RESEARCH ETHICS/ETHICAL DILEMAS

J. Heal Ethics Admin
Volume 6 | Number 1 (Spring/Summer 2020)
www.jheaonline.org
ISSN 2474-2309 | doi:10.22461/jhea.1.71625
https://doi.org/10.22461/jhea.1.71625
Published Aug. 18, 2020

The untold story of plight of Ayurveda in pre and post-independent India

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Abstract: *India will exceed WHO recommended Doctor: population ratio of 1:1000 in 2024 with only MBBS doctors. Thereafter 8 lac registered ISM&H doctors will become surplus. They will have no place to go and no means to survive. Otherwise also as a doctor they were never a part of modern medicine oriented public health care sector. Occasionally whenever they are entertained in this sector, care is taken to keep their status and wages lower than that of a nursing personnel. Delivery of Ayurveda services was never allowed through public health care sector since pre-independence. The script of this neglect was written by Bhore committee in 1946. The Indian administrators in post-independent India, followed the same script. Outside the government, in absence of clear policy on permission or prohibition to practice modern medicine, and without any appropriate training, Ayurveda practitioners, facing occasional prosecutions, continued to practice modern medicine. Today their fate remains undecided. Still 50000+ ISM&H graduates come out every year from Universities to try their luck. This is totally unethical on the part of every responsible Indian and the concerned authorities. This is amounting to mass unemployment and frustration among this youth power. Prohibition on delivery of Ayurveda service through public health service, keeping ambiguity on the issue of permission or prohibition of practice of modern medicine by Ayurveda practitioner, allowing exposure of people to Ayurveda practitioners for receiving modern medicine treatment, when the Ayurveda practitioner is not trained for delivery of such service and allowing exponential increase in number of ISM&H practitioners to the tune of 52000 every year in absence of assured survival means; all these activities are extremely unethical on the part of government authorities. Immediate steps need to be taken to stop these unethical practices and save this deterioration and plight of Ayurveda.*

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+To cite this article: Savrikar, Shriram. "The untold story of plight of Ayurveda in pre and post-independent India" *The Journal of Healthcare Ethics & Administration* 6, no. 1 (Spring/Summer 2020) 26-34, https://doi.org/10.22461/jhea.1.71625

I. INTRODUCTION

Ayurveda, the Indian system of medicine is practiced in Indian subcontinent since the times of Vedas. Till the arrival of colonial rule, the health care of Indian population was looked after by Ayurveda practitioners trained through the tradition of pupillage. In the early period of 19th century, education of Ayurveda was institutionalized. There onwards, the number of institutions imparting Ayurveda education started growing gradually. The last five years witnessed rapid growth of these institutions in India. As reported on 20th March 2020, there are 393 Ayurveda colleges in the country.[1] These colleges produce thousands of graduates every year. However, very few of them practice Ayurveda. The government public health sector refuses to utilize their services for delivering health care through Ayurveda. Following which, majority of them start practicing modern medicine to earn their living. The flip side of this story is, they are not trained to practice modern medicine by professionals qualified to give such training. Moreover, in absence of clarity about legal status of Ayurveda practitioners to practice modern medicine, at times they face legal prosecution. This is the plight of Ayurveda and Ayurveda practitioner. The story of this plight was written by Bhore committee in 1946, which kept Ayurveda out of the domain of public health service structure by ignoring Indian systems of medicine (ISM) initiating their plight.[2]

The legacy of ignoring these systems was carried further by the native administrators in post-independent India. As a result, doors of public health care were permanently closed for practitioners of Ayurveda and other Indian Systems of Medicine and Homeopathy (ISM&H). However, few States did provide employment to these practitioners, which was a miniscule considering their large number. There are 3986 Ayurveda, Yoga& Naturopathy, Siddha and Homeopathy (AYUSH) hospitals and 27,199 AYUSH dispensaries functioning in the country as on 11 Dec 2019.[3] Most of the hospitals, excluding hospitals attached to colleges, are as small as four bed private hospitals. In some States the ISM&H practitioners are made to serve as subordinate health care providers to cater modern medicine services. As compared to Bachelor of Medicine and Bachelor of Surgery (MBBS) graduates, the ISM&H graduates receive miniscule wages. They are not provided required infrastructure and ISM&H medicinal products. The Ministry of AYUSH came into independent existence on 9th Nov 2014.[4] Independent functioning of Ministry of AYUSH raised its own status but it didn't affect the status of ISM&H systems in public health care services of the country. Public health care was always kept outside the domain of Ministry of AYUSH confining it to education and research.

