SYSTEMS OF MEDICINE: ROLE AND RELEVANCE

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While traditional medical systems passed their peak centuries ago, modern medicine has not entirely replaced them. The issue of traditional v/s modern medicine, the authors argue, is essentially an ideological one, governed by political interests; this is illustrated by the variance in the official, semi-official, and progressive views on the subject. Even the Chinese experience, the authors say, demonstrates this. Systems of medicine, as such, in their opinion, are irrelevant in the context of a people-oriented and egalitarian health system, in which they will comprise merely a set of therapeutics. Thus the entire debate on the role of traditional medicine is academic.

The historical development of health care in the western societies has been analysed and explained in various ways. Those analyses bear relevance to the Indian situation to the extent that western medicine (allopathy) had been introduced and developed by the colonial power and after independence, it developed rapidly with State patronage. Traditional systems, however, passed their peak of development long ago, but existed and persisted in Indian society.

Among the traditional systems, the oldest one, Ayurveda, reached a very high level of development. Ayurveda is the fore-runner of Indian scientific development and the father of materialist philosophy. Ayurveda is a comprehensive body of knowledge in medical science having well developed or rather too highly developed theoretical foundation based on empirical data, scientific methodology of observation, experimentation and analysis, and disciplined norms of practice. Ayurveda asserts that all things living and non-living are products of natural matters; disease is the result of material change in the body due to interaction with natural matters; and therefore could be corrected to an extent with the help of natural matters (drugs). Charaka-Samhita declares, "There is nothing in nature without relevance to medicine". There is nothing supernatural about natural and human events. In ancient society, the dominant ideology of the all-powerful ruling class was totally and oppressively anti-materialist. Materialist heretics actually had no right to live. That is why, all extant source books of Ayurveda are found to be camouflaged with enormous amount of metaphysical and religious garbage with a view to project an appearance of conforming to the dominant ideology. (Chattopadhyay, 1977). But what now exists and is practised as ayurveda or sidhha is not the ancient dynamic science of ayurveda but a decadent form which absorbed the alien metaphysical interpolations as truth and degenerated. The other major existing system Unani, the legacy of Greco-Arab medicine, is no different.

The scientific basis of modern medicine developed later. Starting from the 19th century, it developed on the shoulders of physical and biological sciences in the 20th century — achieving a tremendous speed after the 2nd World War. It has been argued that British colonialism brought along with it destruction and decay of the indigenous systems of medicine (Banerji). But there is little data available to substantiate this view. Others claim that modern medicine did not make much impact except with limited urban population; the largest section of the population still depend on indigenous systems, which is dealing more or less satisfactorily with many of the health problems of the local people. (Bannerman et al, 1983)

Although the state health care service has been built on the principles of modern medicine the indigenous systems including homoeopathy have been receiving state patronage in the later period. Budgetary allocation on the development of indigenous systems and homoeopathy has been increasing since the fourth plan period and the number of their practitioners as well as infrastructure have now reached impressive proportions.

	Total No. of Regd. practitioners	Admission capacity	Hospital Beds	Dispensaries
Ayurveda	2,32,247	3,306	9,783	12,027
Unani	22,756	535	627	986
Sidhha	18,190	75	—	426
Homeopathy	1,09,493	7,513	2,249	1,782
Modern Med.	2,68,712	10,934	4,86,805	17,455

Source : Health Statistics of India; CBHI, Ministry of Health & Family Welfare, GOI, 1983. Figures are incomplete due to lack of information from a few centres.

To this figure if we add the number of various paramedical personnel e.g. Pharmacists, Nurses of different categories, MPHW, LHV, Health Assistants and Supervisors, CHG, midwives, one may arrive at the conclusion that India does not need any more doctors at all for a comprehensive health care delivery system (ICSSR-ICMR, 1981). Still the official view, which is inherently wary to admit failure, is that the state health services have been unable to meet the actual health needs and priorities of the people, have been hospital-based and cure-oriented neglecting the preventive, promotive, public health and rehabilitative aspects of health care, and benefiting only the upper crusts of the urban population (GOI, 1982).

