The early history of development of medicine, medical services and of establishment of hospital system for medical relief, is very scanty in India. From whatever scattered records that are available, it may briefly be stated, that till very lately, medical relief in India was confined to treatment of individuals by indigenous physicians, quacks and charlatans and there was practically no existence of any community medicine or preventive services except the traditional sanitary system in the shape of providing housing, streets and drainages in the towns and personal hygiene introduced in the community though religious practices like bathing, cleanliness, exercise (mental and physical) dieting, fasting and recreation. (Manu Samhita)

The existing ancient literature in India has some evidence to show that Kings employed physicians (surgeons) for the care and treatment of the army, in war. The Kings also had their court-physicians but the public had to seek advice and treatment from the private practitioners while in the rural areas people had to be satisfied with
traditional methods through the so-called medicine men with or without training by any accredited practitioner.

The first establishment of medical relief for the general public through hospital, was during the Buddhist era (5th century B.C) and particularly during the regime of Ashoka (3rd century B.C.). Between 101 and 77 B.C., King Datta Gamini established hospitals in eighteen different parts of Ceylon and provided them with medical staff, medicaments and food, suitable for patients and invalids. In the 1st Century A.D. Nighevasa of Kashmir and King Harsha of India in the 7th century A.D. were known to have hospitals with medicine, physician and staff. It is also recorded that King Buddhadisha, in the 4th century, himself nursed sick people in the Institutions established by him. It is said that Alexander when he invaded India employed Indian Physicians for giving relief to his army. During the 12th century King Parakrama Bahou opened a hospital containing many hundreds of rooms and provided it with male and female attendants, good treatment and good foods. Between the 12th century and the British occupation in India in the 18th century, there is very little record of hospital system in India. The change of the political control from the hands of the Hindus to those of the Muslims invading from the North Western Countries considerably disturbed the existing

* (Seigerist, 1951; Rene Sand, 1952)
social institutions including that of the system of medicine and medical practice. During this period, the existing Ayurvedic system was replaced in many places by a new system of medicine called "Unani" (Hakimi) and there is no evidence of any community medicine being provided in the shape of hospital, as we understand at present.

2. DISPENSARIES & CLINIC

In India, the few hospitals that were developed during the Pre-Christian and early Christian era, provided free treatment but it is not known whether a typical dispensary system was maintained, as in the present day. Such a system was already existent, in U.K., France and other European countries since 17th century when the British came to India. They adopted the system for their own army, following their occupation of certain parts of India and established hospital services which were later extended to the civil population.

3. RURAL MEDICAL RELIEF

Till very lately, there was hardly any hospital system for the rural population in India. Although the Local self-Government for the rural areas in the form of
Union Boards with responsibilities of health services, was introduced following Montagu-Chelmsford Reform of 1919. In some districts, District Board Dispensaries with or without beds were provided and a few scattered private dispensaries were established by the Zaminders or philanthropic persons in certain rural areas but such services were insignificant compared to the vast morbidity and mortality conditions prevailing in the rural areas. (Dutta, 1946).

The only other health activities in the rural areas was the provision of a Sanitary Inspector for the control of communicable diseases for every thana area comprising 80,000 to 100,000 population. This brought about the change in emphasis from disease administration to modified health administration. (Shore Committee's Report, 1946).

This service also brought no tangible benefit to the rural population except some anti-epidemic measures at the time of an epidemic, raging in the villages.

The actual change in the provision of medical relief and health services to the rural population began after the recommendations made by the Health Survey and Development Committee were available in 1946. These recommendations were made effective following the attainment of independence in 1947.
One of the revolutionary changes, proposed by the Bhore Committee was the integration of preventive and curative health services under a unitary system of "Health Service". This suggestion was reviewed by the Mudaliar Committee (1961) and followed by a special committee constituted on integration of health services, by the Director General of Health Services, New Delhi in March, 1967. This Committee after a careful consideration of the various viewpoints of Public Health Administrators in India, strongly recommended the policy of integration of preventive and curative health services at all levels of Health Administration.

