Introduction

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Pluralism(s) of Medical Systems

There are various definitions of Medical Pluralism. A broad definition by the German medical ethnologist Pfleiderer focuses on the level of systems: She defines Medical Pluralism as the "juxtaposition of medical systems which is a historical result of cultural and social developments leading to institutionalized forms of medical care".[1] Medical systems may have more or less strict delimitations. They can be differentiated internally. And they may interact with other systems – which they evidently do continuously. The definition underlines the crucial role of social, political and cultural factors – such as for example diversities of class, ethnicity and gender within societies or nation states and external pressures such as colonialism. The importance of history is evident: In the case of health and medicine during the 19th and 20th centuries one must refer particularly to the rise of biomedicine. In the case of India, the role of homeopathy as a "naturalized" medical system is another issue[2], as is the very recent successful commoditization of Ayurvedic and – to a certain extent also – Unani medications, which enlarged the Indian market for these products a hundred times in the twenty years between 1980 and 2000[3].

Medical Pluralism is by now recognized as a reality in many countries. The "traditional systems of medicine" have even found their way into the documents of the WHO. The organization defines them as

> the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health, as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses. The terms complementary/alternative/non-conventional medicine are used interchangeably with traditional medicine in some countries.[4]

In fact the WHO suggests the integration of these systems into the national health care schemes. What a remarkable development after decades of witnessing the ever increasing power of biomedicine! Since the end of WWII and the subsequent introduction of antibiotics, it seemed that there was nothing to stop the march towards a biomedical monopoly. Some medical historians would put the starting point of this triumphant development even further back to the beginnings of bacteriology in the 1880s or to the birth of the clinic at around 1800.

1 Pfleiderer (1995), p. 86; for other definitions s. Dilger/Hadolt: Überlegungen (2010).
2 Arnold/Sarkar (2002); cf. article of Das in this volume.
3 Bode (2008), p. 83. Sales rose from $ 7.5 million in 1980 to 800 million in 2001 and 1,000 million in 2005.
4 World Health Organization (2000), p. 1.

On this issue, history has to be brought into the debate again: The term medical pluralism in its most current meaning has several hidden implications, referring to two specific conditions, that need to be made evident for a critical use of the term: Firstly, it should only be applied to a period after the point of time when biomedicine was established as a distinctive medical system, and, secondly, it must have played or still play a dominant role. Depending on the country or point of view – or the preference of either the role of scientific progress or therapeutic effectiveness of biomedicine – one can locate this point of time somewhere between the 1880s and the 1950s in the case of Germany, and in India at a later time. For earlier eras before the establishment of such a hegemonic position of biomedicine I propose the term "old medical pluralism" (up until at least the 1880s, possibly even until the 1950s); for the "golden age of biomedicine" (from the 1950s at the earliest to the 1980s) I would call it "modern medical pluralism"; for the decades after the 1980s I propose the term "new medical pluralism".[5]

From a European point of view, developments began to take a different direction from the 1980s at the latest: the general public grew dissatisfied with certain aspects of biomedicine, such as the side effects of medications and the impression that physicians took too little time for the individual patient. Other points of concern included the power of the physicians as specialists and the growing dominance of diagnostics over treatment. What was probably even more important was that the limitations of biomedicine became more and more evident. After the end of most epidemics (at least in the rich Northern countries) the importance of chronical forms of disease increased. The ageing of the population – a common trend in rich and poor nations – will make these problems even more acute in the future.

As a reaction to these changes, some physicians in post-industrial countries began, from the 1980s onwards, to add "alternative medicine" to the biomedical treatments, which they continued to provide: they could be naturopathy, herbal medicine, Anthroposophic Medicine, "Traditional Chinese Medicine", Acupuncture, Homeopathy or, more recently, Ayurveda. An enquiry about the year 2000 shows the motivations of these German physicians as a mixture of personal dissatisfaction with biomedicine and the standardized patient care in hospitals. Sometimes they were driven by commercial considerations or a fascination with Asian spirituality or concepts.[6] From the 1990s onwards, between half and two thirds of all general physicians in France and in Germany have occasionally prescribed alternative medications or treatments, particularly homeopathy, and four fifth of the population are inclined to use it.[7] – And what is more: Non-academically trained practitioners supplied these

