CHAPTER X

INTRODUCTION

For understanding and planning medical relief for any group of population, it is essentially necessary to know the extent and nature of the problem to be faced in relation to local circumstances through the epidemiology. Then the epidemiological findings are well established, the health administrators further assess the magnitude of problems and its characteristic variation in respect of intensity, nature, distribution and duration by age, sex and occupation and seasons for determining priority. This is particularly applicable to industrial group of population who suffer from triple influence of

1. Industrial residential environment,
2. Occupational diseases and
3. General morbidity affecting the local population.

The industrial residential environment does directly affect the health normally by affecting the incidence of infectious disease. With regard to occupational and other communicable diseases, it is now well recognized that

the manner in which a man gains his livelihood and the surroundings in which he spends the greater part of his working hours may have an important influence upon his health. The morbidity of industrial population arises not only with endogenous or constitutional variations but also from the exogenous factors due to varying conditions in which people live, work, play and sleep. But morbidity is difficult to define except in terms of disease or illness. Stock (1946) has said "the distinction between living and dead is clearcut, but no such frontier line between sickness and health can be said to exist except in the case of acute illness caused immediately and directly by an external agent". However, on the basis of factual data in respect of morbidity, plan for medical relief scheme is formulated and implemented.
with an aim to prevent the(rgb) of bid oanditicna of a community or to keep them at a minimum level. Thus once the health or medical relief scheme has been operating for some time and the cause diseases are brought under relative check, more refined methods are required to evaluate the magnitude and priority of various morbid conditions and the nature of variation in order to direct more specific measures against them. But all such medical relief schemes will only be successful if accurate and reliable data in respect of sickness of the community are available. There is no system of reporting of sickness condition in any health agency in this country. It is also known that there is no routine source wherefrom quantitative information about the morbidity level of the community and its various aspects can possibly be obtained except incompletely for diseases like cholera and small pox. Information on sickness (morbidity) is only available from certain hospital and dispensary returns and partly even mortality records. But even that the latter is not reliable except in the city like Calcutta where the cause of death has to be certified before cremation or burial. In the rural areas there is no system of recording cause of death before cremation or burial. Moreover, a large majority of cases are not seen by qualified medical men. Realising these limitations and deficiencies, the health administrator has often to satisfy his need for information on morbidity by a partial extent only, by using mortality data which, in as far as they are reliable, give some indications of the level of the fatal diseases of the community. The morbidity data have further lost their significance after the discovery of sulpha drugs and antibiotics which are saving more lives than before and have helped in reducing the crude death rate of the country. Hospital records and other clinical records of selective population groups can also throw some light on the
sickness level, if properly used and interpreted, though no sickness rate can be calculated for the area or the country. In addition to these limitations for calculation of the level of sickness, these sources are further handicapped for not being able to supply reliable information about other important aspects of morbidity viz., duration, disability, pattern with respect to age, sex and other characteristics, etc. Consequently, even more precise and detailed information is wanted, 'ad-hoc morbidity surveys', requiring considerable finance and very competent guidance, have to be contemplated. Such surveys are, however, comparatively simpler if only a 'snapshot' is taken of the population regarding the prevalence of sickness but when a complete picture of morbidity for the entire year is aimed at considerable complexity develops.

This being the position of morbidity statistics, it would be worthwhile to utilise any source of data, however limited, for a study of the sickness level in the community as far as the data permit. Such studies appear to be of particular importance in India where very little information is available from other sources.

In most of the European countries before introduction of social security plans and prior to the introduction of the nationalisation of health services in the United Kingdom, morbidity index was considered as a useful tool for evaluating the actual state of sickness within the community. For working out morbidity indices, authorities collected and statistically analysed the medical records of general practitioners in respect of their patients maintained routinely in one standard form. Though the practitioners kept these records for follow-up of treatment but the authorities utilised them for administrative and research purposes as well as for a planning of the health services
after a careful study and analysis of those records for sickness and morbidity. Through analysis and interpretation of the data, the administrator may form an idea of various items of services, rendered by the medical practitioners to the community and assess the amount and nature of work with a view to improving the condition or extending the scope of existing benefits. The authorities, with the help of morbidity index, can evaluate the actual state of sickness level in a community and the extent of effective medical care offered to the community. The object of the administrator may also be to utilise this information of the morbidity condition for other scientific purposes.

The medical cards obtained from the panel doctors in respect of their insured persons under the Employees' State Insurance Scheme in Calcutta, will partially all the conditions stated above. Through collection, statistical analysis and interpretation, it may be a fruitful source not only for showing a true index of the sickness level of the industrial community but also for the study of variation in sickness incidence due to age, sex and occupation, period of insurance, medical consultation, patient consulting, certification and referrals, the knowledge of which will contribute for any future planning of social security scheme and for nationalisation of health services in a welfare state. These data may be utilised for evolving both the procedure and the execution of such schemes. The health analysist may use these data as a tool to evaluate the efficacy of the running schemes. The industrialists may utilise them for the prevention of absenteeism and disabling sickness within the community with a view to increasing production and thereby doing better justice to our national planning. The above considerations and also the fact, that the insurance medical practitioners' records are likely to yield some useful result, led the author to undertake this study.