CHAPTER - I

INTRODUCTION

Not very long ago India was considered as a land of poverty and millions. The position is, however, progressing towards a change after the attainment of independence. A large majority of her people (80%) lives in villages and depends almost entirely on agricultural economy. Prior to independence, there was very little attempt to develop some rural industry except perhaps weaving and cottage-craft. But the greatest menace of rural living was the high prevalence of parasitic, and infectious diseases like malaria, kala-zar, filaria, hook-worm, cholera, smallpox, diarrhoea, dysentery, skin and respiratory diseases. In fact, the villages were almost working as multiple endemic foci of these diseases throughout the length and breadth of India.

Sometimes villages were devastated by heavy epidemics of malaria, cholera and small-pox, and people were left in perpetual condition of malnourishment, under-nourishment and low vitality condition. But for this major section of population, there was hardly any health services to mitigate their conditions. The only succour, the rural people of limited areas could get, was some very sparsely
distributed dispensaries provided either by some philanthropic persons, local zamindars or by District Boards. But these could not make any impact on the heavy morbidity and mortality prevalent there. The only other health activity, introduced since 1928, was a provision of a Sanitary Inspector for each thana area covering a population of 80,000 to 100,000. This system also failed to change the morbidity conditions in any manner.

On the other hand, too much importance can not be laid on the necessity of providing health services and other measures that would ensure and maintain healthy peasantry, the back-bone of Indian economy. It is needless to mention that much of the backwardness of the population in respect of health, production and economic condition is directly associated with their poor health, illiteracy and absence of medical care which they need most. If one evaluates the loss, which this country has been annually suffering through the avoidable waste of human material and the lowering of human efficiency through malnutrition, epidemics and preventable communicable diseases, the extent of the damage and the loss to the country created by these conditions, can be estimated. Only a stark realisation of the grievous handicap which has been retarding the country's progress
could help to mobilise an all-out effort for a campaign to redress these conditions.

Fortunately for India, such a realisation was made possible by the report of the Health Survey and Development Committee popularly known as the "Bhore Committee" which was published in 1946 as a memorable document, first of its kind in India, to serve as a pace-maker and to bring home to her people and the government the essential need for providing a net-work of Health Centres all through out the rural areas of the country.

A successful pilot experiment on the Health Centre Scheme carried out at Singur in the district of Hooghly by the staff of the All India Institute of Hygiene and Public Health, Calcutta in collaboration with the Health Department of the Government of West Bengal, encouraged the authorities to accept the recommendations of the Bhore Committee and implement them.

It was also simultaneously realised, based on the practical experience of the workers in the field, that the most effective progress even on health matters could not be made in isolation. It needed a closely co-ordinated steps and advances in other complementary nation-building activities such as, agriculture, animal husbandry, irrigation, small-scale industry and crafts, co-operatives, housing, communication, education including
social education, community organisation and social welfare plans. The Planning Commission took cognisance of these facts and felt the need of such a development, and proposed to cover the rural areas with community development projects. Thus the Community Development Projects were started in 1952 followed by the National Extension Scheme, and within a decade covered a considerable part of the country with Community Development Projects which are still operating. Eventually the Health Centres were also absorbed as a part and parcel of these Development Projects following the trend, which demonstrated the principle of integrated decentralisation for health and allied services in different parts of the world.

At the beginning, the functions of the Health Centres included the curative and preventive aspects only namely, (i) medical relief through Out-patient Departments, (ii) control of communicable diseases, (iii) environmental sanitation, (iv) maternity and child welfare, (v) school health, (vi) collection of vital statistics, (vii) immunisation, and (viii) health education. But it was soon realised that morbidity and mortality conditions were so high that medical care services was rather considered essential to bring
immediate relief to the people. Accordingly, it was also decided to provide both in-door and Out-patient Services to as many places as possible. In other words, the efforts of the present-day Government were directed towards establishment of comprehensive health care in the rural areas. And thus the function of the Health Centres have now been directed to give an integrated promotive, curative and preventive service on an organised basis to fulfil the original recommendations of the Bhore Committee.

With the above objectives in view, the Government of West Bengal not only established a net work of Primary Health Centres to gradually cover the entire rural areas of the State but also provided at least three sub-centres per Primary Health Centre to bring the health services as near to the people as possible. After many thoughtful deliberations and scanning of the problem, the Health Department prepared a varied programme of providing hospitals of different bed-strengths at all primary and subsidiary health centres, in as many places as possible within a specified period of time depending upon the availability of trained staff, particularly medical and nursing, and of resources and also of peoples' co-operation and demand. Accordingly, some Primary Health Centres were provided with 50 beds a few with 30, some with 20
and others with 10 beds and a proportion of the Subsidiary Health Centres were provided with 10 and some with four beds during the period between 1949 and 1966.

The author, had the privilege of serving for a period of three years between 1960 and 1963 as a Medical Officer of the 50 beded Hospital at Singur - the first Health Centre established in West Bengal in 1937. During these periods he got the opportunities of studying the value and effectiveness as well as many short comings of the health services provided by these rural health centres. Subsequently he worked as a Medical Officer in the District Hospital of Burdwan and gained further experience in rural hospital system in West Bengal. Since all operations should be followed by evaluation in order to discard the old and ineffective techniques he felt the need for carrying out an assessment of the system, which was not done since the establishment of these hospitals. He considered it to be highly necessary to find out the various administrative financial, economic and social implications which accrued, following the services offered by the hospital system for the benefit of the people.

This ultimately led the author to undertake the study of the problem "Epidemiological study on the morbidity conditions and socio-economic aspects of
hospital admissions and administration in rural health centres of West Bengal under the guidance of Dr. S.C. Seal, Emeritus Medical Scientist, Indian Council of Medical Research.