II. HEALTH CARE POLICY – A MATTER OF ETHICAL CONCERN

As reported on 23rd March 2020, among 7,99,879 ISM&H practitioners registered in India 4,43,704 belong to Ayurveda. Every year 52,720 students take admission in 914 ISM&H colleges. Out of which 25407 students take admission in 393 Ayurveda colleges. (1) It must be a matter of ethical concern for every responsible Indian, particularly the policy makers that not many career prospects are open to this 52000 youth force graduating every year. This youth force gets pushed into the rat race of private medical practice with poor training as a result of poor clinical exposure during their training period. The ISM&H graduate is not a non-professional graduate to fit himself anywhere in the society. But he finds his qualification useless to get entry in the government public health service sector as a doctor. Majority of Indians educate their children for some kind of salaried employment. But such opportunities for ISM&H graduates are virtually non-existent. When offered, the wages are not even comparable with the salary of a nursing personnel. The Government, consistently opening a floodgate of ISM&H institutions every year, has the principal ethical responsibility of providing this youth, the employment opportunity. But concerned government authority shuns away from this responsibility, and refuses to recognize this university graduate as a medical doctor to practice medicine. Contrary to this, the same graduates are set free to practice the same medical system outside the government sector. Ethically the practice which the government considers useless to provide through its own agencies, will be also useless for a practitioner to earn his living outside

[1] Ministry of AYUSH, Govt of India, http://ayush.gov.in/sites/default/files/Medical%20Manpower%20Tables.pdf last accessed on: 23rd June, 2018].
[2] Bhore Committee, Report of The Health survey and Development committee (Vol II), Recommendations, Manager of Publications, Delhi, Government of India Press, New Delhi 1946.
[3] Ministry of Health and Family Welfare, Govt. of India, https://health.ncog.gov.in/ retrieved on 05-07-2020.
[4] Ministry of AYUSH, Govt. of India, https://main.ayush.gov.in/about-us/about-the-ministry

the government sector. Moreover, such practice will also prove harmful for the person who opts its use. Therefore, it is unethical on the part of government to allow this practice anywhere. It is also unethical on the part of government to allow uncontrolled increase in number of ISM&H institutes, producing thousands of ISM&H graduates whose services are not found useful.

III. INDIAN SYSTEMS OF MEDICINE IN NATIONAL HEALTH STATISTICS

The government public health department doesn't consider ISM&H, as systems of medicine, hence these systems do not find any place in the National health care statistics. British rulers were the first to denounce Indian systems of medicine officially. The Indian rulers, post-independence, continued the British legacy of denouncement of these systems till today. Refusing to refer ISM&H practitioners as doctors, the authorities treat them at a level much lower than the nursing services, offering them jobs like Mid-level Health Provider (MLHP) in a Health and wellness Centre, under AYUSHMAN BHARAT scheme, a job also offered to the nursing personnel. As per the concerned operation guidelines, the MLHP would be a Community Health Officer (CHO) - a Bachelor of Science (B.Sc.) in Community Health or a Nurse- General Nursing and Midwife (GNM) or B.Sc. or an Ayurveda practitioner, trained and certified through Indira Gandhi National Open University (IGNOU) or other State Public Health/Medical Universities for a set of competencies in delivering public health and primary health care services.[5] In this scheme to become eligible for appointment as MLHP, showing disrespect to his University degree, the Ayurveda practitioner is asked to undertake a training program and obtain a certificate from IGNOU - a University which has nothing to do with medical systems. Ayurveda practitioners get their degree after passing professional examination following 4.5 years academic training program followed by 1-year internship training program.[6] This length of training is very similar to the length of training of a MBBS graduate. The most agonizing part is that the Ayurveda graduate is compelled to undertake a certificate course of a subject for which he has been already examined and declared passed by the University.[7] Commenting on this attitude of Government agencies towards ISM&H practitioners, Kumar R and Pal R (2018) recommend to stop recruiting ISM&H practitioners as foot soldiers or proxy for pharmaceutical companies, instead, strengthen their services and ensure availability of ISM&H products across health systems.[8]

