



Critical evaluation of paradigm shifts in mainstreaming of Indigenous systems of medicine into Indian healthcare system and allied socio-cultural barriers: A public health perspective

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Abstract

Since the time of independence till today, Indian Medical Health Care System has been approached with a variety of policy and programmatic recommendations for incorporating the indigenous/traditional system of medicines into the mainstream health care system, in order to encourage Medical Pluralism. It initiated with the Bhore Committee Report (1946), recognizing the importance of the Indigenous Medicine Systems and their need into public health sphere, and finally reaching a stage when AYUSH is incorporated under NRHM. Although, the utility of ISM has always been welcomed in health care system, its efficacy remains doubtful from public health perspective considering the cross-practices, hierarchies amongst different systems of medicine, recognition, legitimacy, quality controls, human resources, commodification of the health products including drugs etc. indicating major gaps in policy guidelines and its implementation. So, it becomes crucial to consider the socio-cultural barriers of indigenous societies causing hindrance in acceptance of such policies. This study understands the major policy changes using a critical paradigm since independence till today along with emphasizing on some of the major socio-cultural barriers in the proper implementation of those at the community level. Data was collected from policy documents, programmatic recommendations, major committee reports and the available literature online using the keywords.

Conclusion: There have been very few studies which considered the emic perspective on such issue of integration of the indigenous system of medicine, especially in India. Policy implementation and its impacts need to be assessed in order to make a policy-oriented change in society for the benefit of human society.

Keywords: health care system; medical pluralism; public health policy; sociocultural barriers

Introduction: Understanding Medical Pluralism: Multiplicity of Systems of Medicine

Every human society irrespective of its origin, geography, social background etc. has some or the other form of health care system. Societies stretching from so-called 'indigenous societies' to the 'developed ones' have their own medical system which may or may not be common to each other. Baer (2004) referred to it as "dyadic core" of a healer and a patient prevailing in every society, where a healer can have variable categories as a general healer, as a shaman, specialists, bonesetters, midwives, etc. Medical anthropologists, medical sociologists, medical geographers, and others, therefore, refer to this phenomenon of an array of medical systems that exhibits more or less of a coherent medical system as Medical Pluralism. In general terms, it is the "multiplicity" of health care systems and within health care system, multiplicity in context to health care providers or the healers that vary from one group or community of people to other and has been a special attribute of human society since times immemorial.

The term "medical pluralism" was introduced by the social sciences in the mid-1970s to characterize the situation in the third world, in which people resorted to multiple options for health care outside the government healthcare system that was based on biomedicine. It is not a recent phenomenon and could be easily traced back to its roots through the social stratification and hierarchical structures of early and contemporary human societies. Early works on medical pluralism were conducted in African and Asian societies. According to Fabrega (1997) early societies with simplest

form of organization namely Band and Chiefdom demarcate the beginning of an institution particular to human societies or "system of medicine" that includes medical knowledge embracing cosmology, religion and mortality with the presence of wide variety of healers as priests, shamans, herbalists, bonesetters, midwives etc. He also classified medical systems of early times of civilizations and empires into two broad levels. Firstly, the professional health practitioners who serve the elite class, and secondly the folk or the traditional practitioners serving the locals either free of cost or at nominal charges. He referred the practitioners from the first category as those belonging to the "great medical tradition" which later gave rise to clinical medicine and that ultimately led to commercialization of medical system. Charles Leslie also referred to the mainstream of learned medical practices that originated in Chinese, South Asian and Mediterranean civilizations as "great tradition medicines" as derived from Robert Redfield's work on civilizations. With the expansion of colonialism and invasion by Europeans, allopathic medicine evolved into biomedicine. Moreover, the middle and upper-class people also kept this traditional technology and method of healing as their backup. Thus it comes out to us that, the different form of the medical system go hand in hand with the class and caste concept in human society and has been there since the origin itself. As also stated by Frankenberg that "the societies in which medical pluralism flourishes are invariably class divided."

A variety of factors come into play when we talk about the healthcare seeking behavior as well as health care services

such as cultural, technological, socio-economic, political etc. across time and space. An excerpt from *Susruta Samhita* defines the relationship between the ethnobotanical knowledge and resources and the traditional systems of medicine (especially herbal medicine) as-“...*Yasmin deshe to yojaatah, Tasyatajjaushadhamhitam*” which means “Nature is so benevolently organized that it has provided every micro-environment, the natural resources (as plants, animals, minerals etc.) necessary for typical health needs of people living in that environment (Gangadharan & Shankar, 2009)^[2].