The Question of Different Systems

The official view :

The rising aspiration of the masses and increasing demands of medicare from the disease-ridden people, particularly incensed by the glaring difference in the standard of medicare between the haves and have nots, have so far been chiefly instrumental for increasing allocation in the state health sector. People have also become aware of the discriminatory availability of the state service. The government, therefore, has to admit the existing reality which is self-condemnatory and with the view to find a way out, advocated promotion of indigenous and homoeopathic systems of medicine. To provide ideological cover, a large number of virtues of those systems have been discovered and invoked, e.g. rich heritage, glorious achievements and cultural compatibility (GOI, 1982). The government realises that if the grievance of the larger section is contained by providing them with low-cost non-allopathic systems, the absolutely necessary but costly provision of modern medicine for the affluent urban section can be safeguarded. But, the life-saving contributions of modern medicine cannot be entirely withdrawn from the people. Hence, the question of integration. It has been recommended that the practitioners of the non-allopathic medicine must have a 'basic knowledge of human anatomy, physiology and other necessary medical knowledge'; research should be carried out with modern equipment and diagnostic methodology, so that it becomes acceptable to the modern scientific world; modern technology be introduced for the manufacture of traditional medicine and specific standards be adopted to ensure quality of raw materials and manufactured products. For integration of the indigenous and modern systems, the services of non-allopathic practitioners should be integrated, at the appropriate levels, within specified areas of responsibility and functioning, in the overall health care delivery system (GOI, 1981 and 1982).

The leaders miss the point that if the above measures are implemented, nothing remains of tradition and the very indigenous character is wiped out. They also forget that the non-allopathic systems have little to contribute towards preventive, promotive, public health and rehabilitative aspects of health care. But then, their concern is not so much for traditional systems as for availability of some acceptable form of medicare for the uncovered population.

The semi-official view :

The study group of ICSSR—ICMR recommends that there should be a national system of medicine with 'synthesis', and not 'integration' of different systems; practitioners of indigenous systems be utilised in the national system; each system be allowed to retain its own identity and grow according to its own genius; in medicare institutions patients be offered choice of systems; in course of time all training institutions of medical and health personnel will teach one and same system of medicare with individual systems being offered as specialisation courses at the post-graduate level; and in the same breath, 'in course of time medical graduates from any medical college would be able to provide such multi-system care' (ICSSR—ICMR, 1981). Earlier an official committee also recommended a national system of medicine and health services, in keeping with our life systems, needs and aspirations. (GOI, 1975).

It is clear that these recommendations are s full of self-contradictions and wishful thinking that these cannot be taken as anything but hasty remarks. But one point is obvious. The observers are anxious that somehow the non-allopathic systems be supported and given a place, whatever that may be, in health care service.

The WHO, has since come out as another champion of traditional systems. Facing the reality of shortage of personnel and provisions of MM, and the existence of a large number of practitioners of other systems, the WHO calls for integration at appropriate levels but also suggests selective scientific training for personnel and scientific biomedical research into their therapeutic materials.

The above views, while talking about cultural compatibility, commercialisation and high cost of modern medicine have introduced another ideological

pointthat health is essentially an individual responsibility (GOI, 1975), and that community participation is the process by which individuals and families assume responsibility for their own health and welfare and for those of the community. (WHO-UNICEF, 1978).

