Discussion and Summary

Genesis of the study:

India is still the land of rural agricultural economy. Nearly 80 percent of her population live in villages which have been almost universally affected by high prevalence of parasitic and infectious diseases, which are preventable e.g. Malaria, Kala-azar, Filariasis, Hookworm, Cholera, Smallpox, Diarrhoea, Dysentery, Skin and Respiratory Diseases. Moreover, a large percentage of population suffer from malnutrition and low vitality conditions. Against such a situation there was hardly any public health services in the rural areas except sporadic dispensaries and provision of a sanitary inspector as the sole public health worker for a thana area comprising 80 to 100 thousand population and a district health officer at the district head-quarter.

To mitigate, to a certain extent, the above conditions the Government set up a committee in 1942 popularly known as "Shore Committee". One of the recommendations made by this committee was to establish a net-work of health centres all throughout the country to provide preventive medicine and medical relief nearest to the people. Following the successful pilot experiment in Singur of the Hooghly district in West Bengal by the All-India Institute of Hygiene and Public Health, Calcutta this plan has been in operation in West Bengal since 1948. However, the entire state could not yet be covered.
partly for shortage of trained staff as also finance and partly for reluctance of the medical graduates to work in rural areas.

It was also realised that health services should be integrated with various other socio-economic development in the rural areas and as such rural health centres eventually became a part of the broad programmes under the community development projects. To start with, the functions of these health centres were mostly preventive and promotive but very soon to fulfill the function of medical relief dispensaries and hospital system of different bed strengths (50, 20, 10 and 4) were soon established in both primary and subsidiary health centres. Although this hospital system has been introduced nearly 2 decades ago, no organised evaluation had been done. The present study has therefore been taken up by the author to carry out this work at the suggestion of the then Director of Health Services, Government of West Bengal.

History of hospital development:

From the available records it is evident that medicine was being practised in this country since very ancient time, but community medical service in the form of hospital system was introduced for the first time by Rahul the son of Buddha in the 5th Century B.C. King Asoka during the 3rd Century B.C. extended this hospital system throughout the country, the relics of which have been discovered in Ceylon and Nalanda. Subsequent history is very scrappy and non-contributory. It seems that
very little community health service was practised during the Muslim rules in India, between 12th and 17th Century A.D. It is the British who actually brought the modern type of hospital system to India and since then there has been a steady progress in the development of hospital services in this country particularly in the certain areas. The present system of integrated rural health services as recommended by the Shore Committee (1946), has been established by the national government following achievement of independence.

Functions of Health Centre:

Since it was decided to organise the rural health services on an integrated basis the health centres were proposed to have the following functions:

1. Medical relief through hospitals and dispensaries with home care and follow up

2. Promotive Services:
   (a) Maternity and child welfare including family planning.
   (b) School Health.
   (c) Health Education.

3. Preventive Services:
   (a) Control of communicable diseases including immunisation programme.
   (b) Environmental sanitation.
   (c) Collection of vital statistics.
Rural Pathology

Types of illnesses present in the rural areas are somewhat different from that of the urban areas. While the latter had been enjoying in recent times the privilege of medical and health services through the teaching, specialised and privately organised hospitals and clinics, very little was being done towards medical relief for the vast rural population of India.

The quantum of illness and epidemic diseases were having a heavy toll of life in the rural areas. The morbidity pattern as found out by Seal et al (1955 to 1958) was as follows (arranged in descending order of incidence):

- Fevers, Diarrhoea and Dysentery, Typhoid and Para-Typhoid Fevers, Bronchitis, Pneumonia and other Respiratory Diseases, Scabies and other Skin Diseases, other Disorders of Digestive System, Diseases of Eye, Asthma, Diseases of Pregnancy and Childbirth, Diseases of Ear, Accidents, Rheumatic Fever and other Rheumatic conditions, Diseases of Urinary System, Diseases of nervous system, Anaemia, Malnutrition, Diseases of Liver, Mumps, Caries and other Dental Diseases, Helminthiasis, Tetanus, Piles, Leprosy, Smallpox and Snake-bite — vide Table-1

Objectives

The objective of the present study was to obtain reliable information in respect of morbidity conditions and socio-economic aspect of hospital admissions and administration in the rural health centres of West Bengal. This study included observations on physical set up of the hospitals and out-patient departments,
The staff and facilities provided, type of diseases treated in-door and OPD, end results, bed occupancy rate, duration of stay and treatment received prior to admission and socio-economic condition of patients, cost of treatment and opinions of the public.