A. Need of ISM&H practitioner as against Doctor: Population ratio

Negative attitude of Government Public Health agencies towards ISM&H practitioners is observed growing proportionately with increase in number of MBBS graduates, and achieving expected doctor population ratio over the years. India has achieved World Health Organization (WHO) recommended doctor population ratio of 1:1000 in 2018 with inclusion of ISM&H doctors. This target will be achieved with only MBBS doctors by 2024. Post 2024, ISM&H doctors will not be required even for filling the gap of numbers. As on 31st March 2017, MBBS doctors were 10,22, 849, with doctor patient ratio of 0.77 doctors per 1000 population (current population estimate1.33 billion). From 2017 onwards 4,70,526 M.B.B.S. doctors will be added with annual intake of 67, 219 in next five years. Thus in 2024 assuming Indian population to be 1447, 560, 463, the MBBS doctor: population ratio will be 1.03 doctors per 1000 population.[9] The indigenous systems of medicine were never a part of basic structure of public health services in India. None of the committees, from Bhore (1946) to Bajaj (1986) have considered any role of Indian Systems of Medicine and Homeopathy in

[5] Anonymous, 'AYUSHMAN BHARAT -AYUSHMAN BHARAT: Comprehensive Primary Health Care through Health and Wellness Centers - Operation Guidelines, NHSRC, New Delhi 110067, India - 2018, page 21

[6] Indian Medicine Central Council, Minimum Standards of Education in Indian Medicine (Amendment) Regulations, 2012, Government of India, Central Council of Indian Medicine Notification dated 25th April 2012

[7] Central Council of Indian Medicine, Syllabus of BAMS third Professional course. https://www.ccimindia.org/downloads/3rd_year_syllabus.pdf

[8] Kumar R, Pal R. "India achieves WHO recommended doctor population ratio: A call for paradigm shift in public health discourse!", *J Family Med Prim Care*. 2018;7(5):841-844. doi:10.4103/jfmpc.jfmpc_218_18

[9] Population Pyramids of the World from 1950 to 2100. [Last accessed on 2018 Aug 10]. https://www.populationpyramid.net/india/2024/}

health care delivery in the country. Over the years from colonial period Indian Public health care system has methodically adhered almost exclusively to modern medicine.

IV. HEALTH SURVEY COMMITTEE REPORTS OF ISM

A. Bhore Committee on ISM[10]

Bhore committee report published in 1946 is a blue print of India's post-independence Public health service system. All the committees constituted thereafter, just towed the line drawn by Bhore committee. Bhore committee first time coined the words 'Modern Scientific Medicine' in its report. The purpose of using the adjectives 'modern' and 'scientific' for allopathic medicine, was to denounce the Indigenous systems of medicine out rightly as unscientific and outdated. Select part of Bhore Committee's opinion about indigenous systems of medicine is reproduced below verbatim. This will give an idea about the approach of actual decision makers towards the place of Ayurveda in Public health in today's India.

Bhore committee[11] states, "In considering the question of the place which the indigenous systems of medical treatment should occupy in any planned organization of medical relief and public health in the country, we are faced with *certain difficulties*. We are unfortunately *not in a position* to assess the *real value of these systems* of medical treatment as practiced today as we have been unable, with the time and opportunities at our disposal, to conduct such an investigation into this problem as we would justify clear-cut recommendations. *We do not, therefore, propose to venture into any discussion in regard the place of these systems in organized state medical relief in this country.* We do however say quite definitely, that *there are certain aspects of health protection, which in our opinion, can be secured wholly or at any rate largely, only through scientific system of medicine (modern medicine). Thus public health or preventive medicine,* which must play an essential part in the future of medical organization, *is not within the purview of the indigenous systems of medical treatment as they obtain at present. This in no way reflects upon these systems*." We feel *that we need no justification in confining our proposal to the countrywide extension of a system of medicine (modern medicine), which in our view*, must be regarded neither as eastern or western but as corpus of scientific knowledge and practice belonging to whole world".