In 1998, Charles Leslie conceptualized medical pluralism as the co-existence of what he called “the great tradition medicine” indicating the mainstream of learned medical practices that originated in Chinese, South Asian and Mediterranean civilizations as derived from Robert Redfield’s work on civilizations, “little tradition medicine” and the “cosmopolitan medicine” in medical structure of the society (Leslie, 1998)^[9]. The exploratory framework of Kleinman’s work (1980)^[8] provides an approach to studying the whole culture to understand its health care which includes every medical practitioner including healers and their belief system. The author urges for an integration of social and cultural methods into the routine training of doctors for more appropriate clinical practice (Kleinman, 1981)^[8].

Indian System of Medicine (ISM)

Indian medical system is different from any other traditional forms of medicine as they have a textual tradition that evolved over a period of time and the texts include the knowledge followed by its application in form of a variety of health practices. Those texts are well-documented, verifiable for its authenticity and not necessarily rely on oral traditions. Another important characteristic is that it doesn’t restrict plurality. Furthermore, the development of each specific system is influenced by others, including the incorporation of new elements in pharmacology, diagnostic and treatments practices.

Indigenous medicine (ISM) or the traditional medicine system provides a link in overcoming the barriers to health care services as it stems from the cultural system, unique values and specific health needs of these populations. The World Health Organization says that TM, “of proven quality, safety, and efficacy, contributes to the goal of ensuring that all people have access to care” and adds on by saying it as the “mainstay of health and health care delivery.” (Parker, 2017)^[11]. Diversity, flexibility, easy accessibility, broad continuing acceptance in developing countries and increasing popularity in developed countries, relatively low cost, low levels of technological input, relative low side effects and growing economic importance are some of the positive features of traditional medicine (Payyappallimana, 2009)^[12].

Cosmopolitan Medicine

Development in research and professional association in Europe at the later phase of middle ages led to the worldwide tradition of cosmopolitan medicine. It was an amalgamation of new knowledge, practices and traditional theories of equilibrium (humor theories) that came into existence with industrialization and other movements. Some of the major features of this system are therapeutic effectiveness, institutional teaching, research, publications,

the germ theory of evidence, surgical techniques, social welfare, accelerated professionalization process, use of state power to legitimize and extend its authority, doctors playing a crucial role in vital events etc. It has a special feature of innate superiority due to the above-mentioned characteristics of the other forms of medicine systems.

The present public health system in India is deep-rooted in its development during British rule. The western biomedicine was dominant during colonialism marking a beginning of the Western biomedicine in India. It took over a century to get manifested in the everyday lives of large parts of the Indian population. However, the marginalization of the existing Indian medical systems was contested by their practitioners in various ways. By the time independence from British rule came in 1947, the educated elite who became the decision makers had imbibed the idea of modern scientific supremacy. Yet there was organized opposition to its hegemony, both as a nationalist assertion and as a struggle to preserve what was indigenous and useful, and there was a continued use of Indian medical systems by a vast majority of the population (Priya, 2013)^[13].

Health Care System

Any health care system is judged by its effectiveness defined in terms of the improvement in health standards as well components such as its accessibility to everyone and affordability by everyone. Given the limited resources as hospitals and dispensaries, medical and Para-medical personnel, drugs, etc., the health care system has to be assessed in terms of its cost effectiveness, especially in underdeveloped countries like India. Hence, the relevance of alternative approaches and techniques seems to be appropriate (Panikar, 1979)^[10]. Studies on public health in the developing world repeatedly point to inadequacies in health care financing by the states which have led to a situation of highly limited material and human resources for healthcare services (Payyappallimana, 2009)^[12]. Health inequities have contrasting scenarios in developed and developing countries. External resources oriented, foreign technology and vertically health care programs has been a major uncertain block for not getting desired health outcomes in many developing countries. WHO identifies that the main constraints are income level, low literacy level, socio-culture beliefs and practices, and less than highest standard utilization of health facilities. The heavy burden of communicable diseases and high maternal and child mortality, rapid urbanization and demographic changes, underutilization of public healthcare, increasing privatization of public health facilities, ineffective health supports systems for poor population, environment changes and related epidemics, migration of medical professionals are some other major public health concerns in such economies. The issue of unavailability and inaccessibility is perceived as a challenge of health care services to the economically disadvantaged people of such societies.

