The Employees State Insurance scheme aims at rendering medical services to workers in mechanised industries with income of Rs. 300/- or less per month through medical practitioners employed under the scheme. A medical record envelope is issued for each insured person for recording and follow-up of sickness, and for medical treatment, the total number of envelopes representing the number of insured persons in the list of the panel practitioners.

These records of sickness and corresponding medical services rendered to the insured persons, properly maintained, would serve as a very important and fruitful source for a scientific study of the morbidity among the industrial workers and also for developing the plan for controlling the morbidity as far as practicable from amongst the industrial workers. The Government as well as the industrialists particularly in the developing countries should be equally and keenly interested in the improvement of national wealth through industrial development. Such a study needs a careful rearrangement and grouping of the records to permit statistical analysis of the different diseases and their nature and also for correlating morbidity with various characteristics like age, sex, industry, occupation, season, etc. The morbidity records of about 100,000 industrial employees in continuous employment were available in the lists maintained by 312 panel medical practitioners. As it was not possible to handle the total data critically for statistical analysis particularly in the absence of arrangement for medical processing of the data, the following procedure of study was adopted. Out of the total
volume of records a sample size of 2.3 per cent of the groups representing the major characteristics of sicknesses was taken up keeping the samples as homogeneous as possible. Again, as the industries are extremely variable in size, the population was sampled panelline rather than industry-wise. In order to do this, seven panels of insurance medical practitioners were selected out of the total number of panels by stratified randomisation. For determination of population at risk, only population who were exposed throughout consecutive 12 months of 1959 were taken into consideration for this study.

The selected data obtained from the E.S.I. follow up cards presenting demographic features, unspecified occupation, seasonal onset, cause of sickness and its various characteristic features (i.e. nature, volume and intensity) and type of medical services and benefits, were transferred to 2335 printed card schedules. These were edited carefully and then sorted and tabulated for statistical analysis.

In order to study the sickness and to correlate it with the above stated factors, some indices have been framed in the methodology for statistical analysis. The indices are (1) annual sickness rate, (2) annual patient consulting rate, (3) specific sickness rate classified by cause, (4) age specific morbidity, (5) seasonal sickness rate, (6) occupational sickness rate classified by cause and industries, (7) sickness rate and average sick days per sickness, (8) medical consultation rate classified by cause, average consultation per sickness, per practice population, per 100 sick days, (9) referrals in percentage, classified by cause, and (10) average certificate rate per 1000 sickness and per 1000 sick persons.
The ratings were framed in order to give precise information about the different dimensions of morbidity like, volume, intensity, distribution, duration of sickness and its variations due to age, occupation and season as well as volume and nature of medical service in the form of referrals and certifications. Statistical tabulations were made on demographic features, nature and type of sickness and their distribution by single, two-ray and cross tabulations for analysis of data and the results of analysis are presented in Tables I to XIX.

The observed demographic features were studied on age, sex, marital status and on industry. The percentage composition of insured persons based on demographic features was 23.5 per cent below 25 years age group, 26.4 per cent 25-39 years, 16 per cent 40-44 years, and the residual 18 per cent include last five age groups; 68 per cent were males and 2 per cent females; 68 per cent were married and 34 per cent single and 3 per cent widowed. Regarding occupation 54.6 per cent of the male population were workers in Metallic, Mineral and Engineering Industries and the rest 45.4 per cent were almost evenly distributed among eight other groups of industries. The correlation of sickness and demographic features has been presented in the section of sickness variations due to age groups and the results fully discussed there.

The next important and primary consideration has been given to sickness, its volume, nature and intensity in order of prevalence. The analyses on the basis of groups of diseases or causes and also on the basis of specific diseases yield the following results: It has been found that 73.7 per cent of the insured persons recorded 5532 sicknesses during the period under study showing the annual sickness rate of 2364 sicknesses as per 1000 insured persons and the annual patient consultation
The result shows high rate of sickness among Indian industrial workers in general compared to similar population in European countries. Such a high rate of sickness is extremely injurious to the industries and hence of the national upbringing due to absenteeism prevalent among the industrial workers. This problem is of acute nature and demands immediate careful National Health Planning so that the morbidity index might be reasonably lowered leading to the promotion of national welfare. The pattern of sickness incidence of selected groups of diseases is much more revealing to indicate what should be the immediate plans to guard against the most prevalent causes of morbidity amongst the industrial workers.