The non-official progressive view :

Essentially the progressive views on the question of non-allopathic systems evolve from their critiques of modern medicine. There is no such thing as medicine in general; medicine is always articulated in a given social formation and the mode of production of that social formation gives rise to its corresponding medicine; thus we can only speak of feudal medicine, capitalist medicine, or communist medicine; thus, modern medicine, is capitalist medicine. It has a dual function : (a) dominance and control, exercised to maintain the exploitative relations of production, and (b) useful and needed function, which is necessary in any society, to contribute to the care and cure of the working population. These two functions are not separate but, rather, the control function is exerted through the useful function (Navarro, 1983) Modern medicine is mechanistic and reductionist giving rise to professionalism and mystification, establishing the domination of a class of elite health professionals who propagate, reinforce and maintain bourgeois ideology (Waitzkin, 1984). Perhaps the most profound, impact-making critique is that of Ivan Illich. His analysis of clinical, social and structural iatrogenesis, leading to growing medicalisation of life exposes the negative effects of modern medicine in a telling manner. (Illich, 1977). Modern medicine, based on the paradigm of clinical medicine, even at its most progressive limits persists as an individualistic, class-biased and ideological mode of diagnosing, treating and preventing illness, and is necessarily inadequate as it ignores the socio-political and economic determinants (Turshen, 1977).

To obviate the negative effects of modern medicine, a number of prescriptions have been offered, the promotion of traditional systems of medicine being one of them. The Chopra Commitee (1948) recommended the use of indigenous systems at the lower level and synthesised medicine at the higher levels of medicare, and it has been lamented that had these recommendations been implemented at that time, it would have resulted in a drastically different system of medicine. (Jesani & Prakash, 1984). Though the present official view, is veering round to these recommedations, there appears to be little prospect of the development of a drastically different system of medicine. While emphasising the alien identity of modern medicine and cultural compatibility of indigenous medic ne, and recommending maximum use of self-care procedures and various home remedial measures, services of traditional healers of various systems, and community-selected primary health workers, Banerji conceds a central scientific core in modern medicine and seeks its separation for correct application in Indian care system (Banerji 1982). Others, while deprecating unnecessary polemics between different systems, call for 'a coherent synthesis of the valid elements of the different systems of medicine into a modern scientific health science', and argue that simplified scientific analysis of drugs and remedies of different systems and their propagation among the people will result in self-reliance of both the people and drug availability. "Ayurveda can continue to provide valuable ideas for reserach in basic and applied biomedical research. But this would be possible when Ayurveda undergoes a basic transformation. Ayurveda has to become Ayur-Vigyan (Science)" (Vaidya). Another intensely vigorous view is the Report of the Committee on the Indigenoue Systems of Medicine. Even after a long period of neglect due to absence of State patronage and well over a century after the introduction of western medicine which became the sole recipient of state help, the indigenous systems of medicine were not only serving the need of over 90% of our people, but doing so much more effectively and economically than western medicine" (Government of Madras, 1923). This view denounces the attempt of synthesis by placing the indigenous remedies under scrutiny of modern science and, asserting that the present location of different systems is due to the political process, urges clear identification of a system of medicine that can meet the needs of our people (PPST, 1984). In respect of tribal societies, it is claimed that tribal medicine which is actually based on ancient ayurveda, is competent enough to meet the local needs and for the protection of cultural identity and with the objective of self-reliance, entry of modern medicine should be barred (Shankar, 1985).

The Chinese connexion

All these views almost uniformly draw inspiration from the Chinese model which is hence, discussed separately. The Chinese policy, a few years after revolution, of integrating the traditional medicine and practitioners into the mainstream of medical education and health care service, received worldwide publicity and almost universal

appreciation. It has since been hailed as a success. Attempts have, therefore, been made to introduce this policy in several Third World countries with disastrous failures which have later been explained as due to difference in socio-political-economic structure. But the actual Chinese model has seldom been painted clearly and truthfully.