5 Jütte (2008), p. 382, referring to Cant/Sharma (1998), p. 189; and in more detail to Cheng (2003).

6 On the physicians' motivation see Frank/Stollberg (2006); Stollberg (2010), esp. pp. 241–246. See also Thanner (2010).

7 Stange (2010), pp. 37–38. "Basisdaten Homöopathie" of the DZVhÄ referring to a study of the CAM-Institute: http://www.dzvhae.de/dzvhae-presse/basisdaten/basisdaten-

and many other therapies which could include esoteric forms as well as magic. In other countries, such as the USA, over-the-counter (OTC) sales of non-conventional medical products flourished and showed the growing interest of patients for self-medication with alternative treatments.[8] We must keep in mind that the respective role of healthcare providers and of self-medication varies much between countries, continents and markets. In any case, self-medication hints at the idea of self-help – without consulting a medical specialist – which is another, cultural, element of the critique of biomedicine and the resurgence of alternative medicine during the 1980s.

Since that pivotal decade, alternative or complementary treatments have increased their share in the medical market in postindustrial societies.[9] The public debate forces the custodians of healthcare systems to take a stand and either reject or integrate these therapies – and to make up their minds as to whether to consider them as "complementary" or "alternative". One point is clear: the time of a monopolistic position of academic trained physicians offering "biomedicine" exclusively seems to be over – if such a situation ever existed.

Before looking further afield, I will continue this Eurocentric narrative for the moment. It is typical for this kind of narrative to overemphasize aspects that are tended to be seen as "modern" – in this case the dominant role of biomedicine when referring to Europe or North America. Such dichotomies between the "modern" and the "traditional" still play an important role in the background of public and even scientific debates on medical pluralism, particularly when referring to entire "medical systems".[10] This might be astonishing for scholars versed in postcolonial and postmodern critique. There is no doubt that these dichotomies tend to dwell on differences between medical systems while they neglect common features. It is also true that they conceive systems as being not only different but also stable and quite rigid.[11] One should, in contrast, underline the internal differentiation of systems. Finally, dichotomies are certainly linked more often to discourses about medical systems than to practice. But these dichotomies may be heuristically fruitful when used to deconstruct the Eurocentric narrative. A shared hypothesis in this volume is that there is much more "traditional medicine" in the North than we might have thought possible still twenty years ago! I use the term "traditional" here to signify healing practices that are not "biomedically proven".

During the last decades there is increasing evidence that invites us to doubt the monopolistic role of biomedicine in the "North" even during its

homoeopathie.html (last accessed on April 30, 2013).
For France: "L'homéopathie, un désaccord constant": http://elise10delannoy.free.fr/desaccord.html (last accessed on April 30, 2013); cf. "Homéopathie classique/uniciste": http://www.inhfparis.com/homeopathie-uniciste/hom%C3%A9opathie-classique-uniciste-0 (last accessed on April 30, 2013).

8 Sales nearly doubled from $ 439 million in 2002 to $ 831 million in 2008: Riley (2011).

9 For Germany cf. Stange (2010), esp. p. 37.

10 For a critical discussion of dichotomies see Ernst (2002), pp. 3, 6.

11 Ebrahimnejad: Introduction (2009), p. 4.

"golden age" (from the 1950s to the 1980s): in Germany, for example, a huge market of all sorts of non-conventional health products flourished throughout the 20th century and continues to do so. Products were mailed by companies and pharmacies directly to the homes of people who were prepared to pay large sums for them.[12] They were advertised promising much, but without serious "scientific" credentials. Sometimes, the fake credentials showed at least an implicit subservient reference to the dominant scientific discourse. Too little research is unfortunately still available for other comparable countries. From recent scholarships on Belgium and Germany we know at least that the clientele of magic and religious healers was, and is, vast and included, and includes, users from the better-off strata of society.[13]

