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What Constitutes Health Tourism: An Ayurvedic Viewpoint.Role of Social Venture Capital in Rejuvenating Ayurveda Tradition

保健觀光的組成：社會創投在傳統阿育吠陀療法的角色

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摘　　要

當西元前3500年遠古文明的開端，人們因爲尋找食物及居住的需求而開始旅行。之後旅行也漸漸取代了貿易及領土的擴張；更因爲對神的崇敬人們開始因爲宗教因素及健康上的神蹟而不遠千里地旅行。千年之後隨著對健康的重視，世界各地的醫療觀光及保健觀光變得愈來愈重要。雖然保健觀光在遠古之前就開始(例如阿育吠陀療法就是5000年來重要的替補醫學(Complementary Alternative Medicines, CAM的實證)，但在上個世紀起現代化的醫療觀光已成了歐洲殖民地的重要課題及對抗治療的重要發展方向(例如現代醫療Modern Medicine, MM)。本研究針對保健觀光及醫療觀光的起源、發展、成長、衰退及復甦過程；以印度四個發展保健觀光區域(Bhishak, Dravyani, Upasthata, and the Rogi)爲例，以阿育吠陀療法發展的實證過程佐以當今環境發展進行批判性的分析，並呈現當地的現況。因爲阿育吠陀療法的低成本優點、少等待時間及零付出，人們(多半是由歐美國家)對亞洲國家(特別是印度、新加坡及馬來西亞)的替補療法的發展潛力有濃厚的投資意願。文獻研究發現保健觀光在全球是普遍地，在印度是特殊性的，而且在未來將更爲重要。藉此展望，公部門應該要以合宜且著重的方式推廣阿育吠陀療法包裝出其無醫療行爲且特殊的保健觀光產品，在此一區域以合理及永續地發展保健觀光產業。以社會創投資本投資的可行性來看，以印度地區的阿育吠陀傳統療法的替補醫學將在近年會有復甦的趨勢。

關鍵詞：替補醫學、阿育吠陀療法、醫療觀光、社會創投、印度

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Abstract

From the emergence of ancient civilisations during 3500 BCE, people started traveling in search of food and shelter. Subsequently traveling took place for trade as well as for capturing territories. Then came the concept of god, people started traveling for religious reasons and eventually pilgrimage traveling got mixed up with miracle healing also. Over the years the concept of heath care started gaining prominence and presently health tourism as well as medical tourism are gaining more and more importance around the world. Though health tourism is very ancient practice [use of **C**omplementary **A**lternative **M**edicines (**CAM**), and of which the most prominent one is Ayurveda dating back 5000 years], medical tourism got prominence in the course of European colonisation and the developments of Allopathic treatments [commonly known as **M**odern **M**edicine (**MM**)] during the last century. This paper explores the origin, development, growth, decline and revival of health tourism products (CAM), along with medical tourism products (MM). Issues surrounding health and medical tourism in today's environment are critically analysed in this paper with a special focus on Ayurveda practices in India based on the four basic ingredients (viz.; Bhishak, Dravyani, Upasthata, and the Rogi) and their present status in India. Due to its low cost advantage, small waiting time, and zero side effects, people (mostly from western and European countries) resorting to CAM is gaining more prominence in Asian countries (especially in India, Singapore, and Malaysia) where heavy investments are made for the future growth potential. Literature review shows that health tourism, around the world in general and India in particular, will become more significant in the near future. From that perspective, proper initiative should be taken by the authorities for promoting Ayurveda as a unique health tourism product emphasizing no medical side effects which in turn will attract more people resulting in the development of a profitable and sustainable health tourism industry in the region. By capitalizing on the transformational capability of social venture capital, **CAM** (especially Ayurveda tradition) in India and elsewhere can be rejuvenated in the coming years.

Keywords: Complementary Alternative Medicines (CAM), Ayurveda, Health Tourism, Social Venture Capital, India.

1.Introduction

The written history of mankind reveals that from time immoral there existed quest for traveling for the purpose of gathering food, identifying shelter, for trade, for capturing territories, visiting religious places, and also for gaining health and longevity. Good examples of all such types of

traveling can be seen during the period 3500 BCE – 2008 ACE. Over the years nothing much changed, except the modes of treatments and transportation (due to development in technology) and also means of transaction (due to invention of money as a medium of exchange), but the very basic purpose of traveling remains same. Of all the categories of traveling; traveling for health reasons, to seek cures for ailments, and take measures to preserve the wellbeing remained prominent among all regions (Middle East, Africa, Asia, South America, Europe and North America) as well as all religions (Hinduism, Buddhism, Islam, Christianity, etc). According to Lee (2007) ancient stories, legends, and fables contain many stories of journeys taken by heroes seeking potions and cures for another, often their kings or queens. There were quests in search for the 'fountain of youth' or for other equivalent rewards to seek immortality or perpetual beauty. These ambitious activities are not confined to one culture and stories for the search for the mysterious and supernatural span all cultures. Similarly these quests also include a search of wealth and riches that can guarantee or purchase a comfortable lifestyle and wellbeing.

The present century development in the health care system around the world points towards the importance attached towards preserving the health of people, which reminds us one of the most famous quote in the history of mankind; i.e.; "***health is wealth***". Though the ancient systems of medical practices originated in Middle East, Africa, Asia, and South America got sidelined during the European colonisaiton period (during 1600-1900 ACE), the ***new mantra***, which is being practiced around the world in the case of health care at present, is "***Old is Gold***" or in other words "***Back to Veda's***" (Subhash, et al, 2008) where people from Europe, North America, and also other regions travelling towards Asian countries due to the exponential development taken place in the traditional medicinal system practiced (CAM) and also the availability of low cost modern medical facilities (MM).

Though health tourism is very ancient practice [use of **CAM** and of which most prominent one is Ayurveda which dates back to 5000 years], medical tourism got more prominence due to European colonisation effects and the developments in the Allopathic treatments [commonly known as **MM**] during the last century. This paper explores the origin, development, growth, decline and revival of health tourism products (CAM), along with medical tourism products (MM). Issues surrounding health and medical tourism in today's environment is critically analysed in this paper with a special focus on Ayurveda practices in India based on the four basic ingredients (viz.; Bishak, Dravyani, Upasthata, and the Rogi) and their present status in India. Due to the low cost advantage, less waiting time, and also the zero side effects property, people (mostly from Western and European countries) resorting to CAM is gaining more prominence in Asian countries (specially in India, Singapore, and Malaysia) where heavy investments are made for catering the future growth potentiality. This paper concludes that health tourism will certainly become more significant in the near future. Proper initiative should be

taken by the authorities for promoting Ayurveda as a unique heath tourism product with zero-side effects which in turn attracts more people resulting in profitabe and sustainabe tourism industry in the region.

2.Origin, Development, Growth, Decline, and Revival of Medical Practices (CAM & MM).

In the present world of information, the existence of literature on ancient medical practices followed during the early periods of human settlement is very scanty. From the available bits and pieces of information which got survived during the clash of civilisations during the early stage of human settlement and also the later part of European colonisation speaks about the origin, development, growth, decline, and also the revival of indigenous and ancient medical practices in Africa, Asia, and Middle East. A brief outline of the historical development of medical practices around the world during 3500 BCE till 2008 ACE is provided in **Exhibit 1**, which is not an exhaustive list but an indicative one. And like in any other sector, health care sector also got prominence and paved the way for the development of different varieties of health care treatments/systems over the years among different regions as well as religions.

