Ayurveda and Health Insurance- Status and Opportunity

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Introduction

At 4.2 per cent of GDP India has the lowest healthcare spend amongst BRICS countries, with the Government spending a mere 1.1 per cent of GDP.[1] Of India's total population of about 1.3 billion, around 950 million were covered under various health insurance schemes as of 2019.[2] Government schemes accounted for 630-650 million (Ayushman Bharat-PMJAY- 500 million and State schemes- 130-150 million). Other Government Group schemes such as ESIC, ECHS, CGHS covered another 150-180 million. Private insurance accounted for another 120 million.[3] Close to 400 million Above Poverty Line (APL) individuals by inference from the 1350 million Indian population are not covered currently under any scheme.[4]

Although, as inferred from data provided by the CII[5], 70 per cent of the population is covered under one or the other payer backed schemes, it is quite intriguing that out-of-pocket expenditure accounts for 64 per cent of total health expenditure.[6] This is attributed to the fragmentation of service provision and lower levels of risk pooling. Today, small health service providers perform more than 64 per cent of health service provision.[7] More than 98 per cent of all health service providers in the country have less than ten employees.[8] A fragmented provider market with unclear referral pathways, weak strategic purchasing, and weak or no regulatory/insurance oversight has made the provider-customer relationship transactional, with limited accountability for continuity of care and improved

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outcomes over time, resulting in delayed care and unnecessary expenditures, with sub-optional overall outcomes.[9]

This article attempts to provide an overview of healthcare funding with reference to existing healthcare challenges. It highlights the need, scope, and significance of Ayurveda coverage within the larger payer-backed healthcare system in India and suggests the way forward to realise the full potential of Ayurveda as a mainstream, payer-backed, system of medicine within the pluralistic, universal health coverage paradigm that is envisioned by Indian health policymakers.

India's Epidemiological Transition to Non-Communicable Diseases (NCDs)

There is an increase in the contribution of Non-Communicable Diseases (NCDs) from 30 per cent of the total disease burden, i.e. Disability-Adjusted Life Years (DALYs) in 1990 to 55 per cent in 2016 and also an increase in the proportion of deaths due to NCDs (among all deaths) from 38 per cent in 1990 to 62 per cent in 2016.[10] This shows a rapid epidemiological transition with a shift in disease burden to NCDs.[11] cardiovascular diseases, cancers, chronic respiratory diseases, diabetes, and other NCDs are estimated to account for 61.8 per cent of all deaths in India, making them the leading cause of death, ahead of injuries and communicable, maternal, prenatal, and nutritional conditions.[12] Furthermore, NCDs account for about 40 per cent of all hospital stays and roughly 35 per cent of all recorded outpatient visits.[13] India stands to lose $4.58 trillion before 2030 due to NCDs and mental health conditions. Cardiovascular diseases, accounting for $2.17 trillion, and mental health conditions ($1.03 trillion), will lead the way in economic loss.[14] Notwithstanding, the entire focus of the private healthcare sector continues to be on tertiary-quaternary care. Unfortunately, the Government's own flagship programme, Ayushman Bharat-PMJAY also primarily focuses on acute-emergency care and pays scant attention to the treatment of NCDs unless they have evolved to an acute presentation.

This as we continue to contend with Maternal, New-born and Child Health (MNCH) related morbidity and mortality, particularly among the poor, and the burden of infectious diseases. The current Government strategy to roll out 150,000 Wellness Centres across the country to focus on preventive and promotive health interventions, vaccination, contraception, safe delivery, nutritional interventions, infectious disease control, sanitation, clean air and water and health education among others[15] to some extent addresses this lacuna. To tackle the middle belly of NCDs the Ministry of Health and Family Welfare (MoH&FW), GOI has implemented the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular disease and Stroke (NPCDCS) with the objective to increase awareness on risk factors, to set up infrastructure (like NCD clinics, cardiac care units) and to carry out opportunistic screening at primary health care levels. Integration of NPCDCS with the National Health Mission (NHM) resulted in augmented infrastructure and human resources particularly in the form of frontline workers, i.e. the ANM and the ASHA. With the active participation of these frontline workers, the population-

based periodic screening of hypertension, diabetes, and common cancers (oral, breast, cervical cancers) is initiated to facilitate the early detection of common NCDs. Prevention and management of chronic obstructive pulmonary disease (COPD) and chronic kidney disease (CKD); and better management of co-morbidities such as diabetes and tuberculosis are also considered under the programme.[16]

Integration of AYUSH with NPCDCS is a further step for promoting healthy lifestyle changes among the population. Health promotion through social media is also being used to generate awareness about prevention and control of NCDs, such as the use of mobile technology in applications called 'mDiabetes' for diabetes control, 'mCessation' to help for quit tobacco, and 'no more tension' as a support for mental stress management.[17] But, if these interventions are really working in arresting and reversing the trend is yet to be seen .