Further on, one must keep in mind that in the – specific – German case phytotherapy, Anthroposophic Medicine and Homeopathy have been recognized specialisations of physicians for a long time.[14] Over the last 30 years the demand for complementary and alternative medicine and for homeopathy has been continuously growing in all of Europe, whether one considers the number of physicians with this specialisation or the quantity of medications sold in pharmacies.[15] Whether all this is "traditional", "modern", "post-modern" or a sign of "second or reflexive modernity" might be a topic of academic debate, but it shows that the dominance of biomedicine was never complete. It may be a question of a larger or a smaller market share, but to better understand the significance and the importance of this proportion was one of the aims of the conference that gave rise to this volume.[16]

It is even possible that the growing demand of patients for "Traditional Chinese Medicine", acupuncture and, more recently, Ayurveda in many European countries or in the Americas is just another phase of this long-term "underground" medical pluralism, which is just beginning to come to public attention. The best evidence for this visibility is a national referendum of the Swiss people which decided in 2009 with a majority of two thirds of the population to include the support of alternative and complementary systems of medicine in their national constitution!

To finally move from the Eurocentric view to India, one certainly needs to start by calling attention to the enormous internal diversity of that country and its effects on the medical market.[17] What is even more important in this con-

12 Mildenberger (2011).

13 Schmitz: Médecines (2006); Schmitz: Soigner (2006).

14 For basic information on the German legal and institutional framework for medical pluralism see Walach (2012).

15 Dinges (2014); Dinges (2012).

16 Report at http://www.igm-bosch.de/content/language1/html/11643.asp (last accessed on April 30, 2013). The participants of this conference came from India and Germany, Brazil, the US and Belgium and had very different disciplinary backgrounds – they were physicians, scholars from anthropology, public health, medical and social history and the history of science.

17 English-language literature on the subject is vast and better known to the English-language reader, some of it is cited in Dinges: Versorgungsbeitrag (2011); Dinges: Patienten-

text is the kind of medical pluralism that seems to be quite different from what has been presented so far with regard to Germany and Europe: First of all, "modern medicine" has still a more particular prestige, as only a minority of the population has access to it and can afford it. This distinctive character of biomedicine might be a driving force in fostering the demand for it among the entire population. In this first perspective, the good image of biomedicine might even disadvantage "traditional systems of medicine". On the other hand, biomedicine encountered and may still encounter specific barriers – beyond the already mentioned economic threshold and the simple lack of allopathic healthcare providers in large parts of the country and in the less well-off neighbourhoods, one needs to consider the cultural barriers. One such barrier has to do with difficulties some patients have when they seek treatment in public institutions, because they worry about impurity if members of a lower caste are also attending.

Another distinctive element in many Asian countries such as India is a continuous and more evident tradition of medical pluralism.[18] This is in part a result of prevailing local traditions of rural or tribal medicine. Both are often transferred to the cities by migrants. On the other hand, the Indian medical pluralism is an effect of the history of long-distance immigration. Unani medicine is a good example: it originated as a result of the Islamic appropriation of Greek ("Ionian") medicine, transferred centuries later in a readapted form to South Asia where it was again modified. It continues to be linked to the Muslim community but tends to spread beyond these limits. Ayurveda has certain connections to Hinduism – some, in old Brahmin texts, are real, others are imagined and reinvented. Since the 19th century there have been nationalists who have tried to exploit this fact for political purposes.[19] Medical systems might certainly play a role in the identity building of religious communities, a fact that can contribute to stabilize medical pluralism.

The colonial period added "modern western medicine", which was – quite significantly – called "English (or Angrezi) medicine", to the existing traditional medical pluralism. "Scientific medicine" was appropriated in various ways by the people of the colonies. For a long time the impact of Western medicine was largely limited to the cities. As a reaction to the colonial influences and pressures, Ayurveda had to define its own genealogy, orthodoxy and canon and continues to do so as it keeps reinventing its history.[20] Comparable developments can be observed for Unani medicine.[21] The various medical systems are now under the umbrella of the administrative department of

präferenzen (2011), p. 122, literature referring more directly to medical pluralism is cited below.