If we go by the argument proposed by Sawandi (2002), the credit of developing and practicing herbal medicines successfully (around 10,000 years back) is to be given to Africa, especially to Egypt. Traditionally, ancient African priests would orally transmit their herbal knowledge (from one generation to the next. Not only was African medicine passed from generation to generation, starting in ancient Egypt (Khemit), but from continent to continent. The only true African healing system which is still intact in its original language of African terminology is ***Yoruba medicine***, which is widely practiced on the African continent as well South America, and the Caribbean. According to Sawandi (2002), When Greek physicians took their oath to Aesculapius, they were really swearing in to an African originally named Imhotep. During his lifetime, he was revered as the god of medicine between 2780-2680 B.C. Western society has wrongly given credit to a Greek named Hippocrates, who had actually taken the Aesculapius (Imhotepian) oath and lived 2,000 years after the true father/god of medicine. As per the available informaiton about the origin of human civilisation and the settlement, this argument may be true, but needs to be corroborated.

Sawandi (2002) also argues that origin and development of Ayurveda medicine (around 6,000 years back) in India is also the product of the esoteric philosophy of African medical practices from inner Africa carried over by the migrants from Ethiopia via Isthmus of Suez, who were the founders of

Hinduism in India. This argument seems to be partly correct, because according to many scholars, knowledge of Ayurveda originated from India and influenced the ancient Chinese system of medicine and also medical system practiced in Greece (Varier, P. S 1993; Varier, M.R.R, 1993; Pushpangadan 2002; Shankar 2002; Katsambas and Marketos 2007). But nowhere it is mentioned that it originated from African system of medicine, except that it has a divine origin and was initially possessed by gods. It is believed that Lord Brahma, much before human beings came into existence, created Ayurveda. The concept of god originated around the world at different periods of time, mainly for the purpose of having some uniformity among the group of people and also to protect and safe guard the precious natural resources as well as to safe guard the knowledge base acquired at that time (Subhash et al 2008). If we go by this simple philosophy, the ancient settlers from African continent who came to India carried with them the ancient African medical practice and propagated in the form of Ayurveda by giving the divinity veil to the practice, but failed to mention about their exodus. But subsequently they recorded the spreading of ayurveda to other parts of the world. People from numerous countries came to Indian Ayurvedic schools to learn about this world medicine and the religious scriptures it sprang from.

Exhibit 1: Development of Medical/Heath Care Treatments/Systems [3500 BCE–2007 ACE]

#	Period	Milestones / Landmarks	Clustering Regions / Countries	Medical / Heath care Treatments / Systems
1	3500-2000 BCE Till 1600 ACE	Early civilisations started at Sumerian / Ancient Egyptian / Indus / Minoan / Neolithic	*Middle East* (3500-2500BCE) / *Egypt* (2800-2160BCE) / *India* (2500BCE) / *Greece* (2000BCE) / *Central America (2600 BCE)* **Then the emergence of European and Western Supremacy through colonisation**	* Yoruba Medicine [around 10,000 years ago in Africa (Egypt)] * Aromatherapy [around 6000 years ago in India and Egypt] * Ayurveda & Magnetotherapy [around 5000 years ago in India] * Siddha [around 3-4000 years ago in India] * Acupressure [around 3500 years ago in India and China] * Acupuncture [around 3000 BCE in Magnolia and China] * Tibetan Medicine [around 2000 years ago in Tibet] * Yoga [around 900 BCE in India] * Hydrotherapy [around 500 BCE in Japan/China] *** Clinical Medicine [around 460 BCE in Greece]** * Unani [around 1025 ACE in Middle East]
2	16 – 1700 ACE	Agricultural revolution	Mostly in *Europe* (mainly *Britain*), also in *America* and *Japan*	* Deveopment of Western Medicine / Biomedicine / Scientific Medicine / Modern Medicine – Mostly in Europe [mainly based on Clinical Medicine developed during 460 BCE] * Magnetotherapy [around 16th century got revived in Switzerland]
3	17 – 1900	Industrial	Mostly in *European*	* Homoeopathy [around 1800 ACE in

#	Period	Milestones / Landmarks	Clustering Regions / Countries	Medical / Heath care Treatments / Systems
	ACE	Revolution in Europe / Mass Colonisation of Asia, Africa, and Middle Eastern countries	countries, also in *America*, and also in *Japan*	Germany] * Naturopathy [around 1880 ACE in Germany] *Allopathy [around 1900 ACE in Europe and America, as opposite to CAM] *** Ancient medical practices/systems got sidelined, mostly by force**
4	1914-1945 Till 1960's ACE	Power struggle in Europe led to WWI, and later on WWII	Mostly in Europe, America, Japan -- also Russia became socialist economic power	* Reiki [around 1922 ACE in Japan] * Revival of Pranic Healing, Gem Therapy, and Meditation in Asia and Europe.
5	1960 onwards Till 2008 ACE	New economic order / End of Colonisation / Oil became vital / Unrest around the world / Middle Eastern problems	North America, Europe, Asia Pacific, Middle East & Africa, and Central and South America	* Countries regained independence from the clutches of European colonial powers [Asia, Middle East, and Africa]. * Revival of ancient medical practices in those countries * Development of modern medicine and medical facilities in Asian countries. * Growth of Heath and Medical Tourism around the word. * Countries in Asia became popular destination for health care.

Source: Subhash, K. B; Smitha Govindas Bhandare; and Klaus Weiermair (2009).

The time line given in **Exhibit 1** also gives a clear indicaiton that the first ever medicinal practice started in Africa (mainly Egypt), then spread towards Asia (India, China, Tibet, Mangolia, and Japan), then to Europe (Greece, Switzerland, and Germany). As and when the knowledge of medicinal practice started spreading from one place to other, indegenisation of the knowledge paved the way for the development of various forms of medical/health care systems/practices in different regions. The origin of medical knowledge from Africa was not mentioned in any of the historical documents, but there are many references given about the link of Ayurveda teachings to the world of medicine. Learned men from China (Acupressure, Acupuncture, and Chinese Herbal Medicine), Tibet (Tibetain Medicine), the Greeks & Romans (Clinical Medicine), Egyptians (herbal medicine and aromatheraphy), Afghanistanis, Persians (Islamic Medicine and Unani), and more traveled to learn the complete wisdom and bring it back to their own countries. Ayurvedic texts were translated in Arabic and under physicians such as Hakim Ibn Sina (known as Avicenna in the west who lived during ACE 980-1037 developed Unani medicine) and Razi Sempion, both quoted Indian Ayurvedic texts, established Islamic medicine. This style became popular in Europe, and helped to form the foundation of the European tradition in medicine. In 16th Century Europe, Paracelsus (Swiss alchemist propagated Megnetotherapy in Europe), who is known as the father of modem Western medicine (Allopathic), practiced and propagated a system of medicine, which borrowed heavily from Ayurveda.

Thus, Ayurveda is also considered as the "Mother of all Healings".

During the ***first*** stage (3500 BCE – 1600 ACE) and ***second*** stage (1600 – 1700 ACE) of history of mankind, most of the medical/health care systems/practices developed in different parts of the world. But the drastic change happened in the history of medicine is the decline (mostly by force) of ancient medical practices (CAM) in Asia, Middle East, and Africa during the ***third*** stage (1700 – 1900 ACE). This is the direct result of the industrial revolution started in European region which resulted in mass colonisation of countries in Asia, Africa, and Middle East by European countries to ensure steady supply of raw materials for the industries in Europe. In a way almost 75% of the countries around the world were under the control of Europe. The clinical medicine developed in Greece (around 460 BCE in Europe) got prominance and witnessed a spontaneous growth, spread accross Europe, which resulted in branding this branch of medicine as Western Medicine / BiomedicineScientific Medicine / Modern Medicine during 1600-1700 ACE, subsequently Hippocrates was sworn in as the "Father of Medicine". Thus during the ***third*** stage, the indegeneous medicinal systems practiced in Asia, Africa, and Middle east got sidelined by the mass colonisation by European countries. This being the case elsewhere a new system of medicine (Homoeopathy) got developed by Samuel Hahnemann in Europe (Germany) around 1800 as an alternative of the then existing clinical medicine in Europe. This clearly indicate the power with which the European colonial powers tried to suppress the development of the indegeneous medical systems practiced (mainly labelling them as whitch craft / black magic) and forcefully imposing the clinical as well as homoeopathy medicinal systems in the colonised countries. During the ***fourth*** stage (1914-1945 ACE) Reiki was developed in Japan (one of the super powers at that time). In the ***final*** stage (1960 onwards) world witnessed the end of coloniasation and along with this came the revival of the indegeneous medicinal practices in Asia, Africa, and Middle East. Among all other CAM's, Ayurveda got more prominance and became very popular in India and also abroad. And during the last two or three decades, the development and growth of health/medical tourism activities around the world paved the way for overall development of Ayurvedic treatment facilities to cater the needs of patients coming for health care needs.