Emerging Definition of Preventive Healthcare

Over the years the concept of preventive healthcare has evolved significantly. However, preventive healthcare has been reduced to an undifferentiated, crude concept that is well intended but is rarely effective anywhere in the world and particularly in India. To attempt to move towards a more inclusive, accessible, affordable, and acceptable system of healthcare for all it is incumbent on policymakers to take into account the life cycle of disease and the different roles that disease prevention would seek to achieve

Figure 1

Source: Author's compilation.

at each stage of life and each stage of the disease. Figure 1 highlights levels of prevention in the spectrum of healthcare services that enables a fresh paradigm of healthcare- moving away from mere disease management to lifecycle health management at individual/community level.

Levels of prevention are mainly categorized as primal/primordial, primary, secondary, and tertiary prevention. Primal/Primordial prevention consists of actions to minimize future hazards to health and hence inhibits the establishment of factors that are known to increase the risk of disease. It addresses broad health determinants rather than preventing personal exposure to risk factors, which is the goal of primary prevention. A reductionist, one-size-fits-all approach by the Government has led to India having one of the highest prevalence of underweight/stunted children apart from extremely high maternal and child mortality rates.

Primary prevention seeks to prevent the onset of specific diseases via risk reduction by altering behaviours or exposures that can lead to disease or by enhancing resistance to the effects of exposure to a disease agent. Better sanitation, access to clean air-water, disinfection, vaccination, meeting primary nutritional needs, etc. fall into this category of prevention. Further, in the modern-day context, annual medical check-ups, periodic testing of one's biomarkers to identify emerging risk factors is a ritual that is taken quite casually by almost all concerned. Thus, for all practical purposes, from the common man to the serious healthcare sector investor to the policymaker preventive healthcare is reduced to optional, periodic rituals that are limited in intent. Further, the role of appropriate diet-lifestyle keeping in mind person-place-time is totally missing notwithstanding the sea change in dietary habits of all Indians.

Secondary prevention includes procedures that detect and treat preclinical to early-stage pathological changes and thereby control disease progression. Screening procedures are often the first step, leading to early interventions that are more cost-effective than intervening once symptoms appear. Unfortunately, the symptom(s) alleviation approach prevalent in conventional medicine ignores the root cause of disease and allows it to grow and spread and, in turn, leads to other systemic co-morbidities.

Once the disease has developed and has been treated in its acute clinical phase, tertiary prevention seeks to soften the impact caused by the disease on the patient's function, longevity, and quality of life. For reversible conditions, tertiary prevention shall reduce the population prevalence, whereas for incurable conditions it may increase the prevalence if it prolongs survival. While where the condition is not reversible, tertiary prevention focuses on rehabilitation, assisting the patient to accommodate to his disability.[18]

Interestingly, a new term 'Quaternary Prevention' has emerged[19]: as "action taken to identify the patient at risk of over-medicalization, to protect him from new medical invasion, and to suggest him interventions ethically acceptable." The concept of quaternary prevention makes it easier to "identify patient at risk of over-medicalization. Quaternary prevention has become an essential component of

the prevention concept and it should be applied as a prevention tool in the current scenario in many disease conditions, pertaining to classical "*primum non nocere*" meaning "first, do no harm."

Promotive health is a collaborative, patient-centered process that promotes trust and recognizes patients' self-directed roles and responsibilities in maintaining health. Effective elements of this process may include educating and motivating patients regarding healthy lifestyle, helping patients by assessing their needs, preferences, and readiness for change and recommending appropriate preventive care measures[20]. Beyond the classical definition of tertiary prevention, promotive health should include restoration of positive health in convalescents, in elders, and for rehabilitation at physical-mental levels at any age with a focus on functional health at a whole person level, i.e. enabling the virtuous cycle of good health with good quality of sleep, appetite, metabolism, excretion, state of mind, and vitality- the positive definition of good health as opposed to the mere absence of disease symptoms, in accordance with the ancient, classical definition of a healthy person in Ayurveda.