18 Studied since the 1970s first by Leslie (1976); on his pioneering role see Pfleiderer (1995), pp. 87, 90, and more recently Johannessen (2006), p. 3.

19 Sivaramakrishnan (2006), p. 242; on these inventions of tradition also for TCM Ernst (2002), pp. 6, 8; on the case of Sri Lanka see Jones (2009).

20 Cf. Wujastyk/Smith (2008).

21 Bode (2008); Liebeskind (2002).

AYUSH (an acronym for Ayurveda, Yoga and Naturopathy, Unani, Siddha, Homeopathy), which is part of the Indian ministry of health and family welfare. This selection of medical systems, their clear cut delimitation and the exclusion of other "traditional systems" is to a large extent a long term effect of the professionalization and biomedicalization that first gained momentum around 1900.[22] Given the particular regional, tribal, communal and social fragmentation of the Indian society and its corresponding medical market with very uneven chances of access, medical pluralism continues to have a more important impact in this country than in postindustrial societies such as Germany.

Some authors have even strongly criticized the idea of medical pluralism and suggested to introduce the concept of a "forced medical pluralism": They refer to the fact that Western biomedicine is unaffordable for large social strata in poorer countries.[23] As a consequence, less well-off citizens in these countries are simply obliged to use cheaper forms of medicine. This applies to the medical system used – such as folk-medicine or religious healing (which is, by the way, not necessarily and generally cheap) – as for the type of provider, who is often non-academically trained or simply entirely self-educated. To employ the friendly sounding term "medical pluralism" for this situation of deficient healthcare provision would contribute to dissimulate the social inequalities in access to medical services. From this point of view, the WHO with its recent interest in "traditional medical systems" would simply participate in a neoliberal attempt to add euphemism to social injustice. One implicit assumption of this criticism of the WHO is that "alternative" forms of medicine are less efficient than biomedicine. This assumption is – in such a general way – definitely not true. This idea of the general superiority of biomedicine might be just another Eurocentric bias in this debate.

Nevertheless, the socio-economic core of this criticism needs to be taken seriously. It must be remembered that "pluralism" in the Western intellectual tradition is a term which was coined against privilege, especially the privileges of noblemen. The concept is linked to the bourgeois critique of absolutism and suggests the fundamentally liberal idea of equal chances of access to wealth and happiness. The term "medical pluralism" keeps this normative egalitarian connotation, which always resonates when used against the monopolistic claims of biomedicine. Using the concept of "medical pluralism" implicates heuristically the challenge to conceive at least the normative idea of an equal access to medical care – which in fact does not exist.

This difference between the potentialities and the given reality exists even in national healthcare schemes based on statutory health insurance for literally everybody, as they exist in Germany or, in a different way, in the British National Health System. It is less evident in India. This concerns not only the access to health services but also the quality of these services: if one considers, for instance, the structure of the local medical market in an urban agglomera-

22 Wujastyk/Smith (2008), p. 7; Liebeskind (2002); Pahari (2005); Sivaramakrishnan (2006).
23 A good overview of the recent debate is given by Sheehan (2009).

tion such as Delhi, the qualification of the same kind of providers – private physicians, physicians in PHC, Registered Medical Practitioners – is significantly better in well-off neighbourhoods than in the poorer ones, as recent research has convincingly demonstrated.[24]

We have so far focused on the level of systems which allowed us to make the point about the limitative and productive impact that internal and external political power can exert on medical pluralism in given societies. Some effects of the social inequalities with the possible use of the pluralistic medical offer have come to the surface. The differentiated role of the administrative and institutional framework of medical pluralism was also addressed. The acknowledgement of the somewhat euphemistic connotation of the term "medical pluralism" may be used to critically indicate that it is better not to expect salvation from the market or overestimate its capacity to automatically bring about a more equal access to healthcare.

At any rate, these implications should not encourage us to reject the concept lock, stock and barrel.