India thus being wedded to the philosophy of integrated health services planned her organisation from the periphery to the Centre in a way that, giving the determination to meet the challenge, it would enable her to meet the needs of the largest number of communities in the quickest possible time avoiding as far as possible, wastage of manpower and uneconomic parallelism in the dichotomy of Health Services into Public Health and Medical Care. (Das Gupta, 1952).
4. CONCEPT OF HEALTH CENTRE

The integration that was suggested was based on the philosophy that with the advancement of medical science, the concept of role of health also changed considerably. Now it is not merely cure and alleviation of diseases but it aims at maximum physical, mental and social well-being of the Community-through a co-operative and co-ordinated endeavour of all types of health services providing a comprehensive health care i.e. promoting positive health, preventing disease, detecting and treating diseases at the earliest moment, so as to prevent disabling consequences or at least limit them to the minimum extent and rehabilitating the individual into a useful and as practicable a life as possible under the circumstances. (Seal, 1957 Editorial J.I.M.A.). Thus the Health Administration became fuller and more comprehensive as far as Community Health was concerned.

Such an integrated service could only be given to the rural population through a Health Centre Complex conceived by the Bhaore Committee. Eventually the functions of the Health Centre was broadened in scope and
included both hospital and out-patient services with home care and follow up programmes through medical social workers and health visitors and in certain circumstances services by the mobile units, in addition to the promotive and preventive services such as, (a) maternity & childwelfare including pediatric care, (b) family planning, (c) school health, (d) control of communicable diseases including immunisation programme, (e) environmental sanitation, (f) collection of vital statistics, and (g) health education. The social and economic aspects are taken care of by Community Development Project of which the Health Centre (Health Unit) is only a component part.

Accordingly, the following vertical organisation for medical care through hospitals in the whole State was proposed to be established by the West Bengal Government:

(i) General Hospital (all Departments) usually in the cities and including teaching hospitals.

(ii) District Hospital at the Head quarter of the District.
(iii) Sub-Divisional Hospital at the Sub-Divisional level.
(iv) 50-bedded hospital at the Secondary Health Unit (one for each 60,000 to 80,000 population).
(v) 10-bedded hospital in the Primary Health Centre (1 for 90,000 population).

In practice, there being no Secondary Health Centre, hospitals of different bed-strengths were ultimately distributed as follows:

(i) Primary Health Centres were provided with three-four types of hospitals, namely -
   50-bedded, 30-bedded, 20-bedded and 10-bedded, more or less depending upon the importance of the place, demand of the people and availability of lands and funds.

(ii) Subsidiary Health Centres were provided with ten or four bedded hospitals and in a few places two bedded non-dieted hospitals.

5. FUNCTIONS OF THE RURAL HOSPITALS

In respect of the functions of the rural hospitals
an expert committee set up by the World Health Organization, made some useful suggestions briefly summarized below:

(i) Care of the sick and the injured.
(ii) Promotion of health and prevention of disease.
(iii) Health Education of the public.
(iv) Advancement of research in scientific medicine.
(v) Education of physician, nurses, and other health personnel.

Of these broad functions, the rural hospitals should have the following components:

(a) In-patient section comprising medical, surgical, obstetrical, infectious and emergency beds, the emphasis being laid on maternity and child health and control of communicable diseases (through measures taken by the health staff) following admission of infectious disease cases in the hospital.

(b) Out-patient department with or without special clinics on (i) Antenatal care, (ii) Child health, (iii) Tuberculosis, (iv) School Health
(v) Specialists services such as general medicine, surgery, eye, dentistry and gynaecology etc.

Further, it was also proposed to introduce follow up and home-care services to be provided for certain types of patients attending the outdoor or special clinics e.g. Pediatrics, maternity, tuberculosis, through Public Health Nurse or Medical Social Worker.

(c) Health education to be carried out in hospital wards and O.P.D., designed not only to help patient but also their families at a time when they are specially receptive to the advice of the doctors, nurses, and medical social workers, particularly in respect of antenatal and child-care, and seeking of medical relief as early as possible after symptoms arise.

(d) Clinical laboratories for aiding diagnosis as a part and parcel of the hospital.

(e) Participation of local medical practitioners in hospital activities of the Health Centre. They may be associated in the rural hospital
services by involving them as
(i) member of the Hospital Committee,
(ii) by admitting their patients in
hospital (when bed available) and
(iii) allowing them to see their
cases in the hospital.

5. SCOPE FOR TRAINING AND RESEARCH

Among the five broad functions of modern hospital
enunciated by the W.H.O. Expert Committee, the rural
hospitals have however no direct scope for the func-
tions No. (iv) and (v), but both the physician, and
the nurses will no doubt gain a new type of experi-
ence of dealing with cases in the absence of adequate
facilities made available to them, and this experience
is of greater importance than that of a well-equipped
and well-staffed hospital in cities and towns. At
least, in one particular service namely Family Planning,
doctors will get enough scope for research. Besides,
there are other possible scopes which will be discussed
in this thesis.