshaj*, and *ubhayaj*. Among them only *doshaj* diseases can be cured by medicines. *Karmaj* diseases are the result of wrong actions; they require recitation of name (of God), penance, *anushthan*, etc. *Ubhayaj* are the mixture of *doshaj* and *karmaj* diseases. According to Charak, in the final analysis all diseases (manifestly caused by *vat*, *pitta* or *kapha*, are caused by *manovikriti*, i.e., the strain of mind (Vyas, 2001). *Uttarkand* of *Ramacharitmanas* describes four causes of diseases, viz. *kala*, *karma*, *guna*, *dosha* and *swabhav*, all of which can be removed by blessings of Ram. Gandhiji, the father of the nation, too believed in the therapeutic value of reciting the name of Ram.

In one of the clearest exposition of Ayurvedic principles Vishnudas (2001) says that a disease has two causes: *aadhij* and *anadhij* (or *adhibhautic*). The former includes *saar* or *adhidaivic*, i.e. diseases caused by past actions, and general, i.e. diseases caused by psychosomatic reasons; they are due to internal reasons. The latter include all diseases caused by external factors such as drowning or diseases caused by germs (cholera, gastrointestinal, dysentery, all kinds of fevers). *Anadhij* diseases may be cured by medicines but even they can be cured through spiritual interventions. No wonder that the Kaliyuga which is dominated by *tamas* has the life expectancy of 100 years only (Gautam, 1982). In Sata Yuga (age of Truth) in which people follow dharma the life expectancy is 400 years. It reduces to 300 in Treta and 200 in Dvapara because of proportionate reduction in *dharma* in these ages.

For seers a person was believed to be having five bodies: *annamaya kosh* (physical body), *pranamaya kosh* (etheric body), *manomaya kosh* (mental body), *vigyanmaya kosh* (intellectual body), and *anandamaya kosh* (casual body). The interventions at various levels are:

Physical body:	Six activities: <i>neti, dhauti, kapalbhati, tratak, nauli, vasti</i> , relaxation and exercises, <i>yogasanas</i> , and medicines of various types
Etheric body:	Pranayama, walking, breathing exercises, mountaineering, <i>pran vidya, mantra vidya</i>
Mental body:	Meditation, concentration, recitation, <i>bhajan, mantrochchar, yoga nidra</i>
Intellectual body:	Study of Vedas and Upanishadas, religious literature, meditation, concentration, <i>vipasyana</i> , altruistic acts, bliss
Casual body:	Samadhi, liberation, peace, bliss, <i>sat-chit-anand</i>

According to Ayurveda:

Samadosha samagnisch samadhatu malakriya Prasanna atma mana swastha iti abhidhiyate. (Having a balanced state of Doshas, Agni (Digestive Fire), Dhatus(tissues) and normal functioning of Mala (waste products), cheerful state of Atman (soul), sensory organs, mind are the symptoms of healthy life.)

There is a direct reference to *swasthya* (health) in *Tatva Kaumudi Sanhita*. It says that health means absence of contact with intellect polluted by *rajas* and *tamas* tendencies. *Swasth iti rajastamovritikalushaya budhyaasambhinna*. In another reference to health thirteenth stanza of

Swetaswetropanishad says that the early achievement of Yoga is health; it is characterized by subjective feeling of lightness, absence of any type of disease, end of attachment to objects of desire, radiance of the body, sweetness of speech, good odor from body, and reduction in urine and stool.

In Indian tradition body is supposed to be embodiment of sufferings. At the body level it is impossible to remove sufferings for all and permanently (Aranya, 1987). One's mind and body are greatly the fruits of *karma* (in the sense in which a mango tree will bear mango fruits only, watering of tree and manures cannot basically change the nature of fruits). Interventions at the body level (breathing exercises and medicines) may temporarily and to a limited extent weaken the external causes of diseases but cannot make one healthy. *Niyati* (i.e. all internal causes which force one to engage in a certain action) the nature of self are two important determinants of health or misery. It is very important to understand that what one does in a state of ill-health or health determines the future state of health and happiness. Thus a temporary state of ill-health may lead to better health in the future or a good health may lead to illness. It depends on the nature of self.

The issue is: what does the National Health Policy have to say on the frameworks of health? Is the above framework acceptable to scientists and planners? How will it be reconciled with the scientific or biomedical representations?

Mismatch with science

From a sympathetic perspective, Indian/Ayurvedic approach to health and illness was holistic. It focused on intervention at all levels – physical, mental and spiritual. It also assumed that due to their past deeds different individuals are at different levels of movement and are, therefore, constitutionally different. Even for the same diseases they may require different interventions. However, spiritual considerations are at the root of all cures. This view rejects the scientific perspective as western, alien, and based on study of bodily processes only, thus discarding the mental and the spiritual.

About 3.2 percent of the health budget released during the Eleventh Five Year Plan was released for AYUSH and a similar proportion of allocation (3.3%) is planned during the Twelfth Five Year Plan. But the Twelfth Plan accepts that the medical doctors have some resistance in accepting AYUSH in the programme. The Plan document states: 'Though considerable progress

has been made in documenting identity and quality standards of herbal medicines, scientific validation of AYUSH principles, remedies and therapies has not progressed' (Planning Commission, 2013).