But it reminds us not to fall into the trap of a casual culturalism, when focusing on the interactive and cultural aspects which are also part of the concept of medical pluralism. From the 1970s onwards, these aspects have often been the main focus of research in medical anthropology and ethnology.[25] The patients' ideas of the body and of medicine and their attempts to make sense of it all were at the main focus.[26]

Homeopathy as part of Medical Pluralisms

A particular focus of this collection of essays is the specific position of homeopathy within the German and the Indian medical pluralisms. From its very beginnings at around 1800, this medical system has struggled to find recognition among "allopathic" physicians. This is not the place to enter into the epistemological, nosological, historical and other reasons for this. Suffice it to call to attention one socio-professional aspect that makes the ambivalent position of homeopathy particularly clear: homeopathy has in most countries been mainly, if not exclusively, provided by physicians. The fact that lay practitioners played a certain role added to the difficulties of recognition inside the community of physicians and allocated to homeopathy a marginal role within the medical system.

The debate on homeopathy is in actual fact quite heated again around the globe.[27] A key argument is the allegation that homeopathy is not evidence-based – despite a growing number of outcome-studies with quite differentiated

24 Das/Hammer (2007).
25 Dilger/Hadolt: Überlegungen (2010), p. 15.
26 Nichter (1980) is still very instructive.
27 This is more the case in the English speaking world than elsewhere, cf. Dinges (2014).

results about the efficiency of homeopathy in practice.[28] This current campaign must be seen in the context of the steadily rising demand for homeopathy by patients in Europe, the Americas and a number of Asian countries during the last generation. The counter-attack from supporters of biomedicine, sponsored by pharmaceutical companies, is certainly an expression of their fear to lose markets. Homeopaths reckon that the amount of money pharmaceutical companies would lose if homeopathy could propose an efficient treatment for diabetes would constitute a real financial disaster for them.

Apart from the particular success in the open medical market of the USA, mainly during the 19th century, the position of homeopathy was relatively favourable since its inception in Germany.[29] Homeopathy gained recognition from the board of physicians as a medical specialization in several stages, in 1928, 1937 and 1956. Homeopathic consultation is in fact paid for by the national health insurance scheme – as are medications as long as they are prepared as low potencies. The continuously growing demand over the last 30 years led to a historic peak in the number of homeopathic physicians: The more than 6,200 homeopaths of the first decade of the new millennium represent roughly 1.5% of all active physicians also in hospitals, research, and administration (342,000) and 5% of all physicians in private practice (124,000 in 2011).[30] This is more than the highest levels attained in Germany in 150 years. Between 1860 and the 1970s the proportion of homeopathic physicians was always between 0.6% and 1.2% of all physicians. Considering the ordinary activity of homeopathic physicians the best indicator of their role in German healthcare provision is the comparison with GPs. Here, the proportion of homeopaths was up to 16.2% in 2010, while it was only 5% in 1993.[31] In Germany one must add to this historically high number of physicians the lay practitioners offering homeopathic treatment. These lay practitioners called "Heilpraktiker" are licensed healthcare providers who have passed a medical exam, with physicians on the examination board. Their market share is very difficult to evaluate as they practise homeopathy beside other healing methods and patients' expenditure is – in general – not refunded by the national health

28 Most recent overview in Bornhöft/Matthiessen (2011).

29 On Germany: Dinges: Patienten (1996); on other countries: Dinges: Weltgeschichte (1996); Jütte/Risse (1998).

30 Data from http://www.gbe-bund.de (last accessed on April 30, 2013): "Bei den Ärztekammern registrierte Ärztinnen und Ärzte mit Gebiets- und Facharztbezeichnung (absolut, je 100.000 Einwohner und Einwohner je Arzt). Gliederungsmerkmale: Jahre, Region, Alter, Geschlecht, Gebiets-/Facharztbezeichnung, Tätigkeitsbereich".