Significance of the Study: Need for the Integration of ISM-H into Mainstream

People who believe that bringing qualities in the health sector by simply doing the administration reforms in form of education, technology etc., would actually bring about a change needs to ponder on other much sensitive issues as socio-cultural, political, economic and technological

aspects. Thus, this spectrum of approaches particularly in the health sector has to be pluralistic in its nature (Qadeer, 1988). Folk or the indigenous concepts are majorly treated to be 'subjective' and not as valid form of knowledge.

This study, firstly, aims to understand the major policy changes using a critical paradigm since independence and secondly, brings out some of the major socio-cultural barriers in the proper implementation of those at the community level. This is a review article based on a rigorous literature review in order to extract the maximum of information. Based on available literature, themes and sub-themes were generated and therefore thematic analysis was done. The results and observations were structured as per those themes, analyzed and concluded at the end.

Policy Recommendations: Mainstreaming ISM into Modern Medicine System

Role of State

When the British started hiring medical practitioners for the rich class people, and also to the middle, low class, and poor people, services being provided free of cost especially when the famines and epidemics occur, the State as a central player came into action in persuading the medical care system. State-sponsored medical pluralism was now admitted as a reality of healthcare in the west and no longer a feature of societies that are deprived of biomedical care due to poverty and other economic constraints. But even within the framework of the state-legitimized medical pluralism, the relation between medicine state and society varies considerably across nation states. In the 19th century, a fundamental role was played by the state in banning all the medical practices. The indigenous systems of Britain, Europe and North America namely naturopathy, chiropractic, homeopathy etc. struggled for their existence. On the other hand, Indian subcontinent had no strict ban or rule for indigenous systems of medicine. The following section will explore the shift in policies and efforts made by government and authorities over a period of time in mainstreaming indigenous systems of medicine into the healthcare system.

During Colonial Period in India

The exploitation of Indigenous systems of medicine began since the era of imperialism when medicine system appeared to be a tool for British to make the most of Indian and the ruled ones Unlike American and European continent, it was not easy to introduce and make people accept the modern system of medicine in India as the cultural ideologies of Indian have inborn feature of acceptance towards Indigenous system of medicine such as herbal, Ayurvedic, etc. But the Colonials made quite a few attempts in order to integrate the indigenous systems with the western medicine. Colonialism affected the relation between ISM and state in two ways, *one* by pressurizing the State to adopt one kind of medical system (western) and *second* through policy making and intervention strategies. Some studies also suggest that several colonial administrators relied on services of indigenous practitioners to establish western medicine. As ISM healer were communicated about the essentials and methods of western medicine and asked to impart the health practice in the similar fashion. Initially, they tried to replace the National Medical Institution of Calcutta (which has an orientation of integrating ISM with western medicine) to be replaced with

'modern' medical college which would snatch away all the basic rights of traditional practitioners and other resources such as land for Vaidis taken away, allopathic practitioners associated and working with ISM to be deregistered (Sujatha & Abraham, 2009)^[15].

Midwives delivered the babies like doctors used to conduct at hospitals but, didn't do the cleaning contributing to high rates of maternal mortality and infant mortality. So although there was a strong encounter between indigenous systems and western medicine, indigenous practitioners were passive receptors of developments that occurred. Moreover, the training sessions were given to the *Vaidis or Hakims* along with the traditional midwives (*Dais*) with the intention of developing biomedical measures even in the rural India, where ISM had been highly practiced a form of the medicine system.

End of the 19th century has also found ISM to be integral to the biomedical services in several types. The beginning of 20th century marked the oppositions from colonial administrators against indigenous systems in terms of denial of medical registration, withdrawal of land grants etc. Gradually new institutions for training and commercial production were established with the support of wealthy patrons and princely states of Indian at that point of time. During the British period, 'Bhore Committee' was set up in 1942 which designed blueprint entirely based on modern biomedicine. Bhore committee recommended the importance of Indian Systems of Medicine & Homeopathy (ISM&H) highlighting its need in modern medicine system which advocated to move towards a 'synthesis' of all the systems to formulate one Indian system. In order to integrate ISM&H into mainstream medicine system, there have been many attempts made in form of various policy documents along with a 12th 5-year plan for 2012-17 (Priya, 2013)^[13].