The disease pattern of morbidity was as follows: 26 per cent of the total sickness with an annual rate of 611.4 per 1000 persons are attributed to diseases of the respiratory system. It stands most prevalent among the fourteen groups of diseases.

The variations in the intensity of individual ailments in this group was as follows: The incidence rate of common cold (186.1), Bronchitis (186.1) and Influenza (186.1) were appreciably higher than other diseases within the group. This group of diseases was therefore the most important constituent of the morbidity conditions resulting in frequent absenteeism from duties and also disorganization towards proper discharge of duties.

Next in order of prevalence was the disease of the ill-defined group bearing 24 per cent of the total sickness with annual sickness rates 568 per 1000. The symptoms of diseases of the group represent ill health due to fever (191.0), symptoms referable to Respiratory
system (111.0), symptoms referable to Gastro-Intestinal system (33.1) and general debility (51.0). This form of morbidity is also a serious problem as it leads to a very high rate of absenteeism and disincorporation towards work. The ill-defined nature of diseases demands more precise methods of diagnosis so as to employ fruitful methods of treatment and subsequent regaining of normal health.

The third in order of prevalence were the diseases of the Digestive system representing 25 per cent of the total sickness with an annual rate of 344.2 per 1000 insured persons, mainly contributed by Diarrhoea and Intestinal (35.9) and disease of Dental and its supporting structure (59.9). This group of diseases causes an acutely morbid state amongst the patient studied resulting in high absenteeism and demanding maximum medical services. A little re-orientation in the methods of diagnosis and also in the application of more scientific medical services might bring about a great change in this form of morbidity and thereby may cause immense benefit to the industries as well as their employees.

Next in order of prevalence are the diseases of Infective and Parasitic group representing 13 per cent of the total sickness with an annual rate of 306.7 per 1000 insured persons. Within the group of the diseases Acute Lobar (33.4) and Pulmonary Tuberculosis (12.9) are responsible for such an inflammatory rate. Incidence of Acute Lobar is one of the most frequent causes of illness resulting in frequent absenteeism and temporary disability.
The external cause group contributes a significant proportion of sickness with a rate of 185.3 per 1000 insured persons. The injuries include both employment and non-employment incidences. Out of the injuries within the group of external cause, other violence (16.8 per 1000 insured persons), abrasions, lacerated wounds, contused and punctured wounds (55.2 per 1000 insured persons) also contribute to the high rate of morbidity. In this group of disabling accidents an approach towards reducing the employment injuries as well as the incidence of this group of causes should be a joint responsibility of the Industrial Health Section of the Health Directorate and of the Inspectorate of Factories "through adoption of proper preventive measures. In this group of diseases measures adopted to prevent occurrence of injury, accident and poisoning will be much more preferred than the treatment of workers suffering from such diseases or injuries which are generally due to incomplete and inadequate industrial hygiene devices.

In the study of correlation between age and variation in morbidity, the following facts have been revealed:

The incidence of sickness among the insured persons is greater in the age groups 18-35 (76.1) and 40-54 years (79.0) compared to the lower incidence in the age group 25-40 years (69.9). While studying the incidence of average sickness rate per person it is also found to be high among persons of 18-35 years (4.1) as well as among those of 45-64 years (3.6) compared to that of 25-40 years. While working out the age specific morbidity rate for 14 broad groups of diseases it is found that the high rates of sickness are associated within diseases of the Respiratory group, Unspecified and Ill-defined group,
Infective and Parasitic group and Bones and Joints group. These diseases are the major contributory factors in bringing about an overall high rate among the different age groups.