Expressing this opinion, Bhore committee just stopped short of recommending de-recognition of the ISM&H but indirectly proposed to do so, citing examples of China, Japan and Russia in following words: "We have been informed that in China and Japan, a moratorium extending to a definite period of years was declared after which the practice of *indigenous systems in these countries would not be recognized***.** However, this is the subject on which we are unable to make any recommendations so far as this country is concerned. We feel that it should be left to the provincial governments to decide what part if any, should be played by the indigenous systems in the organization of Public health and medical relief. *It is for them to consider,* after such investigation, *as may be found necessary, under what condition the practice of these systems should be permitted and whether it is necessary,* either during some interim period *or as a permanent measure*, to utilize them in, their scheme of medical relief. What we have said in regard to indigenous systems applies to Homeopathy also".

Confusion about the Government policy with regard to the role of indigenous system in public health in India prevails in the minds of scholars across the world. In this respect Dagmar Wujastyc and Frederic M Smith[12] write "Debate on the educational system of Ayurveda and its implementation into public health schemes is far from resolved even today. The British contrasted modern medicine (presumed to be a monolithic body of knowledge) with Indigenous systems of medicine in general". In fact, such a

[10] Bhore Committee, Report of The Health survey and Development committee (Vol II), Recommendations, Manager of Publications, Delhi, Government of India Press, New Delhi 1946.

[11] Bhore Committee, Report of The Health survey and Development committee (Vol II), Recommendations, Manager of Publications, Delhi, Government of India Press, New Delhi 1946.

[12] Dagmar Wujastyc and Frederic M Smith, 'Introduction', 'Modern and Global Ayurveda: Pluralism and Paradigms', Sunny Press, State University of New York Press, Page 8

debate was never a part of any Government public health authorities since colonial times. The concerned government authorities never considered any role of any indigenous system in public health. Leave aside utilization, Bhore committee indirectly recommended de-recognition of the indigenous systems. First formal recognition of Ayurveda is observed given by Bombay Medical Practitioners Act 1938, by the provincial government, which established the first separate register of practitioners of ISM. Madras Indigenous (Usman) Committee (1923) was the first committee constituted for promoting and regulating the development of ISM. Khan Bahadur *Sir Mohammad Usman* (1884 – 1 January 1960) was an Indian politician, Hakim, who served as the first Indian acting Governor of Madras from 16 May 1934 to 16 August 1934. He was a contemporary of Sir Joseph Bhore. Both were knighted by the British Government. Usman Committee endorsed the significance of Ayurveda in its report and recommended its utilization in public health services. Sir Joseph Bhore later chaired the Health Survey and Development committee in 1946. He never took any cognizance of Usman Committee report, while drafting the committee report. It is very unlikely that Bhore was unaware of Usman Report. Bhore purposefully ignored Usman report to neglect Indian Systems of Medicine. As a British national, Bhore's approach of denouncing Indian knowledge was completely in line with the British policy. But the members of committees constituted after independence, although Indian nationals, also towed the line drawn by Bhore. Only difference was; like Bhore, they didn't have the courage to ignore Indian systems of medicine. However, all these committees took utmost care to keep ISM out of the bounds of public health care.