It is appropriate in the context of the current pandemic to reiterate the critical role that Ayurveda can play in preventive and curative mental health interventions. Stress, anxiety is at an all-time high, not ignoring more severely debilitating mental health conditions. The holistic approach of Ayurveda is ideal in complementing modern medicine.

Ayurveda's evolving role in preventing, mitigating, treating, and rehabilitating COVID patients over the last one year has led to a huge public trust build-up in the system nationwide. This should be cautiously and prudently leveraged with evidence-based products and services for not only COVID but also other Communicable Diseases such as Dengue, TB, etc. that are widely prevalent in the country.

Thus, in developing a public health strategy and an insurance coverage strategy the exclusive focus on management of the acute-emergency stage of disease, and cosmetic focus on primordial and primary prevention, repudiating the finer aspects of life-cycle health assurance- from cradle to grave - is a serious omission that has serious consequences at socio-economic-political levels. This is precisely where Ayurveda has a significant, breakthrough role to play.

Public Healthcare Insurance Schemes in India

Rashtriya Swasthya Bima Yojana (RSBY) and Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY)

The Rashtriya Swasthya Bima Yojana (RSBY), launched on 1 April 2008, was the flagship health insurance program for BPL patients managed by the Ministry of Labour & Employment. The coverage for hospitalization expenses was up to Rs. 30,000/- for a family of five on a floater basis. Transportation charges were also covered up to a maximum of Rs. 1,000/- with Rs. 100/- per visit. At its peak, it covered 36 million families or about 180 million individuals[21]. In 2013, the scheme for the 1st time included Ayurveda treatments under the scope of coverage but restricted it to Government Ayurveda hospitals and medical college hospitals. Practically, this restricted inclusion did not make any significant difference to

the adoption of Ayurveda by the masses since both- service providers and patients- were relatively unaware of this inclusion. Further, with cross-referral from one system of medicine to another, particularly from conventional to Ayurveda, being virtually non-existent in the public health domain, this policy change was effectively stillborn.

The RSBY scheme was dormant for a couple of years and was subsequently subsumed into the Ayushman Bharat-PMJAY scheme in 2018. However, Ayurveda has not been included till date in the scope of coverage of the scheme. In mid-2020, the National Health Authority in conjunction with the Ministry of AYUSH, Government of India, has initiated steps to explore andevaluate the inclusion of Ayurveda/AYUSH systems of medicine under the AB-PMJAY program.

Other Payer Backed Programs (CGHS/ SGHS)

The Central Government Health Services (CGHS) scheme provides free healthcare to the entire base of Central Government and their employees situated across India for which a specific empanelment process exists with a uniform, pre-notified tariff structure for services availed. In 2008 after a tender process the tariff structure was fixed based on a L1 (lowest) quote basis which turned out to be a non-serious quote at about 15 per cent of the actual cost of service provision leading to virtually no Ayurveda hospital seeking empanelment[22]. Effective October 2015, after a fresh tender was called for from AYUSH hospitals that were technically pre-certified by NABH[23], a new set of rates was announced and 21 Ayurveda and five Yoga & Naturopathy Hospitals were empaneled by CGHS[24]. An egregious anomaly in the current CGHS tariff structure is that the room rates for Ayurveda hospitals remain unchanged from rates applicable in 2008[25], although the rates have since more than doubled for equivalent category rooms in Allopathy hospitals- a clear, discriminatory step against the AYUSH sector.

Only by exception, with highly restrictive tariffs, do some State Governments cover Ayurveda treatments for their employees and their families. The Railways and the Indian Armed Forces have initiated some pilot projects to evaluate the provision of Ayurveda/ AYUSH medical care in some of their nodal facilities. Comprehensive Ayurveda medical care with full-scale Panchakarma treatments on an in-patient basis may be absent at most if not all facilities. It must be said that there has been considerable progress in opening up different closed health systems to Ayurveda over the last 6 years consequent to a determined effort from the independent Ministry of AYUSH set up in 2014. Some of the Public Sector Units have visiting Ayurveda/AYUSH doctors but with a limited scope of service.