3.Health Tourism based on CAM Vs Medical Tourism based on MM: Can it be combined for developing a better Health Care system ?

Though between health tourism and medical tourism no major difference exists, health tourism has been in existence from 2000 BCE onwards and medical tourism is of recent origin (Hunter, 2007).

But in the present situation, both terms are being used interchangeably. The medical treatments practiced under health tourism is termed as CAM during the colonisation period, but in medical tourism the treatments are considered as MM. Depending on the type of illness/disease, the patients can go for CAM or MM. As rightly pointed out by AyurVAID (2008), for early to mature stages as well as chronic stages of a disease Ayurveda has excellent answers to the health needs of mankind; while once a person has already reached an acute or emergency health state MM (modern medicine and surgical technique with attendant medical technologies) is unparalleled in its effectiveness. This clearly shows the dividing point between CAM and MM in the present scenario; also the significance of Ayurveda as one of the most sought after CAM by the health tourists around the world. **Exhibit 2** shows some basic differences between CAM and MM.

Exhibit 2: Comparison between CAM and MM

	CAM	**MM**
Origin	Around 10,000 years back	During 1600 BCE
Basis	Patient-centric	Disease-centric
Risk Factor	Limited	Very high
Use of technology	Low	Very high
Cost	Low	High
Stage of disease	Early to mature stages as well as chronic stages	Acute or emergency health state
Side effects	Almost 0 %	Varying degrees
Recovery time	Less	More

Source: Author's own compilation

Ayurveda (CAM) and MM differ in one basic sense. MM is driven by ***Structure*** or the '***Part***' (substantially dependent on scans, ECG, etc), hence purely **disease-centric**. But Ayurveda gives importance to ***Function*** or the effect of '***the Whole***', hence **patient-centric**. When every sub-system functions properly, it is health (AyurVAID 2008). When there is some difference or difficulty in the function, ill-health is caused. In essence one can deduce that the two systems may truly and effectively complement each other when structural knowledge is judiciously integrated and interpreted in the Ayurveda paradigm of 'whole person' functional performance, which is the true spirit of Ayurveda, and also the reason why it survived in all these 5000 years by evolving in to a system which takes care of the contemporary needs and developments making it even more relevant for health tourism promotion.

This inherent property allowed Ayurveda to take different forms (all other forms of CAM)

wherever it got transplanted by indegenisation of the needs, preferences, and also the availability of medicinal ingredients at the respective destinations. Ability of Ayurveda to adapt with the changes allows it to provide better health care facilities to patients, but the changes are to be only in application, not in principles. Thus, one can apply modern tools, modern insight, and modern knowledge whether it is at the biological, anatomical, physiological, or genetic level, in the context of Ayurveda's foundational principles without any contradiction whatsoever. Further, modern advances in risk management, emergency management, organ transplantation, and surgical interventions of all types can only complete and enhance the value of Ayurveda and in no way detract from it. And according to AyurVAID (2008), appropriate integration and collaboration with modern medicine is to the best benefit of humanity and therein lies the future of Ayurveda.

There are many developing countries providing medical tourism services using MM for the clientele from Europe and other Western countries. Along with this, many change agents (governments, entrepreneurs, as well as intrapreneurs) are trying to provide health tourism services using CAM for wellness and rejuvenating the health. India is one among many other developing countries providing both medical as well as health tourism services. Though India is perceived as a low cost and low hygiene environment as broadcasted by a German radio station for medical procedures (Connell, 2006), all three change agents are trying their level best to increase the consumer confidence by providing hight quality and low cost health care solutions to both medical and health tourists (News 2005). Around the world, medical practitioners are trying different permutations and combinations of integrating CAM and MM in such a way that the resulting benefits are passed on to the patients in a better way. The reason is very simple; i.e.; there exists an enormous growth potential in health care products/services (specially to cater the needs of the medical tourists) as it has became part and parsel of the international business scenario like any other product/service. It has entry barriers (trade barriers), it involves financial transactions across two or more countries, it attracts huge investments from domestic as well as international markets, it strategically adapts to the changing environments, and the demand and supply are influenced by both domestic as well as intarnational factors. But the only difference between health care product/service and other categry is that the customers (medical tourists) have to travel to the destinations to experience the facility and get recovered from the illness, just like any other tourism products. The peculier characteristics health/medical tourists is that they are travelling for a specific purpose, hence categorises them in to special interest groups and are falling under special interest tourism segment (Douglas, Douglas, and Derrett, 2001).

As discussed earlier, around the world the concept of health/medical tourism is gaining prominence mainly due to inefficiency, ineffectiveness, and consumer unfriendly nature of the health care system existing in developed countries (Herzlinger, 2006). Thus in the coming years people from developed countries will travel towards other regions for the purpose of enhancing health and general

well-being. If deliberate attempt is made to attract tourists by promoting healthcare services and facilities in addition to regular tourist facilities (Gooderich and Gooderich, 1991), the full potential can be exploited. Along with this Europe is expected to have eight of the ten countries worldwide with the highest percentage of people over 60 (Garcia-Altes, 2005). Over the last few years, the focus of health care tourism has been on the international market (Gooderich and Gooderich, 1991, and Henderson, 2004) mainly because of the long waiting time and also high cost presently existing in developed countries to get the medical services (demand side). On the supply front, hospitals, clinics, spa resorts and tourist operators in developing Asian countries, such as Malaysia, Thailand, Singapore, the Philippines and India are eager to expand their service offering to foreign customers (Zarrilli et al, 1998, and Hunter, 2007). Essentially, they are exploiting their advantages of "lower-cost skilled personnel, cultural factors, natural endowments and unique forms of medicine" (Zarrilli et al, 1998). Several European countries, for example, Hungary, Poland and Slovakia, are also striving to specialize in health care tourism (Garcia-Altes, 2005). To reap the benefits of the future of demand for health/medical tourism products/services, the environment should give opportunities for continuous innovations (Brooker, and Go 2007).