B. Mudaliar Committee on Ayurveda[13]

First Health Minister's conference was held in 1946. It passed a resolution that provision should be made for training and research in indigenous systems of medicine, and practitioners of these systems should be utilized in State Health Programs.[14] In addition, post-independence, the crunch of MBBS doctors compelled the committees to consider the services of Ayurveda practitioners for practicing modern medicine. However, these services were never sought for practicing Ayurveda. As a result, these committees proposed various methods of providing training of modern medicine to Ayurveda practitioners. Mudaliar committee in 1959, proposed that if Ayurveda practitioners are to be engaged in public health, a course for a period of two to three years should be devised to provide the graduates of Ayurveda, with the missing knowledge in preventive medicine and in other areas of medical practice essential for them, as members of the National Health Service. They will not, by these courses of training, become eligible for a degree in modern medicine. They should be also given opportunities to be trained in modern medicine, if they desire so. After completing Ayurvedic course and passing the examination, a student will require 4 year course of training, if he wishes to take the basic MBBS degree in modern medicine.[15] However, Mudaliyar committee's recommendations in this regard were never accepted and implemented by the authorities. These authorities always maintained a safe distance from ISM.

C. Bajaj Committee on Ayurveda

In 1983 National Health Policy took cognisance of large number of practitioners of Indian Systems of Medicine and failure of government in effective utilization of this potential man power resource. The policy then assigned an important role to ISM&H, in the delivery of Primary Health care and envisaged its integration with the modern system of medicine in preventive and promotive aspects of health care. The policy endorsed the necessity of initiation of organized measures to enable each of the indigenous systems of medicine and health care to develop in accordance with its genius.[16] However, this endorsement didn't change the approach of concerned health care authorities or the committees constituted thereafter in this regard. Bajaj Committee in 1986,

[13] Mudaliar Committee Report, 'Health survey and Planning Committee', August 1959 - October 1961, Chapter XIII, Indigenous systems of Medicine, page 438- 443

[14] Bajaj Committee Report on 'Health Man Power planning and Development' May 1986 https://www.nhp.gov.in/bajaj-committee-1986_pg

[15] Mudaliar Committee Report, 'Health survey and Planning Committee', August 1959 - October 1961, Chapter XIII, Indigenous systems of Medicine, page 438- 443

[16] Ministry of Health, Govt. of India, National Health Policy 1983 http://www.communityhealth.in/~commun26/wiki/images/6/64/Nhp_1983.pdf retrieved on 05-07-2020

simply taking note of this recommendation, proposed employment of Ayurveda practitioners in three National Health Programs like National Malaria Eradication Program, National Leprosy Control Program and National Blindness Control Program and further in Family Welfare, Maternal and Child Health (MCH) programs and particularly the program of universal immunisation and nutrition. Within the health care system, the committee suggested that these practitioners can strengthen the components of 1. Health education, 2. Drug distribution for National Control Program, 3. Motivation for family welfare and 4. Motivation for immunisation and control of environment etc. Thus Bajaj committee refused to use Ayurveda practices, but chose to use the services of Ayurveda practitioners for non-medical services such as distribution of medicine and motivation of the people for immunisation and family welfare.

D. Overall approach of health care survey committees on ISM

Review of all committee reports, indicates that although Indian Government recognized ISM&H, none of the government committees accepted them for the purpose of their delivery in public health service sector. Thus modern medicine remained the official system of medicine in public health delivery. Bhore committee[17] in 1946, may be because of political reasons, stopping short of derecognizing these systems, left the issue to provincial governments. Attempts were made by some provinces such as Bombay and Madras to regulate and register ISM practitioners in their provinces. But at national level, the doors of public health services were permanently closed for ISM. However, the ISM practitioners continued to practice their system on their own in private sector. Most of these practitioners were non-institutionally trained. There was no uniformity in their training. In later period, independent institutions were started for giving training in Ayurvda, Unani and Siddha. But they all were functioning without any control. Later in 1971, Indian Medicine Central Council (IMCC) was established to regulate practice in Ayurveda, Siddha and Unani systems of medicine.[18] Central Council of Homeopathy (CCH) came into existence in 1973.[19]