It must be appreciated that unless the payer backed healthcare system opens up fully to Ayurveda medical care the scope for the Ayurveda sector to scale will be limited.

Scope of Ayurveda Medical Care

Multiple studies[26] have reported that a significant majority of deaths in India are on account of chronic diseases- systemic diseases such as heart disease, cancer, COPD, diabetes, etc. Disability is also caused by a large prevalence of muscle-bone-joint disorders and mental disorders. Chronic diseases (CDs- diseases that subsist

in an individual for at least 3 months) more often than not precedes or succeeds the need for tertiary-quaternary care. Non-Communicable Diseases (NCDs) often are also CDs. Modern medicine is almost entirely focused on symptom suppression/ alleviation. Ayurveda, on the other hand, posits an aetio-pathogenesis framework, at a whole person level, that enables root-cause diagnosis and targeted therapeutic framework encompassing personalised, diet-lifestyle-medicine-therapy 'black-box' prescription that, as per Ayurveda science, seeks to reverse the pathogenesis right up to the aetiology to attain true disease reversal and to establish sustained wellbeing. At established, mature Ayurveda hospitals across the country, one can see this black-box therapeutic approach delivering exceptional health outcomes arising from the reversal of the aetio-pathogenesis.

Ayurveda's aetio-pathogenesis reversal strategy is rare and possibly unique amongst the medical systems of the world. Being the oldest system of medicine in the world, with time-tested proof of safety and efficacy and an uninterrupted record of practice for about 3 millennia, it is sad that today a patronising attitude towards Ayurveda prevails amongst many policymakers in the country of its origin without in the least taking the effort to understand the highly evolved, 'systems thinking', 'many causes-many effects' approach of Ayurveda in stark contrast to the predominantly reductionist 'single cause-single effect' symptom suppression/ alleviation approach of modern medicine.

The strategy to tackle NCDs/ CDs must be to focus on primordial/ primary/secondary/ tertiary/quaternary prevention and promotive health rather than solely invest in capacity for tertiary-quaternary care (surgical/emergency care). This lopsided policy framework and budgetary provision at central and state government levels, compounded by a health insurance sector that focuses almost entirely on the surgical/ emergency care aspects has deprived the policy holder of access to effective, root cause Ayurveda treatments that are less harmful in collateral side-effects, and go beyond disease to whole-person positive health and wellbeing.

Current Status of Ayurveda Coverage in Indian Health Insurance

In October 2015 after a gap of approximately seven years the IRDA encouraged Insurance companies to extend the benefit of 'cashless' Ayurveda treatments to Quality Council of India/NABH accredited hospitals as well as at medical college hospitals. Subsequently, in 2016, the Ministry of AYUSH in discussion with the insurance sector notified benchmark rates for various therapies/intervention, along with guidelines for insurance coverage and claims settlement[9]. However, the implementation of this order was largely been kept in abeyance by different insurance companies.

The four PSU Insurance companies had subsequently developed their own PPN (Preferred Provider Network) consisting of Allopathy hospitals who had agreed to an exclusive tariff framework. This PPN tariff was applicable for the top 10 cities in India. Since there is no PPN Ayurveda tariff announced PSU Insurance companies deny cashless Ayurveda treatments to their policyholders in the top 10 cities: a clear case of apathy, if not discrimination, against Ayurveda and

against the best interests of their own customers. In 2019 IRDA has redefined AYUSH Hospital as having at least five inpatient beds, with a full time AYUSH doctor, and with dedicated therapy sections- essentially opening the gates for small AYUSH hospitals to enter the insurance network[27]. Once again, while the notification has been issued, in reality, insurance companies have not heeded this government notification.

Further, significantly, on 1st January 2020, the IRDA notified 'Guidelines on Standard Health Insurance Product[28]' wherein the foundational, base terms and conditions applicable to all new health insurance products to be launched by different health insurance companies have, at the least, to offer this minimum scope of coverage, and which minimum scope includes by default coverage for Ayurveda and other systems of AYUSH fully, without sub-limits, up to the full policy coverage amount. This is a breakthrough stipulation and starting October 2020 new health insurance products to be approved by IRDA shall mandatorily have this benefit.