31 1993: 317,737 (all physicians – active and not active); 44,075 GPs; 2,212 Homeopaths; corresponds to 0.7% of all and 5% of all GPs;
2007: 413,000 (all physicians – active and not active); 42,000 GPs; 6,268 Homeopaths; corresponds to 1.52% of all and 15.2% of all GPs;
2010: 439,090; 42,050 GPs; 6,809 Homeopaths, corresponds to 1.55% of all and 16.2% of all GPs.
Gesundheitsberichterstattung des Bundes, http://www.gbe-bund.de/, various websites (last accessed on April 30, 2013).

scheme.[32] Patients pay most of this expenditure out of their own pocket, something traditionally very uncommon to Germans as they have been used to a comprehensive insurance for more than a century. The fact that the sub-profession of *Heilpraktiker* nevertheless flourishes is therefore a strong indicator of patients' demand – and for some of the patients of a declared distrust in physicians. On the whole, the entire homeopathic choice on offer in Germany – 16.2 % of the GPs and the *Heilpraktiker* together – is still a smaller proportion of the market share than in India.

In India, homoeopathy has been well received as the "other modern medicine" since the 1830s. In this volume Waisse revisits an early historical moment, presenting the Transsylvanian physician M. Honigberger as an observer of applied medical pluralism in Lahore (now Pakistan) during the 1840s. Despite a certain degree of socio-cultural prejudice against the local healing traditions which one must expect for that time, Honigberger praises the institutionalized freedom of choice of the patients who could attend traditional, Hindu and Unani healers in the same hospital. He was also ready to learn about the specific treatments and the materia medica of these other systems, which he appreciated on practical grounds to such an extent that he published a trilingual dictionary, contributing further to medical pluralism in the making.

Homeopathy gained momentum first in Bengal, from where it spread mainly in the Northeast.[33] The contributions of Das and Soman elaborate on this particular important development of homeopathy in Bengal which started during the later 19th century. Das considers the political and intellectual discourses and Soman focuses on lay healing in Bengal. Das calls the Bengal reception a "domestication" of the western category of 'homeopathy', which was based on its claims to indigeneity in the late nineteenth to early twentieth century. She remarks on the overlap of discussions on homeopathy and those on the nationalist reform of Indian families. Homeopathy came to be posited as an efficient disciplining mechanism to reform colonial domesticities – a remedy to cure the institution of 'family' from the corruptions inflicted by colonial rule on the pristine ways of Bengali life. Homeopathic science was even projected as a way of life, capable of producing the ideal family for the nation – a very particular "nostrification" of a medical system imported from abroad.

The contribution of Sharma shows a specific pattern of medical pluralism for the German Empire before World War I. During this period even the elites insisted on the important role of alternative systems and providers for various reasons – liberty of choice, science (!) and national identity – which shows that the hegemony of biomedicine was far from being established. This differs markedly from the contemporary situation, where biomedicine seems to have gained a hegemonic role at least when considering the results of three contributions to this volume on India: it is present in the diagnostic episteme of practitioners of Ayurveda, as Naraindas shows, as well as in the ideas about

32 According to Stange (2010), p. 40, in 2007, € 1 billion of practitioners' fees (of € 517 billion health expenditure) were reimbursed – and € 800 million for medication.

33 Poldas (2010).

research of the south Indian homeopath studied by Dusausoit or the daily practice of a homeopath prescribing allopathic drugs, studied by Barua.

Especially during the 1920s homeopathy spread all around the country. After independence it attained the most advanced state of recognition in India worldwide, being ultimately institutionalized as an integral part of the national health system in 1973. The Central Council of Homoeopathy and the Central Council of Research in Homoeopathy accredit the nearly 190 colleges and organize research in 30 publically funded institutes nationwide. In 2007, 15.4% of all physicians in India were homoeopaths. Growth seems to be very slow and their market share seems to have attained a certain threshold during the last generation, as, already in 1982, homeopaths represented 13.7% of all physicians.[34] Ayurveda with some 32.1% of all physicians had a faster path of institutionalization during the last 30 years. The fabulous market share of alternative medical systems amounts to more than 50% of all physicians including some minor systems such as Unani with 3.3%. The contribution of "complementary" systems to healthcare provision in general is probably even larger when one takes into account the non-academically trained healthcare providers for whom statistical evidence is missing.