Post-Independence Period

Bhore committee report chaired by Sir Joseph Bhore, presented a report with a special mention of the Indigenous System of Medicine as content presented a more biased report towards allopathic or scientific medicine system. This report presented a more disgraceful attitude towards ISM &H by calling them as "unscientific". The services of persons trained in an Indigenous system of medicine should be freely utilized for developing medical relief and Public health work in India. Since the newly independent India was burdened under a high pressure of IMR, MMR and various other NCDs as well as communicable diseases, and Bhore Committee report came up as an action for the same. There was not even a single person who would be representative of ISM&H while formulating the policy recommendations (Bhore, 1946)^[11].

Sokhey committee's objective in training selected *Vaidis* and *Hakims* as health workers only to avert 'impediment to the scientific progress of medicine caused by indigenous systems' is yet another example of how the indigenous systems were accused of being 'unscientific'. Although they tried to give due recognition to the ISM practitioners and even tried to make a maximum in order to integrate into the mainstream by focusing on people-centric approach and pluralistic developmental model. But the kind of suggestions they gave to recommend training for traditional practitioners was to bring forth the "unscientific" nature of those systems of medicine (GoI, 1948)^[11].

In the mid-20th century, various studies were sponsored by organizations like Rockefeller and Ford who had physicians turned social scientist from US and India like Marriott, B. Paul, and Gould etc. who discovered that people preferred IMS over Allopathy, thus came out with suggestions of holding various training programs to ensure acceptance of western medicines. This kind of preference was thought to be because of cultural resistance by some of the anthropologists, which was later corrected by public health scholars that, health education and availability of health centers with well-equipped infrastructure and trained human resources could have to improved acceptance.

Chopra Committee in 1946, was put forth to plan “mutual learning” process between the modern medicine and ISM practitioners, where each one could help in enriching and evolving the knowledge by integrating the two systems (Suajtha & Abraham, 2012)^[16].

During the Second 5-year plan (1961) there was the launch of the Mudaliar Committee Report, in order to access the success of Bhore Committee policy implementations. But again, it followed the track of Sokhey as well as Chopra Committee favoring the modern medicine and seeing this system as comparable to international standards. It stressed upon prioritizing national health services as based on modern medicines. So according to this, even the Ayurvedic practitioners had to get a certification in modern medicine. Some of the major recommendations made by this committee report were: A). Establishment of chairs of ISM in all Medical Colleges; B). at the end of training in Ayurveda, graduates must be trained in preventive, OBG and surgery to maximize their services in health services; C). Promoting research in ISM at central institutes; D). Councils of research and funding support are made for training in ISM courses (GOI, Ministry of Health: Report of the Health Survey and Planning Committee, 1961).

After that, in 1975, The Srivastava Report brought about their support to the evolution of national system of medicine for country by developing an appropriate integrated relationship between modern and ISM&H for the development of comprehensive plan for health services, although it did not give in-depth details of every recommendation apart from that has already been made (GOI, Report of the group on Medical Education and Support Manpower, 1975)^[5]. In the 1980s, medical anthropology as a discipline came forward with “even-handedness” towards pluralism, in contrast to the health administrators and medical professionals who totally opposed local health traditions. Later emerged a public health system based on both Allopathy and the indigenous system but was structured in a particular hierarchical order. Later, “Health for All” Reports by ICSSR-ICMR provided an alternate model of health care which focused on decentralizing the system, making it more democratic and participatory for different systems of medicine, amalgamating traditional as well as modern sciences together rooted in the community, overcoming the major challenges of accessibility and affordability in the health care system. This was based on the values of Ashram concept of life and also the non-consumerist approach of simplicity and self-discipline. (ICSSR-ICMR, 1981) Following it, National Health Policy (1983) critically analyzed the shortage of human resources from ISM background in health

Services and found it essential to integrate the ISM and modern medicine systems as, these ISM practitioners have very high local acceptance and respect which can influence the health beliefs and practices of community (GOI, National Health Policy, 1983). Recommendations from other communities like Bajaj Committee (1986), Expert Committee on Public Health System (1996), CHC Report (1998) led to establishments of several councils, training institutes, national institutes, laboratories as their direct outcome. It means the concern was all upon institutional development, with validation of ISM drugs in laboratories.

ISM marginalized because of disproportionate allocation of resources between allopathic and other forms of medicine, transformations of indigenous systems into methods of teaching, marketing and production followed in biomedicine and, replicating the apparatus of the dominant biomedical system, in Indian systems of medicine and homeopathy. Allopathic practitioners encouraged using indigenous medicines in order to complement than to substitute their line of treatment. The process of pharmaceuticalisation, therefore, gained strength along with standardization and commercialization fostered by the market. Nehru-Gandhi debate on India’s future mode of development was that Nehru favored development by modern science but with a self-reliant base for its production to which Gandhi questioned its relevance in improving the health of rural and poor people.