The basic aim of the Chinese health care service in the fifties was to maintain, develop and raise *production* both in rural and urban context i e. agriculture and industry. It has been repeatedly stressed in the health policy of the government and the party that the principal aim of health work is to ensure industrial and agricultural production. This fact may embarass the strident critics of capitalist medicine and health care which is accused of pursuing the very same aim. Agriculture being the mainstay of the economy, organised rural health care is practically non-existent, health personnel and infrastructure being miserably inadequate, the earlier Mao Tse Tung thought has been invoked, ".... to rely on modern doctors is no solution. Of course modern doctors have advantages over the doctors of the old type, but if they do not concern themselves with the sufferings of the people, do not train doctors for the people, do not unite with the thousand and more doctors and veterinarians of the old type in the Border Region and do not help them to make progress, then they will actually be helping the witch doctors and showing indifference to the high human and animal mortality rates". Mao's reference to withchraft is very real. Joshua Horn's own experience told us that the services of the traditional practitioners was available only to the rural elite, because they were highly professionalized and expensive and the herbal medicines were also very costly. The overwhelming majority of the poor villagers had actually to depend on the village quacks and witch doctors in pre-revolutionary China (Horn, 1971)

Integration of Chinese medicine with modern medicine is only a part of a whole comprehensive health care service. This policy is based on the principles of modern medical science and operated through indigenously available technology, and infrastructure. 'Mass line' in preventive work and environmental protection, emphasis to maintain production, integration of traditional doctors for man-power mobilisation in medicare, comprehensive coverage of population, rapid production of health personnel, and political dominance in health administration — are the basic elements. Regarding integration, the policy adopted at the First National Health Conference (1950) was based on the attitude that in view of the shortage of doctors and medicine, Chinese traditional medicine should be utilized (because it was there and readily available rather than because of any inherent value it had). In the policy of 'unity and reform' the stress was on reform of the traditional system by the western. When this attitude failed to bring the desired results, the political command intervened and the campaign for superiority of Chinese culture and glorious tradition of Chinese medicine was launched which enhanced the social status of the traditional practitioner and resulted in more widespread use of herbal remedies. "Even when herbal remedies were not very effective, they were of considerable importance as they still provided the peasant with some support, whereas if it had been decided that only modern drugs should be used, he would have none at all as expenses would have placed any drug therapy out of reach. The use of herbs for the purpose of psychological support — though not explicitly admitted in the Chinese press — is not much different from the wide variety of placebos offered to patients daily in industrialised countries". (Wilenski 1979).

From the beginning of the sixties, the enthusiasm towards traditional systems ebbed, and professionalism and elitism again started gaining dominance; even the traditional practitioners were concentrated in the larger country towns and served on the basis of private practice Mao's intervention at this stage on the eve of the cultural revolution reversed this direction. In his famous June 1965 directive Mao said, "Tell the Ministry of Public Health that it only works for 15 per cent of the entire population. ... The Public Health Ministry is not a people's Ministry. It should be called the Urban Public Health Ministry or the Public Health Ministry of the privileged or even the Urban Public Health Ministry of the privileged' Medical education must be reformed. .... A vast amount of manpower and materials have been diverted from mass work and are being expended in carrying out research on the high level, complex and difficult diseases, the so-called pinnacles of medicine. As for the frequently occuring illnesses, the widespread sicknesses, the commonly existing diseases, we pay no heed or very slight heed to their prevention or to finding improved methods of treatment. It is not that we should ignore the pinnacles. It is only that we should devote less men and materials in that direction and devote a greater amount of men and materials to solving the urgent problems of the masses. .... We should keep in the cities those doctors who have been out of

school for a year or two and those who are lacking in ability The remainder should be sent to the countryside". (Mao, 1977)