The selective revival of Indian medicines has abandoned this spiritual substratum. And most of the time quick researches are testing the herbs and other medicines statistically with scant attention to Indian understanding of body or western standards of molecular biology or quantum physics. In other words magic is accepted and indigenous theory is abandoned. This attempt may not succeed and the Indian medicines may not win the western game. With little support to identification of herbs, felling of forests, changes in environmental quality and new morbidity patterns the ISM may be left either to play a subordinate role to western medicine or may die a natural death. It may not even be poor man's medicine any more. Revival of traditional medicine makes greater sense when it is combined with traditional thought categories. Gandhi once said that he would oppose even naturopathy if it makes the Indian dependent on outside wisdom.

Although Ayurveda believes in differences in essential nature of individuals and soul in practice such differences are being ignored and a standardized approach to diseases is being developed.

To quote (G. M. Foundation, 2003):

In the Ayurvedic view, an imbalance between the doshas produces a condition called *vikriti*, a Sanskrit word that means 'deviated from nature.' *Vikriti* results from an overexpression of one or two doshas (usually the dominant dosha) and a diminished expression of the other dosha. This imbalance can be caused by eating the wrong foods, chronic mental stress, physical overexertion, negative emotions, or poor sleeping habits, and will eventually lead to the development of disease, obesity and/or mental disorders. As a result, to prevent disease, each individual must maintain the doshas in, or restore them to, their proper balance.

Selective revival of ISM focuses on the magical part. It ignores the fact that according to ISM health is inseparably linked with life. In the Western perspective, health consciousness entails medicalization. It refers to 'the extension of the range of social phenomena mediated by the concept of health and illness, often focusing on the importance of that process for understanding the social control of deviance' (Yadavendu, 2001). According to Touraine (2000) the medicine is unable to treat serious illnesses such as cancer and AIDS and this situation is giving rise to public debates over the relationship between young people and education, or between curing the illness and caring for the patient. In the Indian perspective the relationship between the healer and

people is what may be called 'multiple monopsonic' (Harvey et al., 2002) in which the sick is fully empowered. He is not objectified. Modern medicine involves entry into market but market is not conducive to philosophy of ISM. This rejection of ISM at the fundamental level and acceptance of its magical power is not conducive to creative application of the ISM.

Dysfunctions of AYUSH in the present setup

In the present framework of service delivery, there are several possible dysfunctions of inclusion of AYUSH in the NHP: (a) legitimation of less tested and poor quality health services among the rural poor and other vulnerable sections of society; (b) permissiveness and often promotion of magic and blind faith in traditional practices doing harm to people in the long run; (c) lending support to religious and superstitious practices; (d) rejection of health inequality hypothesis; and often (e) withdrawal from the remote areas. At the moment there is a lack of consensus in the scientific community regarding what AYUSH remedy cures a particular disease and in what quantity. The drugs available in the market lack standardization. In most cases in the name of AYUSH competence of practitioner, training, and knowledge are compromised. It is almost accepted that the AYUSH practitioners are allowed to prescribe allopathic medicines in primary health services (after clearing bridge courses). Moreover, since the traditional practices combine religion, magic, herbal, astrological and many other types of practices, it becomes difficult to separate the effective part of AYUSH from other non-scientific practices and their practitioners. Acceptance of AYUSH in the official program can lend credence to many superstitious and unfounded practices. By including AYUSH in NHM for remote, tribal and vulnerable areas a myth of universal health may also be created falsely.

The issue of evidence is contested. Both scientific medicine and alternative systems claim that they are evidence-based. However, the meaning of evidence is different in the two systems. The scientific medicine is based not only on principles of empirical/experimental evidence, generalization and universality of causes and remedies it is also based on recent advances in molecular biology, bio-chemistry, etc. From the scientific point of view diseases are part of genes or body and the causes and cures are universal: one does not necessarily have to look for spiritual or psychological dispositions to treat a physical symptom. Contrary to this, the AYUSH is based mostly on experimental trials and statistical generalizations.

In the postmodern age media has become an important part of legitimacy processes. Along with official protection to AYUSH when media also links with the business interests to promote specific drugs by specific companies only the people suffer. They have to make choices. On what basis do they make choices? Governments often hide their limitations of planning, distribution channels, and manpower and financial shortages by including AYUSH in the service delivery. Religious leaders gain by supporting them to fight for their cultural and religious authority. Practitioners gain by getting more clients, particularly from the dissatisfied users of modern medicine by stressing permanent cure and absence of side effects. Media gains by showing long sponsored programmes posing as though they are for informative and welfare oriented programmes (quite often without clearly exhibiting that they are advertisements or sponsored programmes). People suffer and waste money. Knowledge and legitimations are produced in different networks which seek support from the doxa or the common belief systems.

Conclusion

This paper explores one of the multiple frameworks of AYUSH. It has shown that the Indian System of Medicine is rooted in a different philosophical framework which has increasingly become marginal although the medicine part of the system is promoted and validated. This is doing immense harm to the value system of the AYUSH and its inclusion in the NHM is ornamental or inadequate. There is a need to critique the manner of integration of scientific approach with AYUSH, and subject AYUSH to scientific scrutiny before it is made a part of state programme. The present approach of convenience is not good for equity, quality and accessibility of health services.

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