In the overall study it is found that the total sickness rate is 230.9 per 1000 insured persons in the age group below 25 and 252.0 in the age group 40-44. It varied between 213.0 and 2367.7 per 1000 in the other age groups. Here it should be stated that the variation in age specific morbidity of other groups of diseases such as Nervous and sensory, Circulatory, Urinary and Genital, and Skin and Cellular tissues is not so significant to affect the overall variation in morbidity due to all causes. The curve is high at the age group below 25; it comes down and remains stationary till 40 and then it ascends sharply in a slope to the age of 54 years and then declining slowly thereafter. The reason for a comparatively high morbidity among the insured persons below 25 is that they suffer from common causes of sickness prevalent in the country. The incidence of these diseases among newly recruited persons in industry being higher than those serving for some time, also, perhaps, to the exposure to the industrial environment as well as to the strain of the rigours of industrial life (e.g., hours of work, food, crowded living, etc.) before proper acclimatisation. This may also be partly due to the lesser sense of health consciousness among newer recruits. The high rate among persons above 40 and below 50 might be an outcome of disability due to advancing age and due to the chronic status of sickness that they suffer from when prevention and even treatment become more problematic than the acute diseases.
The seasonal variations observed in respect of major groups as well as specific diseases are given in Tables XV, XVI and shown graphically in Figs. 15 and 16. Here also it is has been found that the seasonal variations are influenced mainly by the incidences of the major groups of illnesses like Respiratory group, Unspecified and Ill-defined groups, Digestive group, Infective and Parasitic group.

The diseases of Respiratory group shows the maximum sickness rate during the period between October and December, the peak being in November (62.5 per 1000 insured persons). In this group, the maximum level is 38.1 per 1000 insured persons in the month of March. The incidence rate of unspecified and ill-defined groups, also shows a maximum level of sickness rate between October and December with a peak in November (87.8 per 1000 insured persons). In this group also, the lowest level is reached in the month of May (29.8 per 1000 insured persons). The maximum incidence of Infective and parasitic group of diseases is, on the other hand, restricted to the period between August and October and to January, the peak being in the month of August (30.5 per 1000 insured persons). The incidence (9.5 per 1000 insured persons) incidence of this group of diseases is in the month of February. In the Digestive group it spreads over the larger part of the year with small variations between April and October, being 24.7 in April to 19.6 in October. However, the peak obtained in the month of April tends to a fall steadily upto the month of October. The disease has the minimum incidence of 2.1 per 1000 insured persons in the month of December. The next group, though possessing a very low annual sickness rate, is the Allergic group in which a significant seasonal variation has been observed. Its rate is maximum during November to February, the peak being in November (6.5 per 1000 insured persons). Other
groups of diseases do not affect the pattern of seasonal variation of sickness. From the curve depicting variations due to all causes of sickness it is seen that the period between September to January, both months included, brings about the maximum morbidity among the industrial workers, who suffer mainly from the four groups of diseases namely, Respiratory, Unspecified, Digestive and Infective and Parasitic). In the same population, the morbidity status is at its lowest ebb during March and February. In between the intervening period the morbidity status fluctuates, once coming down in May and then there is a significant correlation between the Health of Industrial workers and seasons, the highest index of morbidity being found mainly in the winter season which starts in the end of November and continues till January in the city of Calcutta.

It has been found that the nature, intensity and the sickness rates are affected by the nature of the industry. The results of study of sickness rate due to specific and non-specific groups of diseases on occupational (industries) basis are given in Tables XIII and XIV. The industries were divided into ten main groups, namely

1. Food and Beverage, 2. Textiles, 3. Leather and Lumber, 4. General Industries, 5. Non-metallic mineral industries, 6. Metallic mineral industries, 7. Engineering industries, 8. Transport industries, 9. Paper products, and 10. Miscellaneous. The Food and Beverage Industry shows the maximum sickness percentage (23.8 per cent) closely followed by the Non-metallic Minerals (21.3 per cent); Miscellaneous 20.1 per cent and Textiles (18.5 per cent) among the insured persons of respective industries. The average number of sicknesses in Leather and Lumber industries (4.1 per person), followed by
Food and Beverage industry (3.6 per person) and Miscellaneous (2.4 per person). The major diseases which control the ultimate duration due to all causes in different industries are Respiratory group, Unspecified and Ill-defined group, Digestive group, Infective and Parasitic group, Skin and Cellular tissue group and External Causes group.

The Respiratory group shows higher sickness rate among Leather and Rubber Industries (1135.9 per 1000 insured persons) and the lowest among the Chemical Products Industries (433.3 per 1000 insured persons). Thus a wide variation of the sickness rate is observed when the mortality rates are classified on the basis of industries.