Table 1: Number of Physicians in India (in 2007, in thousand)[35]

System	number	percentage
Allopathic	696	49.2
Ayurvedic	454	32.1
Homeopathic	218	15.4
Unani	46	3.3
Total	1,414	100

Beyond the market offer, legal frameworks are important for the patients' possibilities to choose. The Indian institutional setting is particularly interesting as a way to promote more equal chances for various medical systems and to give the patient equal access to this differentiated medical offer. Since 1973 the department of "Indian Medical Systems and Homeopathy" (IMS&H), under the umbrella of the Ministry of Health, keeps its own register of physicians, decides on training requirements, organizes research and accredits colleges. It is remarkable that homeopathy was integrated with the "Indian Medical Systems", which shows its intermediate position between traditional medicine and biomedicine, belonging somehow neither to the one nor to the other. At the same time this position is a sign of "nostrification" of homeopathy into the

34 Cf. Dinges (2008); the share of homeopaths for 2007 shown is slightly higher than in my earlier publications which were based on figures for allopaths from 2004 – at the time the latest available to me.

35 Human resources in health sector. In: National Health Profile (NHP) of India – 2007, p. 136, http://cbhidghs.nic.in/writereaddata/linkimages/Health%20Human%20Resources 4484269844.pdf (last accessed on April 30, 2013).

Indian medical context. In 2003 the name of this health administration department has changed to the more explicit acronym AYUSH (=Ayurveda, Yoga and Naturopathy, Unani Sidda, Homoeopathy). To my knowledge, such an institutionalisation of alternative medical systems is unique. In other countries the legal requirements for physicians of all systems are exactly the same and they are decided by a unified national body once and for all. This is also the case in Germany: practitioners first have to pass medical exams before they can specialize, for instance in internal medicine or balneology, homeopathy or surgery. In India, on the other hand, the systems have more freedom of decision, for example on whether to prescribe four or five years of medical training for physicians. They also have independent training institutions (medical colleges) for homeopathy, biomedicine, Ayurveda and so on.

Taking public funding into consideration it is evident that the department of AYUSH is not on a par with biomedicine: it receives nine times less research funds than the latter. This is in sharp contrast to the fact that only 49.2% of all physicians in India officially practise biomedicine. For a similar situation – the status of Ayurveda in comparison with biomedicine in Sri Lanka – Jones proposed the useful term "bounded pluralism" to express a formal but not real equality.[36] It is certainly evident that a realistic appreciation of health politics in the field of medical pluralism is only possible if the cash flow is taken into consideration. The relatively limited research of the various medical systems inside AYUSH is another cause as well as effect of inequalities – for the simple reason that some departments of AYUSH do not even spend all the funds allocated to them.

With this organisational structure in place, the various systems have, at least in principle, the chance to gain equality. The institutional potential for equality is even more evident when considering the importance of public institutions of primary healthcare in countries such as India and Brazil: in both countries, the public administration has many possibilities to act and to impose medical pluralism as long as it can recruit qualified personnel in sufficient numbers. Germany has no such system. Here, exclusively private GPs are sharing the market within certain boundaries set by the national health insurance scheme. GPs can choose to qualify as homoeopathic physicians (see above) and provide homeopathic care. Most homeopathic medications are not reimbursed by the health insurances in the general system, which covers around 90% of the population. Some of the private insurance companies covering the remaining 10% do reimburse these medications.

Looking at the question of equality inside the Indian system with regard to the preferences of physicians and lay healers a different picture presents itself: observing the daily practice and the aspirations of some "homeopathic" or "ayurvedic" physicians, Naraindas and Dusausoit argue in this volume that the attractiveness of biomedicine seems irresistible even to non-allopathic physicians. This leads to a kind of practice which combines elements of bio-

36 Jones (2009), p. 118.

medicine – or at least its diagnostic and nosological components – with elements of complementary medicine in an astonishing variety of ways. The result is a kind of hybrid medicine which is neither biomedical nor strictly homeopathic or Ayurvedic.