All the primary health centres were provided with beds but in case of subsidiary health centres some were provided with 10 or 4-beds and some with only 2 non-dieted emergency beds.

Health centre hospitals in West Bengal:

There were altogether 735 health centres - 214 primary and 521 subsidiary by the end of the year 1966. These health centres were provided with hospitals of different bed strengths. The total number of beds provided in these health centres was 5342 i.e. 15.7 percent of the total bed strength in West Bengal. Including the beds in A.G. and P.R.E. hospitals, the total number of beds came to 6526 constituting 19.2 percent of the total bed strength of West Bengal. In other words, there is 19.2 percent bed for 79 percent of rural population against 80.8 percent beds for 20.4 percent urban population. Necessarily these urban beds are also used by the rural people for specialised treatment causing an excessive overcrowding in these hospitals. This pressure can only be relieved if the hospital system provided in the rural areas is improved and bed strength suitably increased.

Methods and material:

For the purpose of the present study only five contiguous...
districts namely Burdwan, Hooghly, Howrah, Nadia and 24-Parganas of Southern West Bengal were selected, as it was not possible to cover the entire state single-handed. In these districts there were 309 health centres divided into 83 primary health centres and 220 subsidiary health centres. Of the 83 primary health centres 8 were provided with 50-bedded, 1 with 30-bedded, 22 with 20-bedded and 57 with 10-bedded hospitals. Of the 220 subsidiary health centres 68 were provided with 10-bedded, 1 with 6 bedded 20 with 4-bedded hospitals and the remaining 131 with 2 non-dieted emergency beds each. Health centres with non-dieted beds were omitted in this study and from the remaining 177, 60 health centres (33.9 percent) were selected by random sampling technique according to the suggestion of Dr. K.K. Mathon, Professor of Statistics at the All-India Institute of Hygiene and Public Health, Calcutta. In the sample selected for study there were eight 50-bedded, one 30-bedded health centre, thirteen 20-bedded and twelve 10-bedded primary health centres and twenty three 10-bedded and three 4-bedded subsidiary health centres.

Two main schedules namely "Hospital information schedule" and "People's opinion schedule" and another supplementary schedule were prepared for the purpose of collecting informations for this study. The informations collected were broadly in relation to history, administration and physical conditions of the hospitals, staff, quarters, types of patients admitted, facilities for treatment, end-results of treatment, budgetary provision and
other facilities provided, people's opinion about hospitals and socio-economic conditions of patients admitted in these hospitals. The period of study extended from August 1967 to June 1969. Statistical analysis of the data was done at the Indian Institute of Social Welfare and Business Management, Calcutta from where the field visits were carried out.

Hospital/Health Centre Units

The identity of a hospital in a health centre is not separate from the health centre itself. In practice, the centre may be called the health centre-cum-hospital unit as all the functions including medical relief are carried out from these composite unit, which consists of the hospital wards, O/D, kitchen, garbage, staff quarters, morgue, incinerator and tube-wells. The size of the units however varied according to the number of beds provided in the hospital section.

The internal and external sanitation of most of the places were bad and the compound was not enclosed with fences for protection against grazing animals, dogs and also trespassers.

The health centre-cum-hospital unit in some instances were not placed in suitable sites and hence difficult to approach by the ailing patients. In regard to sanitation, the two most important items were water supply and disposal night soil. Tube-wells were the main source of water supply in most of the units but in places like Sundarban area the water being brackish, tanks were the only source of supply. The plan of raising the water in over-head tanks and supplying it through pipes did not
materialise. In some places tube wells often went dry causing great hardship for hospital patients and staff. Latrines were modified dug-well type and required periodical cleaning but this was not being done creating insanitary condition. No bathroom had been provided for the patients within the hospital and the patients including women had to take their bath in the open. Kitchen was separate but the sanitary condition was much to be improved.