Many private insurance companies such as HDFC Life, Max Bupa, Star, Future Generale, etc. cover Ayurveda care with varying levels of restrictions- from none to drastic sub-limits and limiting clauses.

OPD Cover

OPD or Out-patient Department Cover is a relatively new feature offered as a novel value add by several private health insurance players as a differentiated offering that includes coverage for doctor's general consultation, pharmacy bills, health check-ups, diagnostic tests, etc. Often a flat rate is paid by the insurance company to the empanelled doctor covering consultation and medicines.

The OPD feature is a strategic move by companies to detect early the policyholders at higher health risk and in turn higher risk of needing hospitalization in the near to medium term. The relative depletion of General Practitioners makes this model difficult to scale. Further, there are clear risks of fraud- by policyholders or service providers. Technology is seen as the way out to authenticate transactions and to ensure an audit trail that prevents fraud. The cost of such technology upgradation, maintenance has to be weighed against potential benefits in attracting more customers and lower average claims.

AYUSH systems of medicine offer an affordable, accessible, and acceptable mode for OPD healthcare. While modern medicine doctors gravitate to specialities a large number of graduate AYUSH doctors may invest in their own clinic-pharmacy outlets that take care of symptom alleviation, patient triaging-referrals. A true patient-centric care model can be created with personalised diet-lifestyle-medicine prescriptions. This is a model that is waiting to happen at scale across the country with one or more organised players coming in and setting up large chains of branded clinics with standardised protocols, billing systems, training, etc. However, insurance companies may not be willing to entirely foot the bill for building this AYUSH service category and the Government of India must engage with the insurance sector to work out a model that is large scale and benefits all stakeholders. Further, Government may be called upon to commit its resources to and to invest in building the AYUSH physician/clinic national network required to service the load.

Recently, CGHS has on a pilot basis permitted Ayurveda OPD treatments in Delhi NCR region for a period of one year.[29] This is a positive step for the AYUSH sector.

International Health Insurance

Several foreign countries offer universal health coverage, with no restriction on the choice of medical system, for every citizen/resident. UAE is a case in point. On the other hand, in Maldives, an adjoining SAARC nation, UHC exists with patients able to come to India for tertiary-quaternary medical care, but the scheme does not currently include Ayurveda. Also, multi-lateral, global organisations (under the United Nations, e.g.) offer medical coverage without restriction. International Health Insurance covered patients offer an excellent opportunity for Indian Ayurveda medical care providers- to tie up with overseas Insurance companies and TPAs (Third Party Administrators) for 'cashless' or reimbursable Ayurveda medical care. This can be a precursor to setting up full-fledged Ayurveda hospitals in select overseas geographies.

Opportunities for Ayurveda

The National Health Policy 2017 posits a pluralistic, integrated health system for India that is visionary in approaching the major health issues that our nation faces today. In practice, however, this integration continues to elude implementation. The issue of fragmentation of healthcare delivery with the private sector playing a major role has been a major barrier. In the Government-run public health system cross-referrals between systems of medicine is largely absent.

The opportunity for Ayurveda lies in offering a mainstream treatment option for approximately 2/3rd of healthcare demand, i.e. as primary treatment (secondary, tertiary, quaternary prevention) for NCDs/CDs, and as complementary treatment (primordial and primary prevention) for fundamental disease prevention. Districts/communities that have a long history of malnutrition may be targeted with an Ayurveda based local strategy that is consistent with age-old practices and customs of the community geography.

With over 25,000 Ayurveda doctors graduating each year and over 4,000 post-graduates in multiple medical specialities qualifying each year, adding to an existing base of an estimated 400,000 Ayurveda doctors[30], doctor scarcity will not be an issue particularly in manning the large number of Wellness Centres (150,000) planned to be rolled out across the country offering primary care that triages-escalates, is predominantly Ayurveda based but leverages modern medicine for management of acute symptoms. Integrated medicine is possible at the Primary Healthcare level leveraging mutual strengths of the two major systems of medicine in India, in the best interests of patients. Thereafter, at higher levels of care, depending on the disease, co-morbidities, severity, and optimal line of management, the patient may be referred to either an Ayurveda or Allopathy tertiary-quaternary care facility.

India can show the way to the world in a cost-effective, just, equitable, gentle healthcare system that is in the best interests of the common man-woman-child, from cradle to grave, from disease reversal to sustained wellbeing.