V. AYURVEDA PRACTITIONERS AND PRACTICE OF MODERN MEDICINE

Another twist and the most sensitive issue for Ayurveda practitioners, was the issue of permission to prescribe and dispense modern medicinal products. On this issue the government policy, by default remained ambiguous. No political power dared to solve it amicably. Due to inevitable influence of modern medicine, Ayurveda practitioners started using modern medicinal products since early 19th century. In later period, following institutionalization, modern medicine subjects were introduced in the course content of Ayurveda courses. The practitioners trained through these courses were more inclined to practice modern medicine. As the influence and attraction of modern medicine grew, the course content and duration of Ayurveda training started equating with that of MBBS course under the disguise of training of integrated medicine. Ayurveda practitioners trained through these courses, expected their status to be considered equal to the status of MBBS practitioner, in terms of wages and designations in the public health care service structure. Nationwide agitations to press this demand were held in 1970. The government authorities refused to succumb. The agitations gave impetus to the Indian parliament, to pass the Indian Medicine Central Council (IMCC) Act 1971[20], leading to establishment of Central Council of Indian Medicine (CCIM). The old training model of integrated medicine was discarded and a uniform model course of pure Ayurveda named Bachelor of Shuddha Ayurveda (BSAM) was adopted all over country. The admission eligibility, duration and course content of this Ayurveda course was nowhere matching with MBBS course. This course couldn't last for even two years. CCIM was compelled to reintroduce integrated medicine training model, but this time through back door. The degree was renamed as Bachelor of Ayurvedic Medical Science (BAMS). The modern medicine subjects were incorporated in the course content under the disguise of Ayurvedic subjects. In old integrated course modern medicine subjects were taught openly as independent subjects by teachers qualified in modern medicine. But now in new BAMS course, these subjects were to be

[17] Bhore Committee, Report of The Health survey and Development committee (Vol II), Recommendations, Manager of Publications, Delhi, Government of India Press, New Delhi 1946.
[18] The Indian Medicine Central Council Act, 1970 (Act No. 48 of 1970)
[19] Homoeopathy Central Council Act, 1973 No. 59 of 1973
[20] The Indian Medicine Central Council Act, 1970 (Act No. 48 of 1970)

taught by Ayurvedic teachers. Teachers qualified in modern medicine had no place in this model. This resulted in deterioration of quality of education. However, this didn't stop the exponential growth of number of Ayurvedic colleges in the country. These courses became very popular with a hope that graduates of this course will get a chance to practice modern medicine.

VI. ISM PRACTITIONERS – A PROXY OF PHARMA INDUSTRY

There are two sides standing opposite to each other on the issue of permitting ISM practitioners to dispense and prescribe modern medicine. The two sides are 1. Indian Medical Association (IMA) of practitioners of modern medicine, staunchly opposing and 2. Associations of ISM practitioners like National Integrated Medical Association (NIMA) staunchly supporting such permission. This issue is observed blown out of proportions today. There are two forces acting to keep the issue unsolved if it can't be solved in their favour. One of the force is silently active and another openly active. The apparently silent but internally very active force keeping this issue unsolved is the Modern Pharma industry. India's domestic pharmaceutical market turnover for modern medicine reached Rs 1.4 lakh crore (US$ 20.03 billion) in 2019, growing 9.8 per cent year-on-year (in Rs) from Rs 129,015 crore (US$ 18.12 billion) in 2018.[21] As of now ISM and H practitioners has become a strong force of 7,99,879 in India.[22] All of them, some officially and some unofficially, barring few exceptions, dispense and prescribe modern medicinal products. It amounts to approx. 50% of modern medicine pharma business. Prohibiting this strong force from prescribing modern medicinal products will lead to a loss of 50% domestic revenue to pharma industry. No industry will like to lose its 50% clientele permanently. This fact supports the observation of Kumar and Pal (2018) that ISM practitioners are being treated as proxy of pharma companies.[23] Madhulika Banerjee also states that Pharmaceuticalization has reduced Ayurveda practitioner to a mere distributer of pharmaceutical products.[24]