Another practical problem of medical pluralism in India seems to be patients' dissatisfaction with the practical functioning of the public health institutions. Naturally, this concerns representatives of all medical systems inside the public health infrastructure. Let me illustrate this with the outcome of German research into a Tamil Nadu rural district, Madukottai, recently published by Alex: in Madukottai, the low caste patients are prepared to use all systems of treatment without giving priority to either biomedicine, AYUSH-systems or other – from a quantitative point of view – even more important folk-systems such as magic or religious healing.[37] The health-seeking behaviour was illness-specific: in case of fever, people preferred private and government clinics, for problems with the bronchial tubes they preferred non-biomedical treatments.[38] In practice, 60 % used biomedicine, 26 % non-biomedical methods, 13 % self-medication (with no further specification).[39] All in all – an ideal starting point for medical pluralism. And what is more: physicians of all medical systems working inside the public health institutions are generally considered to be well trained, of good quality and in general even friendly or neutral. Four fifth of the 150 persons who were extensively interviewed shared these opinions. Nevertheless, 70 % of the same population prefer private practitioners: The two main reasons are

– the physical distance to Primary Health Care Units or hospitals,
– the long waiting lists and overcrowding of the institution.

These two critical points are again shared by four fifth of the respondents.[40] One must see these results in context with the different findings of Barua on Delhi slum dwellers, which provide a different set of dissatisfactions.[41] The point here is that one should differentiate between the potential of the impressive Indian institutional setting and its practical achievements as long as it is considered by many locals as so little satisfactory. Below the level of institutions, medical pluralism seems to function perfectly in Madukottai on the patients' side. They use all sorts of (traditional) healers, local private practitioners, OTC-medicines, the private homeopathic physician or any other means of helping themselves.

37 Alex (2010), pp. 167–168, 295.
38 Alex (2010), p. 302.
39 Alex (2010), p. 275–276.
40 Alex (2010), p. 278–279.
41 Such as bureaucratic paper work before treatment, non-gentle treatment of poorer patients and bribes, to name just a few.

Patients' Preferences and Physicians' Practices

This is the moment to look more closely at practices as the main focus of this volume. The first focus is on the health-seeking behaviour of patients in countries like India as it has been highlighted in medical anthropology. According to recent scholarship one can attempt to reconstruct the "pragmatic patients'" list of motivations:[42]

- most important of all is the local offer of health services and their accessibility;
- second in line is the medical success of a healer or a group of healers;
- in third place are the sort of actual symptoms and their seriousness, which seem to have priority over preferences for medical systems or even for specific healers;[43]
- fourthly, the potential further serious social effects of the illness on the personal network of the ill person is considered;
- fifthly, the explanatory model of medical systems seems to play a minor role for the patients – it might be slightly more important for upper class patients in India and in Germany because of a greater possibility of deliberate choice;[44]
- social norms and social relations on the basis of ethnic backgrounds may be important under certain circumstances;
- habitual user patterns which may be linked to specific family traditions may also have an impact.[45]

This – not exhaustive – list from research exclusively about Asia provides a few interesting points of comparison between the German and the Indian situation.

The actual demand of patients for complementary and alternative medicines (CAM) in Germany is known due to market research, representative polls and in-depth studies. The main outcomes of recent surveys are the following:[46] it is unfortunately not possible on the basis of this evidence to propose a strict ranking beyond the first two reasons for choice of patients.

In Germany, the patients' demand for CAM is

- first of all driven by dissatisfaction with former biomedical treatment, a frustration which plays a crucial role in the rising demand for CAM,
- the assumption that CAM-methods have little side effects, an idea which plays also an important role in India and many other countries[47],

42 This is based on the most recent review of literature by Alex (2010), p. 78, and complemented with further readings; cf. Bourdier (1996), pp. 447–448.
43 Alex (2010), p. 288, which gives in detail the bibliography for each argument.
44 Cf. Dinges (2002), p. 18.
45 Alex (2010), p. 78.
46 Leonhard (1984); Günther/Römermann (2002); Köntopp (2004); Kahrs (2002); Stange (2010).
47 See the studies on India cited in Dinges: Patientenpräferenzen (2011) and on India and many other countries, Dinges (2012).