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Letter to the Editor

Traditional systems of medicine and public health insurance in India: clinical and health systems implications

Sir,

India's traditional system of medicine-Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa- Rigpa and Homoeopathy (Ayush) were institutionally unified under the Ministry of Ayush in 2014, signalling a policy commitment to systematise and promote these diverse therapeutic traditions.[1] Over the past decade, initiatives such as the National Ayush Mission (NAM), co-location of services within various tiers of health care, and the development of standard treatment guidelines have sought to integrate Ayush into formal healthcare delivery.[2,3]

Despite these efforts, Ayush services remain largely excluded from publicly financed health insurance. Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), India's flagship tax funded health insurance scheme and a key pillar of its universal health coverage goal, continues to restrict coverage primarily to biomedical interventions.[4]

From a clinical standpoint, this exclusion has important implications. Physicians frequently encounter patients who concurrently use Ayush therapies, particularly for chronic pain, musculoskeletal disorders, metabolic, and mental health disorders. The absence of AB-PMJAY coverage complicates continuity of care, weakens referral mechanisms, and often results in fragmented or undisclosed treatment pathways.

AYUSH AND THE INSURANCE BLIND SPOT

The exclusion of Ayush from AB-PMJAY reflects a longer historical pattern observed in earlier insurance schemes, where coverage was largely confined to biomedical inpatient care. While selective Ayush coverage exists under schemes such as the Central Government Health Scheme (CGHS) and through some private insurers, publicly financed insurance has remained predominantly biomedical in orientation.[5]

For clinicians, insurance design has a direct influence on care-seeking behaviour and treatment adherence. Patients relying on out-of-pocket payments for Ayush services may discontinue care prematurely or move between systems without formal referrals. Such fragmentation can delay presentation, obscure treatment histories, and complicate clinical decision-making, particularly in the management of chronic diseases.

SYSTEM-LEVEL CONSTRAINTS IN AYUSH INTEGRATION

Evidence and health technology assessment

Although clinical research in Ayush is increasing, robust Health Technology Assessment (HTA) and cost-effectiveness evidence remain limited.[6] Health insurance schemes require standardised outcomes, economic evaluation, and reproducible protocols, areas where Ayush systems continue to face challenges. While standard treatment guidelines have been developed, their uniform implementation and monitoring across states remain inconsistent.[3]

Infrastructure and workforce capacity

Ayush infrastructure and human resource capacity vary widely across regions. Co-located facilities often lack diagnostic support and formal referral linkages, while some states have developed relatively stronger standalone Ayush institutions. Limited interdisciplinary training and weak outreach cadres further constrain integration with routine clinical services.[2,7]

Integration with public health programmes

Although policy documents acknowledge the potential role of Ayush in programmes such as the National Programme for Prevention and Control of Non-Communicable Diseases (NP-NCD), institutionalised mechanisms for implementation remain weak. Unlike the National Health Mission (NHM), the NAM largely functions in a project mode, limiting alignment with mainstream service delivery and clinical workflows.[2,8]

Public trust and disclosure

Utilisation of Ayush is higher among older adults, women, and certain socio-cultural groups, yet scepticism persists regarding regulation, quality, and safety.[9] For physicians, inconsistent patient disclosure of Ayush use poses challenges for monitoring interactions and treatment outcomes.

WHY INSURANCE INCLUSION MATTERS

Healthcare-seeking behaviour in India is inherently pluralistic, with patients frequently transitioning between biomedical and traditional systems of healthcare.

Insurance models that recognise only one system fail to reflect this reality and risk reinforcing fragmented care pathways.

The selective inclusion of Ayush in insurance could improve system efficiency by enabling the appropriate use of traditional therapies for specific conditions, potentially reducing pressure on overstretched outpatient services. Formal coverage would also signal institutional legitimacy, strengthening accountability, standardisation, and regulatory oversight.

CLINICAL IMPLICATIONS FOR PHYSICIANS

For physicians, the exclusion of Ayush from publicly financed health insurance has tangible clinical consequences. Financial barriers contribute to fragmented care, irregular follow-up, and incomplete disclosure of concurrent therapies, limiting coordinated decision-making.

Selective, evidence-informed inclusion of Ayush under public insurance could facilitate structured referral pathways, improve documentation of concurrent treatments, and enhance patient trust. In the management of chronic pain, musculoskeletal disorders, lifestyle-related illnesses, and preventive care, such integration may support continuity of care, provided it is guided by clinical protocols, eligibility criteria, and outcome monitoring.

THE WAY FORWARD

Integrating Ayush into public health insurance requires cautious, phased reforms. Priorities include strengthening clinical research and HTA, building infrastructure and workforce capacity, and designing insurance benefit packages that begin with selectively identified conditions. Institutionalised referral mechanisms and interdisciplinary collaboration are essential to ensure patient safety and clinician confidence.

CONCLUSION

The debate surrounding Ayush is not one of tradition versus modernity, but of designing a health system that reflects real-world healthcare use. For India's physicians, public health inclusion of Ayush is not about replacing biomedical care, but about enabling safer, more coordinated, and patient-centred practice within a pluralistic system. Selective, evidence-guided integration under public insurance represents a pragmatic step toward continuity of care, system efficiency, and equity.

Balasankar Jayapal Mini[1]*,
Neethu Mohanakumar Sreelatha[2]

[1]Department of Community Medicine and School of Public Health, PGIMER, Chandigarh, India
[2]National Ayush Mission, Kerala, India

***Correspondence to**
Dr. Balasankar Jayapal Mini,
E-mail: drbalasankarmph2020@gmail.com

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