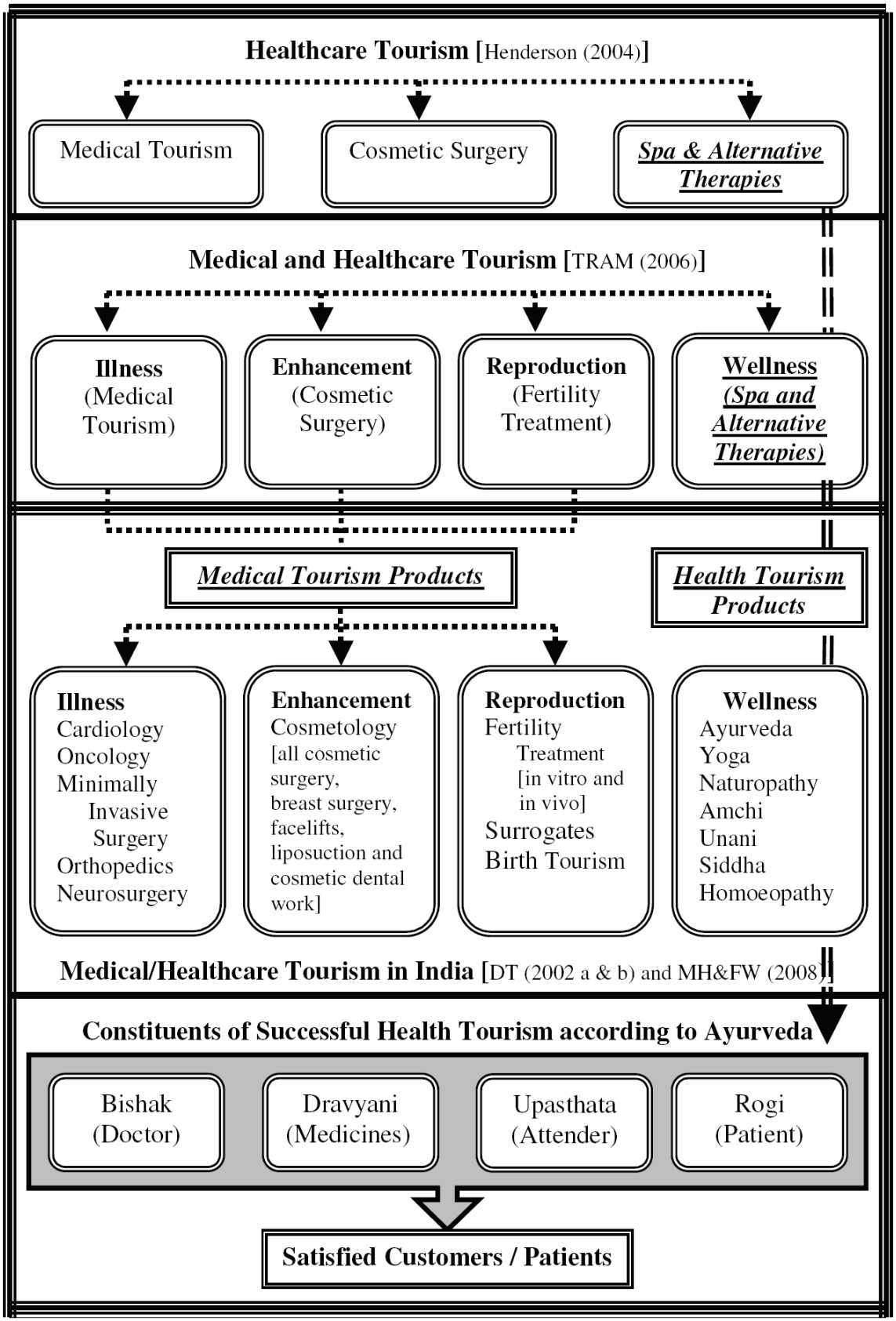
4.Constituents of Successful Health Tourism According to Ayurveda.

Ayurveda, the science of life, prevention and longevity is the oldest and most holistic medical system available on the planet today. Ayurveda is the perfect solution for all human needs, wants, and desires. It is not a mere compendium of therapeutic recipes, nor is it the first one to use herbs, instead; it is one of the earliest frameworks, which systematized the knowledge. This framework is not only self-consistent but also uses cause and effect arguments to correlate manifestations of sickness, its causes, and treatment (Kumar, 2002). From the beginning, during 5000 years ago, onwards Ayurveda identified two main goals; viz.; (1) To maintain the health of the healthy by promotion and preservation of health and also strengthening the healthy, and (2) To heal the sick by eliminating the disease in the ailing and inflicted; i.e.; curative treatments. The Ayurvedic 'chikitsa' achieves these two goals, i.e., (i) removal of the causative factors of the disease, and (ii) restoration of the *doshic (dosha-dhatu-mala)* equilibrium. This depends on the successful mixing of the roles played by the four essential ingredients (four essential limbs of therapy or ***Chatushpada)*** of Ayurveda; viz.; (1) Bhishak / Vaidya / Physician; (2) Dravya / Dravyani / Medicines - both medicinal drugs as well as food substances; (3) Upasthata / Attender / Nurse; and (4) Rogi / Patient. Of these four, the first three are categorised as ***internal*** factors and the fourth one (Rogi / Patient) is the ***external*** factor associated with

an Ayurvedic treatment centre. To make the Rogi / Patient recover from illness and regain health, the first three ingredients are to be effectively managed. **Exhibit 3** clearly shows the classifications and the link between CAM and MM and also the constituents of successful health tourism according to Ayurveda.

The first part of **Exhibit 3** combined both CAM and MM in to health tourism, where Henderson (2004) identified Medical Tourism and Cosmetic Surgery under MM and Spa & Alternative Therapies under CAM. Subsequently Tourism Research and Marketing (TRAM, 2006) broadened the classifications in to Illness, Enhancement, and Reproduction (all coming under MM) and Wellness (coming under CAM). Subsequently Department of Tourism (DT 2002a and 2002b) and Ministry of Health & Family Welfare (MH & FW 2008) gave a detailed picture of what comes under each category of treatments. This was developed based on the existing medical facilities being promoted as health tourism products to cater the needs of both domestic and international tourists. Most of the facilities offered under MM in India, in terms of the quality and technology, are on par with most of the western and European counterparts. Though with respect to medical tourism (MM) India has many competitors; the availability of qualified medical practitioners, well trained nursing assistants, high-tech equipments, and also the high growth in pharmaceutical industries helped Indian hospitals (providing MM) an edge over most of their counter parts from other Asian and Middle eastern countries in meeting the demands of international health tourists. In terms of providing health tourism products (CAM), Ayurveda is being considered as one of the most sought after products by Western and European tourists compared to other CAM products. Other than Ayurveda, many other products are also being provided in India, viz., Yoga, Naturopathy, Amchi, Unani, Siddha, and also Homoeopathy. Unani became popular in India during the Islamic (Persian / Mughal) rule and Homoeopathy became popular during European colonisation period. Ministry of Health & Family Welfare in India set up a separate department called Indian Systems of Medicine and Homoeopathy (ISM & H) in 1995, which was re-named in to Department of Ayurveda, Yoga-Naturopathy, Unani, Siddha, & Homoeopathy (**AYUSH**) to manage, regulate, and promote CAM practices in India from 2003 onwards. The details of all the CAM practices, which are being provided in India, are shown in the subsequent sections and exhibits.

Exhibit 3: Classification of Health/Medical Related Tourism Products/Services &Constituents of Successful Health Tourism According to Ayurveda



According to MH & FW (2008), "with an increase in life style-related disorders, there is a worldwide resurgence of interest in holistic systems of health care, particularly with respect to the prevention and management of chronic lifestyle-related non-communicable and systemic diseases. It is increasingly understood that no single health care system can provide satisfactory answers to all the health needs of modern society. Evidently there is a need for a new inclusive and integrated health care regime that should guide health policies and programmes in future. ***India has an advantage in this global resurgence of interest in holistic therapies as it has a rich heritage of indigenous medical knowledge (CAM) coupled with strong infrastructure and skilled manpower in modern medicine (MM)***. Medical pluralism is here to stay and the AYUSH sector has a critical role to play in the new and emerging situation". Hence from **Exhibit 3**, all the products coming under health tourism are now governed by Department of AYUSH from 2003 onwards.

And the success of any of the CAM or MM depends on proper mixing of the basic four elements, which are considered as the ***Chatushpadas*** of Ayurveda. So one can easily conclude that almost 5000 years ago the proponents of Ayurveda identified the four constituents of a successful health tourism product; viz.; internal (Physicians / Medicines / Attender) and external (Patients) elements. The efficient mixture of the three internal ingredients (supply side of the health tourism sector) will attract the fourth external ingredient, the patient (considered as the customer or demand side of the health tourism sector, which is considered as outside the treatments centers or hospitals). In this regard, India has tremendous potential (***internal elements***) with respect to availability of well qualified physicians, abundant supply of raw materials for making the medicines, and also well trained nursing assistants. Secondly, with respect to the patients (***external element***), being the second most populated country in the world, India does not face the difficulty of shortage of patients. The domestic patients itself is sufficient to cater the demand requirements of most of the CAM (even in the case of MM) providers. Thus both in terms of demand and supply sides of health tourism, India is in a way self-sufficient. But concentrated efforts (both by private and government players) are being made to cater the needs of international health tourists to make use of the medical/health care facilities available in India, there by branding India as the global healthcare destination.