The large numbers of the health professionals, since sent to work in the rural areas soon realised that they could not handle the vast burden of rural ill health and also they could not hope to return to urban institutions without an alternative rural health service. Soon emerged the barefoot doctor who is neither a paramedic nor a doctor's auxilliary, but a part-time doctor trained in diagnosing and treating, without assistance, common or recurrent diseases prevailing in the locality. The scheme succeeded for the chief reason that medicare infrastructure had since been organised on the basis of universal coverage right up to super-speciality at the top most level with efficiently functioning referral system. But the recent trend is a shift towards greater professionalisation and medicalisation of the health system, higher education of the barefoot doctors, greater emphasis on higher quality of medical education with the return to seven-year curriculum, and more research centres, modern hospitals, specialists and technologically sophisticated interventions (Rhode, 1983). China now takes pride in letting us know that she, in 1982, has 9,52,000 doctors of modern medicine compared to 2,90,000 of traditional medicine and 2000 senior doctors of modern medicine also trained in traditional medicine While in the year of liberation, there were 10,000 fully trained and 30,000 partially trained doctors of modern medicine and 5,00,000 traditional practitioners. (Wilenski, 1979).

The culture issue :

Concern for Indian culture is the common issue in the agenda of the advocates of the traditional or integrated systems. "Perhaps the simplest and most useful formulation of the concept of culture is to say that it is acquired or learned system of shared and transmittable ways of adjusting to life situations. .... A common characteristic recognized in all treatises on culture is *change*, a capacity to shift, accumulate or loose components, which makes culture far more flexible and variable than are the somatically determined patterns of behaviour" (Simmons & Wolff, 1954). Culture is not a rigid frame, inert model, or static dogma of guidelines governing community or individual conduct. Culture is built up on complex interactions — involving physical, environmental, ideological, political, and predominantly economic. Economic relations i.e. relations of production, exchange and consumption, find expression in cultural and social responses, and changes in the economic relations bring about profound changes in the cultural matrix. Tradition is not culture. Tradition is the vestiges of earlier cultural trends, and ideologically influences the present and future trends. Just because the peasant lives with the bullock cart for generations, he should not be taken as culturally bound to the bullock cart, or demands to remain so Adherence to witchcraft and ideological allegiance to the metaphysical theory of health and disease do have their roots in economic relations and is a reflection of the stage of development of the productive forces and superstructure. While on the one hand, the capitalist onslaught on the tribal ways of life does produce disastrous consequences, on the other, the urge to protect the tribal identity gives rise to irrational obscurantism which is anachronistic to progress and inadequate to meet the need. Such an urge often leads to the proposition that western medicine is not essential for India's particular needs and we are entitled to a separate scientific medicine relevant to our social-cultural-historical context (Bajaj, 1985).

A carefully planned study of health behaviour of rural population of India has revealed "that the response to the major medical care problems was very much in favour of western (allopathic) system of medicine, irrespective of social, economic, occupational and regional considerations. Accessibility of such services (modern medicine) and capacity of the patients to meet the expenses were the two major constraining factors" (Banerji, 1974). In contrast, the observations of studies conducted in 1951-52 in villages of Rajasthan and UP reveal that the villagers largely rejected the western medicine in favour of witchcraft and traditional remedies (Carstairs and Marriot 1955). This profound change has occurred not only due to the remarkable curing and life-saving remedies of modern medicine but also from economic changes in all spheres of rural community life and consequent politico-ideological changes. A study by 13 social scientists in the Toushan commune health clinic of Kuangtung province, China, concludes that incorporation of indigenous medicine into the organised health care service is a rational move on political, ideological, technical, socio-medical and economic grounds but conceds that 70 percent of patients opt for western medicine. Medicine bag of the barefoot doctor carries 80 percent drugs of modern medicine (Lee, 1982). In Shangdon province, China, the number of x-ray examinations increased by 80% in the rural areas in 4 years ('76-80'). Of the total 4111 x-ray machines in the province, 3824 are situated in rural and district hospitals (Feugetal 1984). The

assertion of cultural compatibility of traditional medicine in India appears to be a myth. The Government of West Bengal has for some years appointed homoeopathic and ayurvedic practitioners in the rural health centres. In all such Centres they not only remain idle but usually their services are utilised for other purposes. No quantitative study is available on the practice of use of modern drugs and implements by the non-allopathic practitioners. Journal of the IMA (June, 1985) published a letter from one Dr Buch who complained that the existing govt rules precluded him from recruiting 15 Ayurvedic graduates, who he interviewed, for a TB hospital at Keshod, Gujarat, which had been suffering from extreme dearth of doctors, even though all those Ayurvedic doctors were practising MM in the nearby villages. He lamented, "Why we continue to waste our national resources on such education which our youth decline to practise in future?"