In the 1990s, health sector reforms promoted commercialization of public sector and private sector justified by the needs for “transfer of technology” and using financial aid through international sources for providing technology-based quality services. Allopathy limitations were faced by all and these loopholes in the medical system that made the situation critical for the pharmacy industry. Thus, the demand for AYUSH accelerated people from rural and urban areas to show an increasing incline towards home remedies, traditional folk healers, and AYUSH practitioners. As a consequence, in 1999 Central Council for Health and Family Welfare recommended that at least one physician from ISM and Homeopathy must be recruited especially in rural areas and government hospitals. Subsequently, there came WHO strategy on Traditional Medicine and National Policy on ISM and H in 2002 thus, state and center funded heavily for Allopathy and AYUSH. According to 2008 report, there were an equal number of dispensaries for both Allopathy and AYUSH, four central research councils, but still very little of GDP (1.3-2.4%) was getting allocated for health departments. The resource allocation got doubled for AYUSH in the 11th plan, but remained only 2.7%, whereas research work in health obtained 3% and AIDS control gets only 4%. Development of planned health services that included biomedicine and six other systems (Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy) labeled as ISM and homeopathy, therefore, called as AYUSH. NRHM also came up with an initiative to strengthening the health system by focusing on access and utilization of services by marginalized groups that is restorative for local health traditions and mainstream AYUSH in health services. As per the guidelines, AYUSH doctors were supposed to implement national programs to RCH and specific disease control programs. Moreover, ASHA drug kit is supposed to contain AYUSH medicines.

Gaps in Policy Implementation: Role of Allied Socio-Cultural Barriers

There is a huge number of reactions based on the experiences of these systems and the ideological hegemony of biomedicine since the colonial times. The majority of people use ISM over biomedicines, as they do not have access to those biomedical facilities and people find ISM more trustworthy, especially those from rural areas. In fact, urban people have ISM as their backups. Traditional Medicine system is believed to be based on the unscientific or subjective logic of unconventional means from the measure of so-called empirical or scientific or conventional technology-rich biomedical system of healthcare. Not having completely or sufficiently theoretical plausibility would face rejection (Gangadharan & Shankar, 2009)^[2]. The growth of AYUSH institutions has reflected that of modern biomedicine, but a lower range and quality. While the public health system seems to have given reflection to the local cultural context in this regard. Unfortunately, the situation more resembles a Huntingtonian 'clash of civilizations', in which the AYUSH systems are inextricably linked to a particular cultural identity and are pitted against each other rather than brought into a conversation (Priya, 2013)^[13].

Conclusion

In general terms, Traditional Medicine approaches tend to be more lifestyle-oriented and preventative than allopathic approaches. Patients advised changing personal habits and behavior rather than just start taking a pill. Because Traditional Medicine providers offer health care services based on community traditions, indigenous, they can also serve as primary access points for those facing socio-cultural barriers to mainstream care. The increase of chronic diseases, awareness about constraint of modern medicine, proven efficacy of TCAM in selected conditions, emerging interest in a holistic approach to preventive health, integrated approach to medical education and awareness among physicians are some of the causes for renewed interest in traditional medicine. Higher quality of care by TCAM practitioners has been reported also as important causes for increasing health-seeking and consumer satisfaction of TCAM. And within developing countries, one can see a divergence of causes in rural and urban trends in the health seeking behavior. While availability, accessibility, cost are important aspects in rural areas, concerns about chemical drugs, limitations of conventional medicine, questionable assumption of allopathic medicine, changing values and reduces tolerance of paternalism, greater public access to information, ecological and fitness consciousness etc., are reasons for accessing TCAM in urban areas as in developed countries. Thus, emerging economies like India and China where there is a vital gap between the rural and urban centers proactive policies on TCAM will have an effect on the population. India and China have purposively sought to develop the TM sector in order to strengthen their TM heritage. Simultaneously, enable cost-efficacy in health care delivery to their people. However, in India, the fact and enormous presence of folk medical stream were unrecognized in policy indicating an alienation from ground realities. While on the one hands the public at actively integrating various health systems for a variety of causes such as access, efficacy, convenience, ethical and moral reasons, cost, the policy and institutional

mechanism area gradually address various issues related to such integration.

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