This being the case of Indian CAM (and also MM) market with respect to health tourism, there are some inherent problems prevailing, which hinders the growth potentiality of CAM as a health tourism product, especially Ayurveda. According to a study conducted based on Kerala Ayurvedic centers (Subhash, et al, 2008), some of the problems related to the internal elements are identified. With respect to ***Bishak*** and ***Upasthata***, shortage of traditional training centers is considered as one of the critical factor, which leads to shortage of trained human resource for the smooth functioning of the centers. With respect to ***Dravyani***, (1) inadequate supply chain and logistic management leads to the shortage of medicinal herbs, and (2) difficulty in uniformity in medicinal formulations leads to

differential quality standards which may create bad image in the minds of potential and prospective customers. These internal difficulties have to be managed efficiently to create a good image, which ultimately generates high demand for Ayurveda products. In spite of these difficulties, flow of domestic customers is happening without much difficulty. But there are other associated problems, which hinders the growth prospects of catering the needs of increased flow of international customers. Some of the problems are: (1) reluctance of entering into tie-ups with tourism and hotel industry, (2) reluctance to intensify marketing, and (3) inertia of going for expansion. All these shows the negative attitude of the Ayurvedic treatment centers towards modernization and expansion to cater the increased demand from international markets.

5.Present Status of Ayurveda in India.

As discussed in the preceding section that Ayurveda is considered as one of the prominent CAM being practiced in India for the last 5000 years, which has been successfully transplanted to many countries, and through indegenisation it got evolved in to different forms of medicinal practices around the world. Ayurveda also provides the four essential ingredients (***Chatushpadas*** of Ayurveda) for making CAM as a successful health tourism product. In India, Department of AYUSH is setup to manage, regulate, and promote CAM practices in India from 2003 onwards. The following **Exhibits 4** and **5** reveal some of the interesting facts about the CAM in India during the period 2007-08.

Exhibit 4 indicates the infrastructure facilities available under AYUSH, which clearly shows the popularity of Ayurveda as one of the most prominent CAM practice in India. This information is only an indication, because the private sector information is completely missing from the government publication. Hence the present study has the inherent limitation, which can be rectified by conducting a detailed study to reveal the real picture of CAM practices in India. But some of the interesting characteristic features; i.e.; the ***Chatushpadas*** of Ayurveda, which are identifiable from exhibit 4 are as follows.

Almost 75% of the total AYUSH hospitals are of Ayurveda hospitals (including 70% of the total bed capacity under AYUSH). Almost 50% of the institutions providing education and training for AYUSH practitioners are also catering the needs of aspiring/potential Ayurveda practitioners. An overview about the two of the four essential limbs of therapy or ***Chatushpada*** of Ayurveda (***Bhishak*** and ***Dravyani***) is also available. With respect to the ***first*** and foremost Chatushpada of Ayurveda (i.e., ***Bhishak***) is concerned, 63% of the total practitioners are falling under Ayurveda (a breakup of this shows that 64% of the total of the institutionally qualified practitioners as well as 59% of the

non-institutionally qualified practitioners are from Ayurveda). This is a clear-cut indication that there are two streams of practitioners, one who are getting training through formally recognised government institutions and the other through informal private organisations. Almost over 25% of the practitioners are getting in to Ayurveda practice by obtaining training from private players / institutions. This is a positive sign of private participation in promoting Ayurveda as an employment provider to the educated youth. The significance of the ***second*** Chatushpada of Ayurveda (i.e., ***Dravyani***) is clear from the two sets of information, i.e., Dispensaries as well as Manufacturing units. Almost 65% of the dispensaries are coming under Ayurveda and with respect to the number of manufacturing units, 86% belongs to Ayurveda. The other prominent AYUSH practices are Homoeopathy (European origin), Siddha (Indian origin, contemporary of Ayurveda, most prominent in Tamil Nadu), and Unani (Middle Eastern / Arab origin). These three accounts for almost 25% and Ayurveda accounts for almost 75% of AYUSH treatments in terms of most of the infrastructural facilities available in India.

Geographical breakup of the information about 'Bhishak' (AYUSH practitioners) in India is shown in **Exhibit 5**. The three most prominent CAM practices where most of the medical practitioners involved are in Ayurveda, Homoeopathy, and Unani. Most of the states in the three first regions; viz.; North India, South India, and West India, are having all these three main categories of medical practitioners. But in the East India region, though the total number of practitioners is falling under Ayurveda (Bihar accounts for almost above 94% of Ayurveda practitioners, which alone contributes almost over 59% of the total number of practitioners in this region) majority of the states are having Homoeopathy practitioners instead of Ayurveda (may be due to the influence of Christian missionaries during European colonisation period). In the case of Union Territories, none of them are having any type of AYUSH practitioners. Another peculiarity, which can be observed from Exhibit 5, is about the Siddha and Naturopathy. Except South India, none of the other regions are having any Siddha practitioners (6% of the total practitioners). Even Naturopathy (just over 1%) is practiced in South India only (except in Madhya Pradesh from North India). This may be the main reason why the share of Ayurveda practitioners got reduced to only 49% compared to other regions. Thus geographically speaking, the spread of AYUSH / CAM practitioners are more in Ayurveda (on an average over 63%); secondly in Homoeopathy (on average over 30%); and thirdly in Unani (on an average over 6%).

Exhibit 4: Summary of Infrastructure facilities under AYUSH as on 01/04/2007

	Facilities	Ayurveda	Yoga	Naturo--pathy	Amchi	Unani	Siddha	Homoe--opathy	Total
1	Hospitals	2,398 *(75 %)*	8 *(0.2%)*	18 *(0.6%)*	1 *(0.03%)*	268 *(8%)*	281 *(9%)*	230 *(7.2%)*	3,204
2	Beds	42,963 *(70 %)*	135 *(0.2%)*	722 *(1.2%)*	22 *(0.04%)*	4,489 *(7%)*	2,401 *(4%)*	10,851 *(18%)*	61,583
3	Dispensaries	13,914 *(65 %)*	71 *(0.3%)*	56 *(0.3%)*	86 *(0.4%)*	1,010 *(5%)*	464 *(2%)*	5,836 *(27%)*	21,437
4	Regd. Practitioners **(i)** Institutionally Qualified. **(ii)** Non-Institutionally Qualified.	4,53,661 *(63%)* 3,24,242 *(64%)* 1,29,419 *(59%)*		888 *(0.1%)* 839 *(0.2%)* 49 *(0.02%)*		46,558 *(6%)* 23,982 *(5%)* 22,576 *(10%)*	6,381 *(1%)* 2,926 *(1%)* 3,455 *(2%)*	2,17,850 *(30%)* 1,54,240 *(31%)* 63,610 *(29%)*	7,25,338 5,06,229 2,19,109
5	(i) AYUSH Colleges (ii) Capacity (UG/PG)	242 *(50%)* 12,216 *(42%)*		10 *(2%)* 385 *(1%)*		40 *(8%)* 1,817 *(6%)*	8 *(2%)* 460 *(2%)*	185 *(38%)* 14,509 *(49%)*	485 29,387
6	(i) Colleges (UG) (ii) Capacity	240 *(50%)* 11,225 *(41%)*		10 *(2%)* 385 *(1%)*		39 *(8%)* 1,750 *(7%)*	7 *(2%)* 350 *(1%)*	183 *(38%)* 13,425 *(50%)*	479 27,135
7	(i) Colleges (PG) (ii) Capacity	62 *(59%)* 991 *(44%)*				7 *(7%)* 67 *(3%)*	3 *(3%)* 110 *(5%)*	33 *(31%)* 1,084 *(48%)*	105 2,252
8	(i) Excusive PG (ii) Capacity	2 *(33%)* 40 *(20%)*				1 *(17%)* 28 *(14%)*	1 *(17%)* 30 *(16%)*	2 *(33%)* 99 *(50%)*	6 197
9	Manufacturing Units	7,621 *(86%)*				321 *(4%)*	325 *(4%)*	628 *(7%)*	8,895

Source: Annual report 2007-08 prepared by Ministry of Health & Family Welfare

% share of each to the total shown in ( ).