The Unspecified and Ill-defined group has also the highest rate (990.3 per 1000 insured persons) in the Leather and Rubber Industry, the minimum (458.3 per 1000 insured persons), being in the Non-Metallic Mineral industry. The maximum incidence of the diseases of Digestive group is also in the Leather and Rubber Industry with a rate of 572.8 per 1000 insured persons, closely followed by Food and Beverage (555.1), Non-Metallic Mineral Industries (492.4) and Potters industry (264.4). The minimum rate is seen in the Chemical Products industry (239.6 per 1000 insured persons).

The Infective and Parasitic group of diseases shows the maximum rate of sickness in the Leather and Rubber Industries (543.7 per 1000 insured persons) and Non-Metallic Mineral Industry (941.7 per 1000 insured persons). The minimum rate (154.5 per 1000 insured persons) is in the Metallic Mineral industries.
In the group of diseases related to Skin and Cellular tissues, contrary to the previous findings, the maximum rate is in the Food and Beverage industry (203.1 per 1000 insured persons), followed by Transport industry (165.4) and Leather and Rubber Industry (165.1). The minimum rate (111.7) per 1000 insured persons is in the Engineering industry.

The diseases due to External Causes have the highest rate (213.6 per 1000 insured persons) in the Leather and Rubber industry being closely followed by the Transport industry (201.5), Miscellaneous (191.6) and Metallic Mineral (181.4). The incidence of this group of diseases is the Paper Products Industry (197.2). All these major groups of diseases show more or less wide variation in respect of different industries and they explain the major deviations observed in the causes of diseases as classified by industries. It is evident from the foregoing results that the Leather and Rubber industry had the maximum rate due to all causes (4038.8 per 1000 insured persons and the Chemical Products Industries, the minimum (1830.0) per 1000 insured persons. The rates for other industries were as follows: Food and Beverage industry - 2081.3, Nonmetallic Mineral - 3888.5, Textile industry - 2664.7, Miscellaneous - 2883.6, Transport - 3011.2, Metallic minerals - 3377.0 and Engineering industry - 3283.8 per 1000 insured persons.

It is also interesting to note that when the specific diseases are distributed according to industries, a significant variation is observed in the incidence rate of Acute Upper Respiratory
Diseases, Anemia, Hypertrophy, Vitamins Deficiency, Malaria and Intestinal, Fevers and Diseases of Eye and Injury. Here also the major industries in which the above diseases are more prevalent are Leather and Rubber, Food and Beverage Industry, Miscellaneous Industry, Transport Industry and Paper Products Industry. The result of Industry-wise classification due to overall causes of sickness and due to individual group of diseases are presented in Table Dagen in Fig. 14. It is evident that among the insured persons under study those of the Rubber and Leather Industries show the maximum morbid status followed by those of Food and Beverage Industry and Non-Metallic Industries, the third important group of industries showing a fairly high morbidity index is the Textile Industries, Transport Industries, Miscellaneous Industries and Paper Industries. From this standpoint of National wealth of economy, these industries are extremely important, both from the standpoint of National utilization of wealth as also for earning foreign exchange. It is thus clear that no real national welfare can be achieved until such high morbidity conditions amongst so many important industries are sufficiently controlled.

The above discussion on the incidence of sickness or morbidity relates to the features of Demography, Seasons and Occupation. In order to study the problem of morbidity in its total dimension, the above factors do not fully cover the subject of study. Although it gives the spectrum of morbidity on a disease basis, it cannot give an idea about another very important facet of morbidity, namely, the severity and the duration of the sickness. This factor enables us to conclude
more quantitatively the loss induced by morbidity. As mild or chronic sickness may have pretty long duration in certain cases, the study of the problem of morbidity cannot be complete without the knowledge of severity and duration. So, the next point of view of the study was an analysis of the duration of sickness with the following results: The duration of sickness is defined as the recorded period of the total number of days of medical consultations or total number of days of observation or attendances for a particular cause of sickness or injury and gives an index of sick days per sickness. In Table XIII are presented the data of the number of sick days, their rate, percentage and average duration per sickness as classified by cause. Here also it is seen that the major five groups of diseases are responsible for the major proportion (62 per cent) of total sick days. To be more precise, these diseases are of: Respiratory group (22 per cent), Ill-defined group (11 per cent), Infective and Parasitic group (15 per cent), Digestive group (17 per cent) and External causes group (6 per cent). As expected, all specific chronic diseases have a tendency to increasing the sick days per case and all acute specific diseases show fairly short period sick days per case.