**Staff position in hospitals**

Staff provided for the hospitals of health centres varied according to the number of beds attached to them and also to the type of health centre namely primary or subsidiary. Medical officer, nurse, pharmacist, general duty attendants and sweeper have been provided for all categories of hospitals. While the number of these different categories of staff depended on the number of beds provided, clerk and laboratory technician have been provided in some of the primary health centre hospitals only. Graduate medical officer could not be posted in many of these health centres and only very few health centres could be provided with lady medical officer. Most of the subsidiary health centres were managed by licenciate medical officers some of whom were in fact working beyond their age of superannuation i.e. 58 years. The number of doctors provided in 50-bedded, 20-bedded and 10-bedded primary health centre hospitals was respectively 4, 3 and 2 whereas in subsidiary health centres
with 10 or 4-bedded hospitals, a single medical officer had been provided for carrying out preventive indoor, OPD and family planning works constituting a very strenuous task. Recently, state health directorate was attempting to engage doctor from local medical practitioner in the health centres on part-time basis. Moreover, specialists were attending some of the health centres to see special cases selected for them but such a system has not yet been regularised. Trained nurses could not be provided in some health centres. In fact, a few subsidiary health centres were managed by untrained nurses. Only one pharmacist was provided in each health centre irrespective of the number of beds attached to it. He has also to do some clerical work in subsidiary health centres where no clerk was posted. The general-duty attendants were doing various odd and multifarious duties by turn such as, ward attendance, washing of utensils, office bearer, cooking, cleaning of car (jeep) and also accompanying the female public health staff while they were visiting the villages for field work.

Preventive and public health work

To carry out public health work the primary health centres were provided with public health nurse, health assistant, trained dai, midwife, sanitary inspector and social worker. In subsidiary health centres, only one health assistant and one trained dai were posted.
Family planning work:

For family planning work a computer, an extension educator, a clerk-cum-store keeper, and a field evaluation assistants were posted in primary health centres only. A few of the subsidiary health centres were provided with some field workers only.

Laboratory facilities:

Laboratory facilities were provided in some primary health centres but only in a few of them laboratory tests were actually being done. Chemicals for laboratory tests were not supplied adequately and regularly. Medicine and equipments had to be indentated from district head-quarter. The supply of these materials had neither been regular nor adequate while no local purchase was permissible.

Diet and other facilities:

The cost of diet per patient per day was Rs. 1.75 paise only. This was considered inadequate by most of the medical officers. Facilities for storage of servicable as well as unservicable materials were grossly inadequate in most of the places. In the majority of the health centre hospitals kerosine lamp and lanterns were being used for lighting purposes and only a few of them were provided with electricity. This was not always due to non-availability of electric current in the locality. Only 3 out of 60 health centres were provided with telephone. Ambulance was provided in some of the 50-bedded hospitals while UNICEF supplied a jeep each in
a large number of primary health centres to carry out field work in the villages. Maintenance of these vehicles was not satisfactory in some units.

Morbidity pattern of patients attending OPD's

In the present study OPD’S were found to be detached in a few of the health centre hospitals. Distinct arrangement for holding the out-patient clinics was not observed in many of the subsidiary health centres, in fact, they were being held in the office rooms.

The biggest handicap in the arrangement of the, OPD was the absence of a shed, space and latrines for waiting patients. The patients face even greater difficulties during monsoon.

The average number of patients attending these OPD’S daily was considerable and varied between 92 in the group of 4-bedded hospitals to 189 in the group of 50-bedded hospitals. Actually in one of the 20-bedded hospitals more than 300 patients were attending OPD daily.

The percentage distribution of patients of different diseases for which the rural people attended OPD was as follows (arranged in descending order):

Respiratory diseases - 10.75; Amoebic Dysentery - 10.14;
Gastro-enteritis and Colitis - 8.85; Diseases of Liver, Gall bladder and other digestive organs - 8.74; Influenza including upper respiratory infections - 7.3; Diseases of mouth, teeth and gums - 7.26; Disease of skin - 6.6; Accidents and injuries - 5.27; Muscular rheumatism - 3.6; Scabies - 4.49; Diseases of ear - 3.74; Diseases of eye - 2.3; Anaemia - 2.19;
Diseases of female generative organs - 1.34; Other helminthic infestations - 1.09; Hypertrophy of tonsils and adenoids - 1.09; Fracture of limbs and dislocation of joints - 0.91; Complications of pregnancy and child-birth - 0.71; Diseases of muscles, bones and joints - 0.62; Asthma and other allergic disorders - 0.66; Rickets - 0.30; Ankylostomiasis - 0.35; Diseases of nervous system - 0.47; Diseases of male generative organs - 0.18; Diseases of urinary system - 0.15; Diseases of intestine and peritonium - 0.12; and Diseases of circulatory system - 0.09 percent.