The other issues :

Mystification : is more pronounced in the traditional systems which draw sustenance from metaphysical philosophy and fatalistic belief regarding health and disease, isolated from environmental and socio-economic-political determinants. In contrast, the body of knowledge of modern medicine is not only universally accessible but, shorn of its avoidable terminology, this knowledge can be and has been mastered by non-medical personnel. Because of its integral relationship with other physical and biological scientific disciplines, modern medicine has largely been demystified at the higher functional level. The mystification of the practice of modern medicine is not an isolated phenomenon but is prevailing in all other professions including even the legal profession which does not depend on science and technology. This mystification is a feature of market economy and an instrument of exploitation and profit. Demystification at the level of practice can be brought by change in the economic relationship and not by replacing with more mystified traditional systems.

Professionalism : which also is utilised for profit and exploitation is similarly a feature of commodification of medicine and has little to do with systems of medicine. With the gradual dimunition of the commodity character of medicine, China has curbed professionalism to a great extent. On the other hand, in post-revolutionary Cuba, professionalism has been encouraged and strengthened in a State monopoly health system but that did not pose any constraint in the way of establishing an egalitarian health care service. Though professionalism prevails in Cuba to an absurd extent (only doctors are entitled to give injections), still Cuba has made remarkable strides in raising the health status of the people and the health system is free from professional explotiation.

Individualism, Mechanicism, Reductionism, Class-bias, Commodification, etc : These are not peculiar to any system but owe their roots to the economic base and the dominant ideology. Rather it can be conceded that modern medicine is least endowed with these vices; because it has opened up the possibility of taking a materialistic and holistic view of health and medicine, owing to large expansion of the data-base and knowledge-base of the natural sciences and social sciences; growth of socialisation of production is bound to develop socialisation of medicine. Choice of systems of medicine has little relevance to this change.

On the other hand, a rational view towards all these elements should also be evolved. One who vigorously attempts to expose the bias of capitalist medicine against people's interests, may run the risk of making a fetish of these elements. Individualism, mechanicism, reductionism etc. are not touchstones that turn everything they come into contact with ugly. In all social functions, some practice of mechanicim and a reductionist analysis are inevitable at the micro level. Given the operation of socialist analysis and policy in the health care programme of a socialist society, at the micro-level it is reduced to providing treatment for sick individuals who, having similar socio-economic background, may happen to differ widely among themselves in respect of physical, psychological, behavioural characteristics as well as in the quantity and quality of their responses to medical intervention. Indeed, the situation is necessarily reduced to taking a mechanistic, individualistic and interventionist approach in performing the instant task of attending to a sick indivdual who is not only a number as featured in the policy and programme making at the macro-level, but also a human being possessing a distinct personality and capable to respond to and interact with, employing his own judgement, the medical provisions earmaked for him by the organised society.

The Real Issue

The real issue is to formulate, organise and develop an egalitarian health care service — with preventive, promotive, curative and rehabilitative

