CHAPTER IV

RESPONSE OF THE GOVERNMENT TO THE MODES OF

HEALTH CARE DELIVERY

This chapter deals with the essential features of the Government's Policy and approach in the delivery of health care to various sections of the population through such schemes as (1) Subsidised Rural Medical Relief Scheme, (2) Primary Health Centres, (3) Family Planning, (4) School Health Services, (5) Port Health (quarantine), and (6) Role of the Voluntary Health Organisations.

The pattern of expenditure on Medical and Public Health activities has been taken up first for examination:

PATTERN OF EXPENDITURE ON HEALTH CARE

The pattern of expenditure of the State Government on health care under Medical and Public Health is indicated in Table 4.1. The trend shows a clear preference for curative side (Medical). This trend continues throughout the period 1940-'53.¹ During 1943-'44 the expenditure incurred on curative services was more than four times than that on preventive side. Similarly, during 1941-'42, 1944-'45, 1945-'46 and

¹ Madras State Administration Reports - 1940-'41 to 1952-'53.
<table>
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<td>380.34</td>
<td>5.56</td>
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(Rs. in lakhs)

Source: Madras State Administration Reports, 1940-'53.

*Increase was mainly due to the transfer of Rs.1.00 crore to the Fund for the Development of Rural Water Supply.*
1950-'51 the expenditure on curative side was more than three times than that provided for preventive side. During the other financial years also the increased expenditure on medical (curative) continued. As compared to 1940-'41 the total expenditure on preventive side and curative services increased by 3.74 and 5.77 times respectively during 1950-'53 though the quantum of expenditure on preventive services (Public Health) was only Rs.205.71 lakhs as against Rs.360.34 lakhs for curative side (Medical). The increase of expenditure on preventive side of health care from Rs.35.63 lakhs in 1940-'41 to Rs.205.71 in 1952-'53 clearly shows the relative importance given to preventive side also over the years. However, the trend of expenditure during 1940-'53 shows a clear preferential position for curative side of health care. However, it must be assumed that on the whole the Government's desire to allocate more funds for health care systems was limited by resources constraints.

In the following sections an attempt has been made to understand the way in which the Government had proceeded to deliver health care to the people. Here the focus is mainly on Government Policy in determining the mode of some of the measures introduced.
RURAL HEALTH SCHEMES

The allopathic system of medicine was introduced in India by the British rulers in the 18th Century. Dispensaries and hospitals were established in an ad hoc manner in the rural and urban areas. As the Government realised that existing medical facilities in rural areas were not adequate, it introduced for the first time in 1924 a scheme of Subsidised Rural Medical Relief Scheme (SRMRS) specifically designed to bring medical relief within easy reach of the rural population through deployment of trained medical men. Till mid 1920s the rural population had no opportunity to come into contact with qualified medical men. They largely depended on the so called quacks and unqualified practitioners of Indian Systems of Medicine.

The question of expansion of rural medical relief by the Government was beset with constraint of finance. Government had, therefore, put a ceiling on the total amount it could afford to spend in future. This was about double the amount it spent in 1924 on medical relief for the whole Presidency i.e., about Rs.100 lakhs. However, funds required for opening new hospitals and dispensaries were not available. The likelihood of their becoming available in the near future

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2 G.O.No.1522, Public Health, 22 October 1924.

3 ibid.
was bleak. Therefore, the Government resorted to cheaper mode of giving medical relief without serious loss of efficiency. Three alternatives were studied. Government thought that these alternatives would ensure that the expenditure would not go beyond the funds available. The alternatives were:

(i) to open a large number of ayurvedic and unani dispensaries;

(ii) to start mobile dispensaries;

(iii) to encourage qualified private practitioners of allopathic medicine to settle down in rural areas for practice by giving them incentives.

The first alternative could not be implemented since there were not sufficient qualified practitioners of indigenous systems of medicine. Though the second alternative was tried for a few years because of its financial advantage as compared to the expenditure on establishing new dispensaries, it was subsequently abandoned. The main reason was that the mobile dispensaries cannot generally be had on the spot when wanted by the sick villagers. When it was present,

4 ibid.

5 Ayurveda, Unani and Siddha Systems of Medicine are called Indigenous Systems of Medicine.

6 G.O.No.1522, Public Health, 22 October 1924.
there might be nothing at all for the medical officers to attend. Thus, the third alternative was the only course available viz., Subsidised Rural Medical Relief Scheme. The scheme was introduced in 1924. It was thought to be the best method to expand health care delivery system in villages. The scheme contemplated subsidising qualified private practitioners who came forward to settle down in villages.

The main conditions governing the scheme were:

(a) The medical practitioners had to agree to settle down in villages specified by the Presidents of the Local bodies;

(b) They should treat the very poor patients whose income was less than Rs.30 p.m. free of charge;  

(c) They would not be considered as Government servants;

(d) Subsidy of Rs.600 per annum for graduates and Rs.400 per annum for licentiates in medicine;

(e) Rs.100 per annum to the qualified midwives;

(f) The local boards concerned should supply medicines worth Rs.360 per annum to each of the subsidised

7 G.O.No.399, Medical, 17 September 1971;  
G.O.No.1454, Public Health, 1 November 1921.
dispensaries, 8 to be given to patients free of charge:

(g) The total expenditure incurred by a dispensary came to about Rs.1,000 per annum which should be shared by the Government and the Local bodies in the ratio of 3:2. 9

The SRMRS faced many problems after its introduction in 1924. They were:

(i) Absence of clear conditions regarding the length of tenure of the medical practitioners. This led to misuse of power by the Local Boards. This discouraged the medical practitioners to establish themselves permanently in the rural areas:

(ii) Another defect was the conditions governing the supply of drugs. Each subsidised rural dispensary was getting a standardised package of drugs/medicine costing not exceeding Rs.360 per annum. The drugs/medicines supplied had no relation to the disease - pattern in the area concerned: 10

(iii) Paucity of qualified midwives, compounders, etc.