The duration of sickness per case for Pulmonary Tuberculosis, Gastric Ulcer and Disease of the Eye and Injury were respectively 75.1, 25.8 and 15.8 days whereas that of Appendicitis and Enteritis was only 3.6. Thus it appears that though the specific sickness rates give an idea of the total volume and intensity of sickness it may not always reflect the acuteness of disease but this can be obtained by the
study of the duration of sickness. The average duration was only 7 days per sickness and 17 days per sick person of which 11 days constituted absences due to sickness. In this respect, the chronic diseases were contributing the larger share of the morbidity status of the community, and hence caused greater loss of industrial production, indicating that more emphasis should be laid on the adequate treatment of chronic diseases. Only a well thought-out plan and its proper execution might reduce the incidence of the chronic diseases if the State Insurance Organisation wishes to tackle the problem of morbidity.

The duration of sickness not only reflects the chronic nature of sickness but also the medical consultation rate and the average consultation index which could be utilised as other yardsticks for the measurement of morbidity. Another important index of measurement of morbidity is the patient consulting rate indicating the proportion of suffering persons requiring medical consultation expressed in terms of 1000 sick persons. Unfortunately, the patient-consultation rate classified by cause of sickness or injuries could not be worked out for insufficient data. However, the analysis of the data on the medical consultation rate and average consultation rate shows that the diseases of the Respiratory system had the maximum consultation rate with a maximum average consultation index, signifying again thereby that the morbidity due to Acute Upper Respiratory diseases was the severest. All other diseases, including even those with high rates of consultation, were not as severe as their average consultation rate per sickness was rather low (2.4 to 2.6). Among the diseases other than those of the upper respiratory group which would require special consideration the total number of medical consultation may be mentioned of the following:
Ill-defined and Unspecified Illness, Infective and parasitic diseases, External causes, Liver-disease all forms, Skin and cellular-tissue and Malignant and sarcoma (with rates of 860, 1771, 1091, 1002, 740 and 591).

Any form of disease whose diagnosis was not feasible through the insurance medical practitioners was referred to the specialist for medical care and the total number of such referrals in this present study was 546 against the total number of 5522 admissions, i.e. 6.2 per cent. On analysis of all these referral cases, it was found that the magnitude was not entirely dependent upon the sickness rate. The diseases with ill-defined symptoms or diseases for which no treatment was possible without the help of specialists always had the higher percentage of referrals, namely ill-defined group - 27.3 per cent, Diseases of Eye and Injury - 17.4 per cent and External cause group - 9.3 per cent. It was also found that the disease like amoebic dysentery, measles and bronchitis had low proportions of referrals though their incidence rates were fairly high. This was because these were more easily clinically diagnosed and treated by the insured medical practitioners themselves. It was unfortunate that some of the important diseases like venereal disease, Cancer, Leprosy, Dental disease, Mental disease and Skin disease had no provision for specialised medical care under the prevalent Medical Insurance Scheme. Larger number of referrals would, however, be needed if these diseases were included. The incidence rates and the total consultation rates due to these diseases were high enough to be included in the E.M.I. Scheme to reduce the total morbidity rate in the insured persons.
Since the ultimate effect of morbid state upon industrial workers results in sickness, certification rate gives a quantitative measure of sickness of morbidity prevalent among the industrial workers. It was interesting to note that within the time period of this study for a total sickness of 5522, the number of certificates issued was 2780 indicating thereby that practically for every two sicknesses there was one certificate issued. This result may have its farther significance in showing that out of the total number of sick persons, approximately 50 per cent could not report for work. The total number of sick persons were 1192 and the number of sickness per sick person was 3, though the duration for absenteeism was dependent on the amount of the sickness. For instance, out of the total certificates issued, the highest percentage went to persons suffering from Respiratory Diseases, nearly 34.8 per cent. The percentages of certification in other diseases were: Parasitic - 16.7 per cent, Ill-defined - 22 per cent, Digestive group - 17 per cent, Group diseases being responsible for 85 per cent of the total absenteeism.