Channels of admission:

Patients were admitted by medical officer-in-charge from OPD, referred cases from subsidiary health centres and general practitioners/emergency cases, the labour cases being admitted provisionally by nurse on duty.

Distribution of ward:

Three types of ward namely, male, female including obstetrical patients and infectious were maintained in 50-beded, 20-beded and a few of the 10-beded PHC hospitals. In a subsidiary health centres, only male and female wards were provided. The average annual admissions varied from 181 in the group 4-beded hospitals to 1965 in 50-beded hospitals. In fact, one 50-beded hospital treated more than 3 thousand patients annually.
Bed-occupancy rate:

Bed occupancy rates varied between 63 percent in 4-bedded hospitals and 93.2 percent in 20-bedded hospitals. In some health centres bed occupancy rate was more than 100, indicating extra beds.

Referral of patients:

The number of patients transferred to bigger hospitals for better management varied from hospital to hospital, the largest number of patients being transferred from 4-bedded hospitals.

Morbidity pattern in in-door:

13,100 patients (excluding labour cases) suffering from various diseases were admitted in 56 out of 80 selected hospitals during the year 1966-67. The diseases have been included in 34 different disease groups. The percentage distribution of these disease groups in descending order is given below.

- Gastro-intestinal diseases - 22.45;
- Accidents and Injuries - 15.6;
- Fever (others) - 9.0;
- Diseases of female generative organs - 7.0;
- The respiratory diseases - 6.5;
- Anaemia - 5.3;
- Skin diseases - 4.7;
- Infectious diseases - 2.8;
- Diseases of circulatory system - 1.9;
- Diseases of nervous system - 1.9;
- Asthma and other allergic disorder - 1.77;
- Diseases of kidney and Genito-urinary system - 1.74;
- Helminthic infestations - 1.45;
- Diseases of male generative organs - 1.4;
- Diseases of ear, nose and throat - 1.36;
- General debility - 1.3;
- Viral infection - 1.27;
The percentage distributions of patients were comparatively low for diseases like Nutritional Disorders, Diseases of eyes, Diseases of mouth, teeth and gums, Tuberculosis, Diseases of lymph glands and lymphatics, Diabetes, Tumours (malignant), Parasitic diseases and a few others.

The list of diseases given above shows that as much as 41.3 percent patients were suffering from preventible diseases. Thus, by augmenting and placing greater importance to preventive aspect of health services and by organising better OPD services for early treatment of cases the pressure and demand on hospital beds could be considerably reduced. That such an achievement is possible has been proved in the Singur rural health and training centre where Cholera, Smallpox and Malaria have been almost completely stopped by epidemic control methods, the illness rate among the school students have been reduced to negligible extent by organising school health service, and maternal and infant deaths have been reduced appreciably by maternal and child welfare service.

Change in pattern of rural pathology:

This disease pattern as observed in the present study was somewhat different from that observed in previous rural health surveys undertaken by Seal et al (1955, 1957). Malaria was conspicuously absent in the present study but accidents and injuries, gastritis and ulcers of stomach and duodenum and abortions have assumed higher proportions and incidences of typhoids and para-typhoid fevers were on the increase.
The average duration of stay for different diseases varied between 1 day to 111 days. It was also seen that 25 percent of the total number of patients were kept on an average between 9 to 10 days which is near equivalent to the over-all average stay of 10.3 days among 13,100 patients under the present study.

Average duration of stay of patients was particularly high (more than 2 weeks) in the following diseases:

- Hodgkin's disease
- Osteomyelitis
- Anaemic hepatitis
- Hypertension
- Pleurisy
- Rheumatic fever
- Nephritis
- Diseases of lymph gland and lymphatics
- Malignant neoplasm of stomach
- Anaemia
- Heart diseases
- Arthritis
- Jaundice
- Burns
- Nutritional diseases
- Debility
- Ileo-rectal abscess and fistulas
- Skin ulcers and wounds
- Diabetes
- Ankylostomiasis
- Other paralytic conditions
- Cirrhosis of liver
- Malignant condition of liver
- Tuberculosis of intestine
- Scabies
- Hydrocele

Only 742 out of 972 beds available in the 56 health centres, were occupied. Of these 742 beds 364 (49 percent) beds were utilised for labour cases and 378 (51 percent) beds for general cases.