aspects. Such an ideal is realisable only in a non-exploitative economy Doyal and Pennell have shown that in the Capitalist economy, development of medicine and organisation of health care follow the needs, priorities and prerogatives of economic relations. That is why we find changing emphasis on public health, curative medicine, individualistic medicine, population control and so on in different periods. "It is ultimately profit, rather than a concern to improve overall living standards, which is the most important determinant of economic and social decision-making in Capitalist society" (Doyal & Pennel, 1981). Rejecting the anti-technology, anti-industry and anti-modern medicine stance of Ivan Illich, and acknowledging its positive achievements in the health sector, they argue that modern medicine is neither a value-free science nor an altogether evil force, and that its till effects could be overcome in a radically changed socio-economic order. Indeed, the idea of changing the character and organisation of discriminatory and exploitative health care by choosing and introducing a particular system of medicine, itself appears to be a mechanistic, instrumentalist and utopian view. True, it is conceivable that mobilising the large number of traditional practitioners and comparatively cheaper herbal remedies under the State sector following the Chinese model, a large section of uncovered population may be offered some form of medicare. But such a view is hardly relevant in the Indian context on two counts. One — unlike China there is no state-monopoly control over the health system in India and hence it is not feasible. Second — it needs to be assessed first, if India lacks in the necessary number of trained personnel in modern medicine for the operation of Primary Health Care Service of comprehensive coverages Commenting that "the argument in favour of the use of traditiona practitioners does not question why even modern practitioners of private medicine have not been properly integrated into third world health care services", Oscar Gish stresses that the major obstacle is not the limited resources or technological deficiency, but the social system which places a low value on the health care needs of the poor (Gish, 1979).

Why then all these debates about traditional systems? Since the political independence of the colonies, in the era of neocolonialism the poverty of the third world masses continue to be a headache of the imperialist camp. 'Economic growth' approach was introduced stating that the primary need is rapid increase in GNP which will necessarily trickle downwards to alleviate poverty. After two decades when this strategy failed, lately a new 'basic needs approach' has been advocated. Ibrahim Samater has, in an analysis of the strategy and tactics of the controllers of international economy, shown that this new approach is another attempt to contain the growing unrest among the exploited and deprived population of the third world, and that it is also bound to fail because without any change in the property system, in power relations and in the demand structure, the basic needs e.g. food-cloth-shelter-water-sanitation-health etc. cannot be met. The ruling class needs to uphold and maintain the image of the state as the benevolent arbiter for the masses and the state thereby needs to put priority on relief and medicare. Physical ailment, debility, death are extremely sensitive elements with political consequences. The benevolent image of the state distributing medical relief often atones for its other failings. One may be poor or unemployed but when the state is there to save him from death due to illness, the benevolent image brightens. But this benevolence is difficult to mediate through the provisions of modern medicine. The cost is prohibitive and will necessarily erode the profit margin reducing capital accumulation. The only alternative way appears to be the glorification of the achievements of the traditional systems with a coating of the theory of cultural compatibility. The culture of course, refers to poor people's culture — not of those who can afford to purchase modern medicine. The vigorous promotion of traditional systems by official and semi-official circles is not out of conviction in the efficacy and inefficacy of traditional and modern medicine respectively, but out of pragmatic political considerations with the purpose of co-opting and weakening any challenge to the existing exploitative socio-economic order which actually is the cause of the deprivation of the basic needs e.g. health care. An uncritical support to this strategy by the progressive health activists will be a liberal humanist deviation propelled by subjectivism.

From the foregoing it is evident that choice of a particular system or any integrated systems is of little relevance to the demand of a people-oriented egalitarian health system. The traditional system, at their best, can offer a few remedies in curative practice. A comprehensive health system will have to be based on scientific tenets, but while the underlying theoretical pre-conceptions of scientific will need to be critically re-examined to identify the elements of class-bias and mechanistic paradigm, the operative infrastructure should be explored to resist and eliminate the commercialism, mystification, professionalism of the medical practice. Scientific

medicine is a product of modern science developed in the Capitalist regime. While welcoming and practising modern Science and Technology in all fields of social life and economic development, rejection of modern medicine is not only anachronistic but utopian.

The role of traditional systems therefore appears to be limited to effective (organic and functional) remedies for medicare, emoloyed under the same regulatory mechanism as that of modern drugs. Relevance of the apparently unending debate on the choice of a suitable system of medicine is only academic and sterile in the context of our search for a people-oriented comprehensive health care service.

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