The Employees State Insurance Scheme itself has not yet come up to the required standard being only a few years old and for most of desirable and efficient technical set. However, an approach to the study of morbidity pattern provided by such an organisation would necessarily suffer from certain limitations which should also be mentioned here for proper assessment of the value of this study.
Some of the limitations are avoidable and some are unavoidable. These are discussed below. The E.S.I. Scheme, as it stands, suffers from three major limitations: First, the medical practitioners in the Scheme are engaged on panel system in which an annual capitation fees per person is allotted to them. As the doctors are not engaged as whole time employees under the Employees State Insurance Scheme and as they are allowed private practice, there are certain chances of the panel doctors to attend more to their private patients than to the insured persons. A probable error may thus arise in the recording of morbidity for not strictly following the constitutional procedure in diagnosis and treatment as enumerated by E.S.I. Scheme, though this might be an extreme case, yet the incidence of such cases cannot be totally overlooked. It is presumed however that such extreme cases are not common to vitiate the ultimate conclusions reached by this present study of morbidity statistics. However, it should be seriously considered whether these insurance medical personnel should be employed on full time basis.

The second limitation is related to the engagement of specialists for treatment of sick insured persons. Specialised treatment by way of referrals is rendered to all diseases other than Cancer, Leprosy, Venereal, Skin and Mental diseases. The present system of the E.S.I. Scheme may, therefore, lead to wrong or delayed diagnosis of these diseases and also may lead to a long and protracted treatment and hence unnecessary long duration of sickness in such diseases, though the error introduced in the totality of morbidity due to such disparity may not be significantly large owing to their negligible incidences as seen at present. The ultimate error in misrepresentation
of data will be insignificant. While mentioning this, it should be borne in mind that absence of any form of sickness due to Cancer, Leprosy, Mental and Venereal diseases does not indicate that there was no insured person suffering from these diseases but it might be that the actual incidence escaped the notice of the medical practitioners and consequent recording. These lapses could have been overcome if there were scopes of referring them to suitable specialists and thereby the volume of diseases in the ill-defined group could have been diminished. In this connection, it should also be mentioned that the object of the R.H.I. Scheme is to render medical care to all sick persons irrespective of the nature of sickness and thereby to reducing morbidity to its minimum level. Lack of specialised treatment for the aforesaid diseases might leave the sufferers as potential sources of danger to others in the community, especially if the diseases are of infective nature.

The third limitation though in now affects the validity of the present data, is the fact that the insurance does not cover the sickness prevalent in the family of insured persons including the sickness in the babies born of insured mothers. This incomplete service lends not only to a mental stress of the insured worker but gives rise to higher morbidity status due to spread of the infectious diseases if left untreated.

The next defect was in relation to the diagnosis of certain illnesses, a large proportion of sickness being classified under ill-defined and unspecified group. The name 'ill-defined' implies that the majority of the sicknesses belonging to this group escaped
proper diagnosis while only a part of those might have been really complicated cases whose diagnosis in spite of the best clinical approach was difficult. Thus the morbidity data presented here suffer from certain amount of lack of precision in diagnosis, leading to the grouping of a sizeable section of illnesses as ill-defined and unspecified. In most of the advanced European countries and also in the U.S.A. where similar studies have been undertaken it is found that incidence of sickness due to ill-defined and unspecified group is extremely low due to more precision being applied to diagnosis. Unfortunately, such precise diagnosis in cases of ill-defined ailments is not possible by the insurance medical practitioners here particularly in the absence of specific training being organised for the purpose and to explain the aims and objects of the insurance schemes which not only provide medical care to the sick person but also aim at achieving a low morbidity of the community with which it is concerned. Precision in diagnosis in such cases also demands that there should be a fairly large number of well-equipped clinics to which the medical practitioners can refer such cases for diagnosis of the cause of sickness. However, this limitation could not be avoided in the present study.

The next point of importance is the limitation of the population at risk due to its fluctuating nature throughout the year. However, this limitation has been guarded in the particular study by rejecting all incidental exit and re-entry of cards from the sampling population under study. In the methodology of study proper care has been taken to avoid limitations arising out of stringency...
of definition of sickness by introducing a broader definition of sickness thereby minor and non-disabling diseases of short duration have been included and also classification of diseases has been guarded. In order to avoid errors due to vague terms in respect of medical consultation, spells of sickness or duration, certification and referrals, precise definitions of the aforesaid items were introduced.