Exhibit 5: State wise Number of Registered AYUSH Practitioners [Category-Wise] and State wise Number of AYUSH Practitioners per 10,000 Population As on 01/01/2007

#	States / UT's / Others	Ayur veda	Unani	Siddha	Homeo -pathy	Naturo -pathy	Total [#]	Projected population as on 1-3-2007 (in 000's)	Doctor Per 10000 [##]
1	Madhya Pradesh *	47,602	609	-	9,380	2	57,593[4]	68,046	**8.5** [5]
2	Uttar Pradesh	51,240	13,289	-	27,790	-	92,319[3]	1,87,380	4.9
3	Haryana	18,726	2,212	-	5,570	-	26,508[11]	23,410	**11.3** [2]
4	Punjab	18,424	4,033	-	3,742	-	26,199[12]	26,288	**10.0** [3]
5	Chandigarh *	-	-	-	297	-	297	1,037	2.9
6	Delhi	3,088	1,625	-	3,149	-	7,862[15]	16,563	4.7
7	Himachal Pradesh	7,236	456	-	1,111	-	8,803[14]	6,488	**13.6** [1]
8	Jammu&Kashmir	1,952	1,956	-	-	-	3,908	11,974	3.3
9	Chhattisgarh	794	9	-	221	-	1024	23,255	0.4
10	Uttrakhand	1,065	41	-	-	-	1,106	9,358	1.2
11	Jharkand	-	-	-	-	-	-	29,597	0.0
NORTH INDIA		***150,127 (67%)***	***24230 (10%)***		***51,260 (23%)***	***2***	***225,619 (100%)***	***216,016***	***10.5***
1	Andhra Pradesh *	15,231	5,022	-	9,422	374	30,049[7]	81,315	3.7
2	Karnataka	20,352	1,121	4	5,003	234	26,714[10]	56,775	4.7
3	Kerala	15,068	64	1,326	9,273	-	25,731[13]	33,902	**7.6** [6]
4	Tamil Nadu	3,612	1,014	5,051	17,268	278	27,223[9]	65,838	4.1
SOUTH INDIA		***54,263 (49%)***	***7,221 (7%)***	***6381 (6%)***	***40,966 (37%)***	***886 (1%)***	***109,717 (100%)***	***237,830***	***4.6***
1	Goa	290	-	-	274	-	564	1,581	3.6
2	Gujarat	20,985	256	-	8,503	-	29,744[8]	55,617	5.3
3	Maharashtra	63,030	4,079	-	38,407	-	1,05,516[2]	1,05,511	**10.0** [3]
4	Rajastan *	23,861	1,619	-	4,778	-	30,258[6]	63,549	4.8
WEST INDIA		***108166 (65%)***	***5954 (4%)***		***51962 (31%)***		***1,66,082 (100%)***	***120,747***	***5.0***
1	Arunachal Pradesh	-	-	-	94	-	94	1,185	0.8
2	Assam	442	-	-	669	-	1,111	29,471	0.4
3	Bihar	1,32,981	4,202	-	27,864	-	1,65,047[1]	92,340	1.8
4	Manipur	-	-	-	-	-	-	2,594	0.0
5	Meghalaya	-	-	-	240	-	240	2,504	1.0
6	Mizoram	-	-	-	-	-	-	968	0.0
7	Nagaland *	-	-	-	1,997	-	1,997	2,160	**9.2** [4]
8	Orissa *	4,448	17	-	3,106	-	7,571	39,483	1.9
9	Sikkim	-	-	-	-	-	-	587	0.0
10	Tripura	-	-	-	145	-	145	3,466	0.4
11	West Bengal	3,234	4,934	-	39,547	-	47,715[5]	86,835	5.5
EAST INDIA		***1,41,105 (63%)***	***9,153 (4%)***		***73,662 (33%)***		***2,23,920 (100%)***	***261,593***	***2.3***
1	Puducherry	-	-	-	-	-	-	1,058	0.0
2	A & N Islands	-	-	-	-	-	-	403	0.0
3	D & N Haveli	-	-	-	-	-	-	255	0.0
4	Daman & Diu	-	-	-	-	-	-	183	0.0
5	Lakshadweep	-	-	-	-	-	-	67	0.0
UNION TERRITORY								***1,966***	***0.0***
	TOTAL	**4,53,661 (63%)**	**46,558 (6%)**	**6,381 (1%)**	**2,17,850 (30%)**	**888 (0.01%)**	**7,25,338 (100%)**	**11,31,043**	**6.4**

Source: Compiled from Annual report 2007-08 published by Ministry of Health & Family Welfare, Government of India.

* = Information has not been received for Current year; hence latest available information is repeated.

\# = Ranking is shown as superscript

\## = Ranking is shown as superscript for those states whose AYUSH Doctor per 10,000 is above the state average of 6.4

Exhibit 5 also indicates the details about the ratio between AYUSH practitioners and the population reveal that at the national (all India) level, 6.4 doctors are available (per 10,000 people), which is comparatively very low when we compare with some of the states. This is a clear-cut indication of the shortage of AYUSH practitioners in India. Only region having a ratio which is equal to or above is North India (10.5), and the reason being that four states in this region are having a high ratio than the national average. Only seven states in India are having above national average ratio. The states which are having a high ratio are; Himachal Pradesh (13.6), Haryana (11.3), Punjab (10.0), Madhya Pradesh (8.5), Kerala (7.6), Maharashtra (10.0), and Nagaland (9.2). Except in Nagaland from East India where Homoeopathy is the only AYUSH/CAM practitioners exist; all other states are having all the three (Ayurveda, Unani, and Homoeopathy) practitioners. In Kerala even Siddha and Naturopathy is prevalent. Thus in general one can conclude that with respect to the availability of 'Bhishak', there exists a shortage at the national level and also in many states in India, hence a concentrated effort should be made to increase the awareness among the people (specially among the students) so as to increase the number of practitioners in the coming years to cater the needs of domestic as well as the international health tourists.

Keeping in mind the future growth potential, Indian government has taken some bold initiatives for the promotion of AYUSH/CAM during the 10th and 11th plan periods, which are shown in **Exhibit 6**. According to the report by MH&FW (2008) three areas of the four essential limbs of therapy or ***Chatushpada*** of Ayurveda were given more emphasis during the 10th Plan period (2002-07); viz.; (a) ***Bhishak*** / Doctor [upgradation of AYUSH educational standards], (b) ***Dravyani*** / Medicine [quality control and standardization of drugs, improving the availability of medicinal plant material, and R&D], and (c) ***Rogi*** / Patient [emphasis was also given on awareness generation about the efficacy of the AYUSH systems domestically and internationally with a view to expand the market for the AYUSH products/services]. For the last Chatushpada; i.e.; ***Upasthata*** / Attender, no such special initiatives were provided during the 10th Plan.