**Socio-economic factors:**

It was observed in the present study that 33.5 percent of patients fell in the age group 20 to 30 years, the largest among the age groups. The male patients were much larger in number (64 percent) than the female patients (35.9 percent).
labour cases being excluded; 72.4 percent of the patients belonged to poor or very poor classes. The majority of them i.e. 57.6 percent did not take any treatment prior to admission and others took some form of treatment - scientific or unscientific. 47 percent of patients were ill for not more than 7 days before they were admitted to the hospital. A considerable percentage of patients, however, suffered months together before they took hospital admission. Early treatment in OPD or hospital should be advocated through social worker, and public health nurse.

End results of treatment:

The average fatality rates among the patients in these hospitals varied between 2 percent in 10-bedded SHC hospital and 4.22 percent in 50-bedded hospital, both of which are comparatively lower than those in the city hospitals.

Economics of Hospital Care:

There were 4 main items in hospital expenditure namely staff salary, diet for patients, medicine, linens and equipments and contingency. On an average the annual expenditure was Rs.1,34,152/- for 50-bedded, Rs.74,406/- for 20-bedded, Rs.50,917/- for 10-bedded PHC, Rs.30,585/- for 10-bedded SMC and Rs.22,411/- for 4-bedded hospitals.

The per capita average daily expenditure for in patients only of 50, 20, 10 PHC, 10 SMC and 4-bedded hospitals were rupees 8, 7, 12, 9 and 16 respectively. Thus the 4-bedded
hospitals were the costliest of all hospitals, the minimum expenditure being noted in 20-bedded hospitals. The difference in per capita daily cost between 50 and 20-bedded hospitals being small preference may be given to the 50-bedded one for the sake of greater efficiency and coverage.

**Staff Pattern:**

In the subsidiary health centres a single medical officer has to look after administration over and above the usual preventive and curative works. But in primary health centres where more than one doctor is placed, the duties were shared between them, the in-door as well as administration being the entire responsibility of the medical officer-in-charge. The administrative works entailed many things namely, preparation of duty roster for the staff, timely submission of various reports as well as indent, submission of pay bills for the monthly salary of the staff and to bring the cash from the headquarter. The medical officer-in-charge had no authority to take any disciplinary action against any staff of the health centre. He was a whole time worker without any day off in a week. Considering all points of view efficiency can perhaps the better improved by the decentralisation of hospital administration. In 10 and 4-bedded SHC only two nurses were posted and this system put a lot of hardship on the nurses. Only one pharmacist for 50 and 20-bedded hospitals was considered inadequate. The pharmacist in 10 and 4 bedded hospitals had to do the work of a clerk over and above his usual
duties. Only one sweeper was posted in the subsidiary health centres. But it became much inconvenient on the part of female patients if the sweeper happened to be a male one. From the above facts it appears that the hospital organisations in SUC hospitals whether 10 or 4-bedded are uneconomical and unsatisfactory, and some better arrangement should be worked out as an alternative. It has been observed that sometimes two sanitary inspectors were working in the same block, one under the management of medical officer of health centre and the other under the district health officer. This system was most inconvenient and uneconomical too.

Hospital Buildings and Staff Quarters:

Rooms provided in the staff quarters as well as in the hospital were found to be inadequate in most of the health centres. Separate office rooms for different category of staff, nurses working room, sufficient store room, separate operation room, bathroom for patients and health centre staffs were lacking. Maintenance of these buildings had been unsatisfactory in most of the units. Unless the above facilities were provided, an efficient and satisfactory hospital service can not be expected.

Maintenance of Medical Records:

System of maintenance of medical records had been imperfect in most of the health centres. During the present study difficulty had to be faced in obtaining certain data only three years back prior to 1967.
Medical records are of vital importance in the study of morbidity pattern which has assumed greater importance than mortality as the latter has been considerably reduced.

Public Opinion:

In respect of health centres, opinions of 2019 persons of different vocations were obtained from people residing around 51 health centres. Of these persons 40.9 per cent was illiterate and 59.1 per cent was literate of which some were medical graduates, some were non-technical post-graduates or under-graduates and the rest were undermatri. Some of the people interviewed were members of Anchal Panchayet (Local Self Government), Local Zilla-Parishad (District Organisation), one was an M.L.A., a few were members of different political parties and commissioners of different municipalities.