The Way Forward

Several initiatives can be taken towards building an effective and resilient insurance programme in Ayurveda:

- AB-PMJAY must include Ayurveda hospitalised medical care for secondary and tertiary prevention of diseases. This will accelerate Ayurveda hospital capacity creation in the private sector as also enable Government hospitals and medical college hospitals to upgrade the quality of services. Further, the maturity of the entire Ayurveda sector (products and services) will leapfrog with this one enabling step. This will be a great win-win because it will have a significant impact on DALYs, and on the total cost of healthcare in the country enabling a continuum of care from primary to quaternary care that is pluralistic and in the best interests of the citizen.
- The Ministry of AYUSH must intimate the GIC Council to take corrective steps forthwith to direct the 4 PSU insurance companies to fix and announce PPN rates for Ayurveda hospitalized care.
- CGHS must revise its room rates for Ayurveda hospitals and make it identical on an on-going basis to that applicable for a given room category (private/semi-private/ward) in Allopathy hospitals, in the same geography.
- In this case too, the Ministry of AYUSH must intimate the CGHS administrators to take corrective steps forthwith.
- In general, it would be fair to say that while several progressive policy measures have been announced in recent years by the Ministry of AYUSH and IRDA, in reality, insurance companies have been relatively indifferent to implementing the same.
- Decision makers amongst different players in the health insurance sector-insurance companies, brokers, TPAs, regulator, MoH&FW, NHA- need to be oriented to authentic Ayurveda *chikitsa* (medical management) at established Ayurveda hospitals across the country. Direct, in-person, perception of *chikitsa* in action and interaction with a cross section of patients by this set of insurance sector leaders alone shall enable right perception and understanding leading to implementation of policies in letter and spirit. The Ministry of AYUSH should enable this process of orientation/interaction and premier Ayurveda hospitals in the government and private sector to play their part in transformation of prevalent stereotypical mind-sets about Ayurveda.
- Three diseases where elective surgery is the prevalent choice (OA-Knees, Sciatica on account of IVDP, Cervical Spondylosis, for e.g.) may be taken up for a robust, longitudinal, comparative study on cost versus benefit (objective clinical outcomes in addition to quality-of-life parameters) on a short- and medium-term bases. This study is expected to reveal the significant reduction in pay-outs for Payers with significantly happier patients on a sustained basis, i.e. to establish the socio-economic benefit rather than trying to prove the mechanism of action or building evidence for Ayurveda which may be a secondary objective or may demand targeted research for this specific purpose. If the Ministry of AYUSH were to take the

initiative the insurance companies are likely to welcome and partner in this longitudinal compilation of data that is in the best interests of all stakeholders- most importantly, the patient.

- A public awareness campaign must be initiated by the Government to educate the general public, the insurance sector, and medical professionals from other systems of medicine on the true and complete scope of Ayurveda medical care- of Ayurveda as *'chikitsa'* or medical/health management system that diagnoses and treats the root cause of disease, at whole person level, for disease reversal and sustained wellbeing.
- Ministry of AYUSH must engage with the insurance sector to open up Ayurveda/AYUSH OPD insurance coverage. It is likely that insurance industry shall expect the government to share the cost of building the clinic network, development of standard protocols, training, and finally to build awareness of the insurance product and its benefits. This could be a great win-win for all stakeholders.
- An Ayurveda based Nutrition-Primary Health-Wellbeing strategy must be tested and validated in the most vulnerable communities-districts. The proposed 12,500 exclusive AYUSH Wellness Centres that are currently under rollout must be used to demonstrate a new paradigm of community health at the grassroots level. This implies that the Vision, Objectives, Key Performance Measures must be defined in advance and adequately resourced-supported.

Conclusion

Ayurveda is the potent *Brahmastra* weapon that India is fortunate to have. For India to meet its health goals, including the UN SDG 3.0 overarching goal by 2030, i.e. 'To ensure healthy lives and promote wellbeing for all at all ages' Ayurveda (and Yoga) is mandatory to be mainstreamed and leveraged. All healthcare stakeholders must not lose this opportunity due to short-sightedness or arrogance. Policymakers need to go beyond shibboleths and take concrete steps to leverage the potential of Ayurveda with a well-considered strategic plan. Ayurveda's time has come. All stakeholders must work together with an open mind in the best interests of the Indian citizen.

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