VII. EDUCATION BARONS AND ISM

The other openly active force is the force of barons of education industry. In India, education has become an industry. According to Federation of Indian Chambers of Commerce and Industry (FICCI) and Ernst and Young report on higher education, 91% Engineering schools, 95% Pharmacy, 64% business, and 50% Medical schools in India are non-government.[25] Every year hundreds of private ISM&H colleges are coming up all over country. Absence of employment opportunity is not found stopping students from taking admission, paying huge fees, in these private colleges to get the ISM&H degree. This is happening with the only hope that they will be able to dispense and prescribe modern medicinal products, when they start their private practice. As soon as the ambiguity in this regard is removed, and the ISM practitioners are strictly prohibited from practicing modern medicine. The students will turn their back towards private ISM&H colleges, initiating their closure. Therefore, if the permission to practice modern medicine can't be given to ISM&H practitioners, the education barons openly want the issue to remain ambiguous. Sensing the complexity of the above problem, Srivastava Committee[26] (11 April 1975) felt a need to evolve a National System of Medicine for the country by developing an appropriate integrated relationship between modern and indigenous systems of medicine. However, the committee expressed its inability to provide any details on this subject. On this background a dire need on the part of government should be felt to clarify its stand on prohibition or permission of ISM&H practitioners to dispense and prescribe modern medicinal products. It should notify accordingly in clear terms. In a situation, where permission is to be given, arrangements for providing appropriate training to ISM&H students by teachers qualified in modern medicine should be immediately done. Presently ISM&H practitioners

[21] Indian Pharmaceuticals Industry report updated March 2020. Indian Brand Equity Foundation (IBEF) https://www.ibef.org/industry/pharmaceutical-india.aspx#:~:text last accessed on 30 June 2020

[22] Ministry of AYUSH, Govt of India, http://ayush.gov.in/sites/default/files/Medical%20Manpower%20Tables.pdf last accessed on: 23rd June, 2018].

[23] Kumar R, Pal R. "India achieves WHO recommended doctor population ratio: A call for paradigm shift in public health discourse!", *J Family Med Prim Care*. 2018;7(5):841-844. doi:10.4103/jfmpc.jfmpc_218_18

[24] Dagmar Wujastyc and Frederic M Smith, 'Introduction', 'Modern and Global Ayurveda: Pluralism and Paradigms', Sunny Press, State University of New York Press, Page 8

[25] Tiwari Rajesh etal, 'Role of Private Sector in Indian Higher education', GALAXY International Interdisciplinary Research Journal (GIIRJ), Vol 1 (2), Dec 2013

[26] Srivastava Committee Report 1975 https://www.nhp.gov.in/shrivastav-committee-1975_pg

do not receive training in modern medicine by teachers qualified for that. Still they are permitted to practice modern medicine in some States. It is not only unethical but equally harmful to public health in general and also for the future of youth taking ISMH education.

VIII. CONCLUSION

The above elaboration very clearly brings forth the poor status of Ayurveda graduates in the public health service sector in India. In this respect prohibition on delivery of Ayurveda service through public health service, keeping ambiguity on the issue of permission or prohibition of practice of modern medicine by Ayurveda practitioner, allowing exposure of people to Ayurveda practitioners for receiving modern medicine treatment, when the Ayurveda practitioner is not trained for delivery of such service and allowing exponential increase in number of ISMH practitioners to the tune of 52000 every year in absence of assured survival means; all these activities amount to unethical practices on the part of every responsible Indian and concerned government authorities. Immediate steps need to be taken to stop these unethical practices and save this deterioration and plight of Ayurveda.

The issue is becoming more and more complicated with every passing day. There is a dire need of taking a different approach to secure the future of 8 lac presently registered ISM practitioners and more than 50,000 ISM&H graduates entering in the field every year. The ISM&H authorities should concentrate on strengthening their mother systems to secure the future of their practitioners. If ISM&H graduate will not ever get the status of an **MBBS** graduate, why he should be made to spend five and half years for graduation. A serious thought should be given to introduce an exit point at the end of three years in the training program of these systems for those who want to enter in general medical practice. One who wants to enter in teaching profession or specialisations may be asked to continue their education further. This way the ISM&H graduates will be saved from humiliation of rejection faced by them in public health sector. Similarly, the government should also insist the state governments to establish independent parallel ISM&H public health service structure, which will open career opportunities for ISM&H graduates. If this doesn't happen, the future of ISM&H practitioners will gradually fade away in the dark. Such an event, may not be much troubling for the policy makers but will always prove their behaviour extremely unethical.

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