The distance between their residences and hospitals was less than one mile to more than three miles. Of them, 43.7 per cent did not avail of the OPD services. As high as 64 per cent of people were not satisfied with hospital services and their various suggestions are given below:

Improvement of the quality and quantity of medicine supplied - 71.1 per cent, sympathetic behaviour of staff - 44.4 per cent, improvement of quality and quantity of diet supplied - 17.6 per cent, better administration and discipline within the hospital - 16.7 per cent, better functioning of public health staff - 11.1 per cent, more beds - 7.4 per cent. Among the other
Suggestions, mention may be made of the following:

Improvement of road system, provision of ambulance, provision of OPD shed and waiting room, installation of X-ray machine, facilities for laboratory tests of urine, stool and blood, and provision of oxygen cylinder.

It is apparent from the list of suggestions given that the people were quite conscious about the hospital services provided for them. Some of the suggestions were sensible and justified. The Government should attempt to comply with these suggestions as far as practicable.

Concluding Remarks:

The present study was undertaken mainly for two fold purposes namely (1) to obtain an idea of the rural pathology by (a) studying the nature and types of patients admitted in the rural hospitals, their duration of stay and end results; (b) the nature and types of patients attending out patient's department, and (2) to ascertain the facilities provided and efficiency of medical care services reached under the existing conditions of financial, administrative and personnel positions. Such a study was considered necessary as no objective evaluation of the working of the rural hospitals had been officially done since the hospital system was introduced nearly two decades ago. The rural health centre plan as recommended by Bhore Committee was to develop an integrated health service finally leading to comprehensive.
medical care placing more stress on preventive services than curative. But from the results of this study it appears that the health centre idea has been made sub-servient to medical care and hospital treatment (though inefficiently done), because doctors are more interested in clinical medicine than in preventive work. The current trend however is that the health centre in its most comprehensive form should provide the surrounding areas with preventive and curative services, the latter mainly through efficient out patient care which should serve as an out post for hospitalization of only confirmed cases of diseases which are outside the scope of out-door treatment. On the other hand, rural hospital meets with various obstacles such as disproportionate running costs due to the small number of beds provided and occupied and problems of staffing and technical equipments. In fact a hospital with 10 to 20 beds can never provide composite, diagnostic, and therapeutic services owing to its very limited facilities. This is why, in the broadened concept of rural hospital system, it should include establishments which should be economic and whose sole function would be to provide treatment and preventive care from out patient clinic as far as possible.

**Bread Findings:**

Although the districts under study have been fairly well covered by the health centre system as also by hospitals except in a few areas, certain deficiencies in the organisation and
administration have been noted. All hospitals are not conveniently situated in respect of approach and distance from the populated areas. The layout and condition of the buildings are not always sanitarily healthy nor adequately equipped. Their maintenance is also poor.

All the functions of the health centre including OPD services are held in the hospital building itself and necessarily space and number of rooms are in great shortage. Most of the hospitals having no boundary walls neither the compound is protected against trespassers and animals nor the security and safety of the patients as well staff are assured particularly at night time.

The staff are not equitably distributed according to the load of work. Special mention may be made of the subsidiary health centres where a single medical officer has to look after, in-door, OPD, family planning, preventive and administrative works. Neither for in-door nor for the OPD laboratory facilities are provided nor utilised even in places where a laboratory technician and microscope are available. Inspite of these deficiencies the present study has revealed that the demand for the OPD services is considerable but the services at present provided by the OPD'S have generally been poor even in respect of basic requirements like the quantity and quality of medicines and their regular supply, absence of shed or space and sanitary arrangement for waiting patients and lack
of diagnostic facilities. The present study has also shown that more than two-thirds of the patients (actual 72 percent) were labour cases, the remaining one-third or less were general cases, of which, again 50 percent were suffering from preventable diseases indicating greater emphasis to be put on maternity and child welfare and family planning. Bed occupancy rate was extremely variable ranging between 33 and 132 percent and the best utilised hospitals were the 20-bedded ones. But high bed occupancy rate does not necessarily indicate the efficiency of the hospital because the hospitals are not properly equipped with facilities for any major type of operation nor for treatment of serious cases. Hence arises the need for transference of cases to larger hospitals but the ambulance is provided only in a few places and even some of the primary health centres are not situated on a motorable road side.

Administratively, the present system has been found to be very inconvenient, the Chief Medical Officer of Health of the district being the controlling officer, all medical officers of either primary or subsidiary health centres have to come personally to district head-quarters for staff salary every month and have to depend on the time and convenience of the busy C.M.O.H. for official orders.