The increase in the actual expenditure indicates that the greater level of activity has been achieved during the 10th Plan; i.e.; the original approved outlay of `.775.00 crore for AYUSH was increased to ` 1,214.00 crore (almost over 57% increase over the original). This being the case, the actual expenditure incurred was only ` 1,029.00 crore (only over 33% over the original). Apart from the core areas for AYUSH sector identified in the 10th Plan period (education, research, industry, and medicinal plants), four more additional dimensions were included in the 11th Plan; viz.; (a) role of AYUSH in publication, (b) technology upgradation of AYUSH industry, (c) international cooperation, and (d) revitalization of community based local health traditions of AYUSH; for the purpose of enhancing the social and community outreach of AYUSH during the period 2007-12 both domestically and internationally. For achieving this, the total approved outlay during the 11th Plan is

kept at a higher level; i.e.; ` 3,988.00 crore (almost 229% increase over 10th Plan outlay of ` 1,214.00 crore).

Of the 4 additional dimensions in the 11th Plan; viz.; revitalization of community based local health traditions of AYUSH, it was proposed to carryout pilot projects via NGOs and research institutions to document, assess, and promote sound local health practices. The main reason behind such an initiative is due to the fact that the local health traditions constitute the folk or "Prakrit" roots of AYUSH, which are available now with around a million village-based healers and also among several million knowledgeable households having the useful knowledge of local grains, cereals, wild fruits and vegetables, and locally available medicinal plants. This partnership approach is expected to (a) broaden perspectives, (b) bring in greater transparency and accountability, (c) enhance talent, and also (d) to pool resources for better utilisation.

Exhibit 6: Department of AYUSH 10th and 11th Plan Outlay (2002-07 & 2007-12 periods)
[Amounts given are in ` Crores]

Serial Number	Name of Scheme	10th Plan (2002-07)			11th Plan (2007-12)	
		Approved Outlay	Sum of Annual Outlay	Sum of Actual Expenditure	Approved Outlay (07-12)	Approved Outlay (07-08)
	Centrally Sponsored Schemes (CSS)					
1	**Promotion of AYUSH**	**224.40**	**443.13**	**487.63**	**1400.00**	**177.00**
	a. Development of Institutions	120.00	155.72	120.81	550.00	47.00
	b. Hospitals and Dispensaries	59.00	243.85	310.15	625.00	120.00
	c. Drugs Quality Control	45.40	43.56	56.67	225.00	10.00
2	**New Initiatives**	--	--	--	**605.00**	**5.00**
	a. Public/Private Partnership for setting up of specialty clinics / IPD's	--	--	--	50.00	5.00
	b. Medicinal Plants Processing Zones	--	--	--	555.00	0.00
	Total CSS (1 + 2)	**224.40**	**443.13**	**487.63**	**2005.00**	**182.00**
	Central Sector Schemes (CS)					
1	**Systems of Strengthening**	**99.59**	**147.88**	**72.67**	**262.75**	**29.48**
	a. Strengthening of Dept: of AYUSH	22.50	28.56	27.02	47.00	6.50
	b. Statutory Institutions	2.65	2.75	0.69	2.95	0.65
	c. Hospitals and Dispensaries	28.94	61.69	15.72	162.80	12.00

Serial Number	Name of Scheme	10th Plan (2002-07)			11th Plan (2007-12)	
		Approved Outlay	Sum of Annual Outlay	Sum of Actual Expenditure	Approved Outlay (07-12)	Approved Outlay (07-08)
	d. Strengthening of Pharmacopoeial Laboratories	26.50	36.17	9.97	25.00	3.33
	e. Information, Education, and Communication	19.00	18.71	19.27	25.00	7.00
2	**Educational Institutions**	**116.50**	**147.75**	**125.18**	**188.68**	**67.02**
3	**R&D Including Medicinal Plants**	**234.00**	**340.99**	**337.11**	**719.57**	**143.95**
	a. Research Councils	140.50	206.78	195.64	359.50	63.95
	b. Medicinal Plants	93.50	134.21	141.47	360.07	80.00
4	**Other Programmes & Schemes ***	**100.46**	**134.20**	**6.95**	**85.00**	**7.55**
5	**New Initiatives ****	**0.05**	**0.05**	**0.01**	**727.00**	**58.00**
Total CS (1 + 2 + 3 + 4 + 5)		**550.60**	**770.87**	**541.92**	**1983.00**	**306.00**
Grand Total (Total CSS + Total CS)		**775.00**	**1214.00**	**1029.55**	**3988.00**	**488.00**

Source: Annual report 2007-08 prepared by Ministry of Health & Family Welfare

* Re-orientation Training Programme of AYUSH personnel / Continuing Medical Education (ROTP/CME); Cataloguing, Digitizing and AYUSH IT Network; (i) International Exchange Programmes; (ii) Programme for training/fellowship/exposure visit/up gradation of skills etc; (iii) Incentives to AYUSH industry for participation in fairs/conducting market study; (iv) Acquisition, Cataloguing, Digitization and Publication of Text Books & Manuscripts.

** (i) Setting up of North Eastern Institute of Ayurveda and Homoeopathy & North Eastern Institute of Folk Medicine; (ii) Assistance for International Co-operation; (iii) Assistance to accredited AYUSH Centers of Excellence in non-governmental sector; (iv) Development of common facilities for AYUSH industry clusters; (v) Funding of NGOs engaged in local health traditions / midwifery practices etc under AYUSH; (vi) Ayush & public health.

With respect to (a) role of AYUSH in publication, (b) technology upgradation, and (c) international cooperation; many initiatives are envisaged during the 11th Plan period. ***Firstly***, Setting up of modern Pharmacopoeia Commission with adequate representation of stakeholders and to develop standards that are in line with internationally acceptable Pharmacopoeial standards (presently standards for around 40% of the raw materials and around 15% of the formulations have been published during the 10th Plan period). ***Secondly***, to conserve gene pools of red listed species, support large-scale cultivation of species that are in high trade, involve forestry sector in plantation of

medicinal tree species, and establish modern processing zones for post-harvest management of medicinal plants (around 6,000 species of medicinal plants, 300 species of medicinal fauna, and around 70 different metals / minerals used by AYUSH are documented in medical and ethnobotanical literature during 10th Plan period). ***Thirdly***, digitizing traditional medical manuscripts (mostly in Sanskrit and other regional languages) in an official database and in international language through Traditional Knowledge Digital Library (TKDL, a collaborative project of AYUSH and CSIR) so as to enable rejection of frivolous patent claims on products derived from AYUSH knowledge systems (TKDL started during 10th Plan period and also Department of AYUSH initiated the need for an internationally binding legal instrument for protection of traditional knowledge and generic resources). ***Finally***, to develop more comprehensive plan for international cooperation in such key areas as research, education, clinical services, and industry. (Promotion and upgradation of Indian System of Medicine abroad to sensitize the world community about strengths and efficacy of AYUSH started during 10th Plan through conferences and trade fairs)

Thus it is clear from the preceding discussion that concentrated efforts are being by Department of AYUSH to strengthen the four essential limbs of therapy or ***Chatushpada*** of Ayurveda, not only in Ayurveda but also in every other CAM practices in India. Though the importance given to ***Upasthata*** / Attender appears to be slightly lower than the other three elements, during the 10th Plan (2002-07) AYUSH attained a commendable position in the global arena as one of the promising health tourism product/service, both domestically and internationally. During the 11th Plan period (2007-12), more initiatives are envisaged, and if everything works out as per the plan, one can see an exponential growth in health tourism in India. In this line, government and private sector players are trying their level best to make the AYUSH products/services on par with internationally acceptable standard. One peculiar feature is that India has vast potential in AYUSH in comparison to any other country, which needs to be effectively and efficiently utilized to capture ever-increasing health tourism consumers.