The reliability of age recording depends upon rigid enforcement of Factory Act at the time of recruitment. As the age structure is selective, the entire range of age of the population cannot be studied. The population was distributed more in younger age group than in higher age groups. Within the sample population, the proportion of males is much higher than that of the females, and the latter is somewhat under-represented in the sample selected. Similarly, married people are much over-weighted than the single and the widowed people. In view of the stated limitations in respect of occupation, income and socio-economic status, the observed population has been classified under broad groups industries, half of them being under the Metallic Mineral and Engineering Industries and the other half are evenly distributed among eight other groups of industries.

From the point of view of National Health Service, the R.S.I. scheme has proved beneficial to the workers though there are plenty of scope for improvement. The morbidity survey data furnished by the scheme should prove to be useful for future planning of medical care for the insured persons and to remove the defects.
It should be stressed that the ultimate aim of the E.H.I. Scheme should not only be the mitigation and care of the sick insured persons but also to reduce the morbidity to a minimum in the community. In order that such an objective might be realised through the Scheme, the plan should be reoriented in its scope as well as execution. The first and the foremost objective of this Scheme should be to develop a positive attitude towards checking morbidity more than towards curing morbidity. This presupposes that the E.H.I. Scheme should make a plan for regular check up of the health of the insured persons in order to avert potential sources of diseases and ailments before the condition precipitates into a mortal state; secondly, it must lay a guard against more prevailing forms of diseases and evolve processes for finally fighting out diseases on a mass scale. This can be done effectively by establishment of a network of well-equipped scientific clinics and health centres. Although such a procedure would require a big finance at the initial stage, yet it would be the cheapest in the long run. But money should not be a serious concern when it return he shall get a healthy working community for all industries and industrial enterprises in the country and increase in the National Health in the form of productive labour for which a sound state of physical health is essential. In fact, the ultimate wellbeing of the nation comes through utilisation of its physically fit and productive man power. The physical fitness comes through rendering the morbidity rate to its minimum.

The aim of the present study of the nature of sicknesses prevalent in the industrial community of the city of Calcutta was to give the authorities opportunities to scientifically work out more noted.
effective methods of medical care to bring down the existing high rate of morbidity. Although the present attempt is only a miniature study in respect of the vast problem of morbidity prevalent in the country, it was to show the way how such studies can be done in respect of all other working communities who are directly and indirectly involved in the uplift of the national welfare. This classification of diseases (morbidity) might be broadly based on respective industries or professions like agriculture, steel and mineral industries, non in defence services, population engaged in educational institutions, non utilized in administrative job, etc. If in the different sections of the population, such morbidity studies are undertaken, it may be possible to provide the necessary medical care through a network of health insurance schemes gradually covering the population step by step. Such an object can be achieved through scientifically planned morbidity studies on lines similar to those presented in this study.

Similarly, it might be stated that the incidence of ailments in the present study can be rated as follows in order of decreasing incidence:

1. Diseases of Respiratory system including Influenza, Bronchitis, Acute Upper Respiratory,
2. Ill-defined and Un-specified group including Pneumonia,
3. Diseases of Digestive system including Diarrhoea and Intestinal and Diseases of Dental and its supporting structures,
4. Diseases of Infective and Parasitic origin including Acute Dysentery and Pulmonary Tuberculosis.
In regard to the age specific morbidity, the maximum morbidity was found in the age group below 25 years, possibly due to exposure to new environment and strain after employment in the industries as non-earners.

 Industry-wise, the morbidity rate was higher among the employees of the Rubber and Leather Industries, Food and Beverage and Metallic Mineral industries than in other industries. It is a matter of further study whether any of the morbidity rate is correlated with the specialty of any particular industry in which more appropriate steps might be taken to control it. By way of suggestion, e.g., example may be cited that the higher morbidity rate in the Leather and Rubber Industry was due to the high rate of infectious enteritis, disease of stomach and duodenum, diarrhea and enteritis and also of bone and joints. The question arises whether the nature of work and the structure of the industry are responsible for such high incidence of these diseases. In such situations, appropriate plans and measures can be formulated to reduce these diseases in Leather and Rubber industries to a minimum.

 As revealed in the studies of the periodicity of morbidity, it is found that the lowest incidence was in the month of February whereas the highest was in the month of November.

 The average duration was only 7 days per sickness and 17 days per sick person of which 11 days constituted absenteeism due to sickness.

 The medical consultation rate and the average consultation rate were significantly high due to the diseases of the Respiratory group, Unspecified and Ill-defined and Infective and Parasitic groups.