6.Role of Social Venture Capital in Rejuvenating Ayurveda Tradition

There are many social entrepreneurs around the world having the idea of providing social venture capital for economic transformation in the rural areas of under developed and developing countries (BOP, 2008; SVC, 2008a; Glasner, 2008; Tiku, 2008 and NEF, 2008). Social venture capital is a form of venture capital investing that provides capital to businesses deemed socially and environmentally

responsible intended for providing attractive returns to investors and to provide market-based solutions to social and environmental issues (SVC, 2008b). Though it is not clearly specifying the rural economy transformation, many social venture capital funds are focusing on rural developmental issues. As it is rightly pointed out that social venture capitalists are those new breed of venture capitalists interested in and also willing to consider unusual models of business ideas. There are many social venture capitalists around the world, of which one such social venture capital fund is **Acumen Fund** (a nonprofit venture philanthropy fund that invests in social enterprises addressing poverty in South Asia and Africa), one among the top 45 social entrepreneurs who are trying to change the world (Collaco and Subhash, 2008). One of the social entrepreneurial investment success stories of Acumen Fund in India is AyurVAID Hospitals (equity investment of Rs. 4.5 crores), which focuses on offering affordable healthcare services to low-income communities, enhancing both the quality and the accessibility of medicare available through its '***AyurVAID Seva***' program (AyurVAID 2008a and 2008b). This institution combined the traditional Ayurveda with the modern medicine and is a successful one from inception and now they have six hospitals in India providing health care services to needy people, both in the domestic market as well as international, and also to all income strata. It is a clear indication of social venture capitalists changing attitude towards assisting socially responsible, economically viable, as well as having potential in solving social problems (issues, which is considered as opportunities) business ideas. Though this is in health care area, a potentially viable business proposal can be devised in promoting rural tourism, which attracts social venture capitalists. There is great potentiality in promoting health tourism specially integrating Complementary Alternative Medicines (CAM, where Ayurveda is prominent) and Modern Medicines (MM) which many countries (including India) is trying to capitalize on in the coming years (Subhash, et al 2008e and Subhash, et al 2008f) and rural herbal medicines can also me used as one of the rural tourism product/service. By capitalizing on the transformational capability of social venture capital, **CAM** (especially Ayurveda tradition) in India and elsewhere can be rejuvenated in the coming years.

7.Conclusion

It is been very well established fact that the urge of human nature for longivity; i.e.; enjoying a health life to the extent possible during the life time; which spring from the basic human instinct of multitude of needs/wants with the limited means; specifically the life span (Varier, P. S, 1993). And the present Globalised scenario, the trend clearly indicates the tendency of people turning to "***green***", as more and more people the world over prefer plant-based medicines; which is generally known as herbal medicines (Pushpangadan, 2002) and to date excluded from conventional allopathic medicine

(Becvar et al 1998) now a days at the forefront of revolutionary changes in health care delivery. These practices are now being designated as Complementary Alternative Medicine (CAM). The term Complementary / Alternative / Non-conventional medicine are used interchangeable with traditional medicine in some countries and the World Health Organisation estimated that 80% of the world population relies on traditional medicine for primary health care, and also the use of plant remedies is on the increase even in the developed countries especially among younger generation (Muraleedharan, 2002).

The written history of the world reveals that around 10,000 years back the CAM practices started and slowly and steadily it spread around the world along with the exodus of brave people in search of new place for settlement as well as during the development of ancient trading practices. The history also reveals that Ayurveda is considered as "Mother of all healings", it is being considered as Complementary Alternative Medicine (CAM) among the Western and European medical practitioners. But there is a gradual shift is happening from allopathic medicine (MM) towards CAM in general and towards Ayurveda in particular in India. In the industrialised countries, the consumers are seeking visible alternatives to modern medicine, which has its associated dangers of side effects and over medication (Pushpangadan, 2002). Other factors contributing to the increased use of CAM services include their lower cost; less waiting time; their success in treating some diseases, particularly chronic and terminal illnesses, that do not respond to allopathic approaches; the support provided for self-responsibility in making health care choices; the emphasis on health promotion; and degree of success in treating high levels of chronic and acute stress (Murray & Pizzorno, 1998).

Though between health tourism and medical tourism no major difference exists, health tourism has been in existence during the last 5,000-10,000 years and medical tourism is of recent origin (Hunter, 2007). But in the present situation, both terms are being used interchangeably and are falling under medical tourism. The present health care scenario reveals that effective and efficient integration of MM and CAM is the order of the day in many of the countries around the world and a similar trend can be seen in India also, especially in the case of Ayurveda. The inherent property allowed Ayurveda to take different forms (all other forms of CAM) wherever it got transplanted by indegenisation of the needs, preferences, and also the availability of medicinal ingredients at the respective destinations. And according to AyurVAID (2008), appropriate integration and collaboration with modern medicine is to the best benefit of humanity and therein lies the future of Ayurveda.

And to have a successful CAM health tourism product/service, Ayurveda identified the four essential constituents almost 5,000 years ago, which are relevant even in the present globalised scenario. The need of identifying, developing, and promoting the four essential limbs of Ayurveda (***Chatushpada***) is very crucial; viz.; (1) ***Bhishak*** / Vaidya / Physician; (2) ***Dravya*** / ***Dravyani*** / Medicines - both medicinal drugs as well as food substances; (3) ***Upasthata*** / Attender / Nurse; and (4)

Rogi / Patient. Of these four, the first three are categorised as ***internal*** factors and the fourth one (Rogi / Patient) is the ***external*** factor associated with an Ayurvedic treatment centre. To make the Rogi / Patient recover from illness and regain health, the first three ingredients are to be effectively managed. Concentrated efforst are being made by the Department of AYUSH in India during the 10th Plan (2002-07) and more assistance is provided in the 11th Plan (2007-12) period also. The total approved outlay during the 11th Plan is kept at a higher level; i.e.; **Rs.3,988.00 crore** (almost 229% increase over 10th Plan outlay of **Rs.1,214.00 crore**) for the development and promotion AYUSH domestically as well as internationally.

Thus the present paper tried to provide a basic insight on otherwise unexplored area of (a) the origin, development, and growth of health tourism products/services; (b) using CAM as a product/service to cater the needs of the health tourism customers; (c) possible ways of integrating CAM and MM practices to have multiplier effect on improving the health of people; and also (d) the essential factors required for making the CAM product/service a successful one. There were very few studies carriedout on health tourism, specially considering CAM as a health tourism product/service.

The present study has some inherent limitation in the sense that a detailed survey is to be carriedout to get the full information about the effectiveness of various CAM hospitals/centers in terms of the existance of the four basic ingredients (***Bhishak***, ***Dravyani***, ***Utastathada***, and ***Rogi***) and evaluate the data to get the ground reality in India so as to avoid any major medical mishap happens. This extensive survey may provide some insights for the authorities to identify some proactive strategies. And it can be concluded that health tourism (using an integrated approach of CAM and MM) around the world in general and India in particular will certainly become more significant in the near future. Proper initiatives should be taken by the authorities for promoting CAM/AYUSH (specially Ayurveda) as a unique health tourism product with zero-side effects which in turn attracts more people resulting in development of profitable and sustainable health tourism industry in the region.

Given India's cost competitiveness in the health and tourism industry and given its long-standing tradition, i.e., expertise in "authentic Ayurveda" treatment, health tourism in India is forecasted to become a fast rising sub sector of tourism. Before this will happen much has to be done as yet in terms of both broadening the scope of Ayurvedic treatment within the tourism industry in India and with respect to better marketing and branding it internationally (Subhash, et al, 2008). This paper concludes that health tourism, around the world in general and India in particular, will certainly become more significant in the near future. Proper initiative should be taken by the authorities for promoting Ayurveda as a unique heath tourism product with zero-side effects which in turn attracts more people resulting in development of profitabe and sustainabe tourism industry in the region. By capitalizing on the transformational capability of social venture capital, **CAM** (especially Ayurveda tradition) in India and elsewhere can be rejuvenated in the coming years.

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