8 G.O.No.761, Public Health, 7 April 1925.
9 G.O.No.1522, Public Health, 22 October 1924.
(iv) Those serving in the subsidised dispensaries were paid much less than their counter parts in the Government medical institutions; \(^{11}\)

(v) Lack of schooling facilities for the children of the medical practitioners which discouraged them to settle down in villages; \(^{12}\)

(vi) Lack of scope for private practice. \(^{13}\)

Inspite of the above drawbacks the SRMRS expanded initially. But, the scheme came to a halt in the 1930s as a result of the economic depression of 1929-’33. The attitude of the Government was not encouraging for expansion of the scheme for delivery of health care in rural areas. The scheme was in existence for a period of about five years.

It is clear that in the pre-independence colonial regime, rural areas were treated with neglect in the matter of development of welfare services. Medical services consisted mainly of a few dispensaries scattered at long distances rendering medical relief a rare commodity to those who were in dire need of it. Public health services were concerned


mainly with chasing epidemics through the efforts of the District Health Officers with his grossly inadequate staff. Both preventive and curative services were negligible.

In 1946, the Bhore Committee recommended the establishment of Primary Health Centres (PHCs) for making medical and health services available to the rural population near their homes. This process started in 1951. In this connection it has to be observed that in providing health services to a country one must also bear in mind the present concept and goal of health. Health services should not concern merely with diagnosis, treatment and rehabilitation of the sick, not even prevention of diseases, but should look beyond and strive for maximum physical, mental and social efficiency for the individual, his family and for the community. In other words, it means co-ordinated health services aiming at providing a wide spectrum of comprehensive health care, promoting health, preventing disease, treating promptly to prevent disabling sequences and restoring the individual to a state of health in which he can again be a useful member of the community.

Government realised that the existing facilities in rural areas were inadequate. During 1925, the total number of Medical Institutions in the State were 735.14 During the

14 G.O.No.1606, Public Health, 22 November 1921.
INTEGRATED HEALTH CARE

Different health workers approaching a rural family for their own programmes while the family is worried about their sick child.

Under an integrated health programme, multi-purpose Male and Female health workers provide service for all relevant health problems in a family.
economic depression of 1929-'33 no additional hospitals were started. The Table 4.2 shows clearly the number of medical institutions classified into rural, urban, subsidised rural dispensaries, State, local bodies, private etc., functioning in the State during 1940-'52. The variation in the number of institutions was mainly due to the closing of the subsidised rural dispensaries as the response from the medical men to take up appointments under the scheme continued to be poor. Some of the dispensaries were converted into dispensaries of Indigenous Medicine.\(^\text{15}\)

The Primary Health Centre is an institution which offers a package of services to the people living in its jurisdiction which is usually the area covered by a Block viz., Panchayat Union.\(^\text{16}\) The P.H.C. has been established in all the blocks in the State. The services rendered by the P.H.C.s are improvement of vital statistics, family welfare planning, general medical care, improvement of maternal and child health service, improvement of environmental sanitation, safeguarding of drinking water resources, prevention and control of communicable diseases by immunisation with suitable vaccines and by surveillance to detect the occurrence of communicable diseases like smallpox, cholera and malaria and institution

\(^{15}\) G.O.No.466, Health, 27 February 1954.

\(^{16}\) ARDPH, 1973, p.4.
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<td>904</td>
<td>320</td>
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<td>244 251 503 127 54 45</td>
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Source: Annual Reports on the Working of the Civil Hospitals and Dispensaries in Madras State.

- Break up
  1) General Hospitals and Dispensaries: 1121
  2) Institutions for Women and Children: 58
  3) Specialist institutions such as for T.B., Ophthalmia, Mental, Leprosy, infectious diseases Hospitals etc.: 45

Total: 1224
of suitable control measures, nutrition education and control of nutritional diseases, collection of morbidity statistics, health education and publicity. 17

Sub-centres were subsequently created which functioned through the P.H.Cs. A P.H.C. is intended to serve a population of 80,000 to 1,00,000, while a sub-centre is expected to serve a population of 5,000 to 10,000. Today, sub-centres as well as P.H.Cs exist in all the blocks into which the State is divided for development purposes. A P.H.C. is provided with two or three medical officers, one of them being designated the Block Medical Officer. In addition to the medical officers, staffing pattern for a P.H.C. has been prescribed which include personnel for the dispensary, family welfare, basic health service, malaria, smallpox, etc.

A Primary Health Centre usually services 8 to 10 sub-centres. Each sub-centre has a male multi-purpose worker, invariably an Auxiliary Nurse Midwife (ANM). In addition, there is usually a provision for the appointment of a trained dai (midwife) to assist the ANM. The staff is meant mainly to look after maternal health, child care and family planning. The sub-centres are supervised by senior-level para medical staff including those who worked as Sanitary Inspectors, Block Extension Educators or Multi-purpose Health Assistants. The

17 ibid., p.4.
Block Medical Officer bears overall responsibility for the P.H.C. and all the sub-centres working under it.

Facilities exist in the P.H.C. for attending to out-patients and in-patients. In some cases, beds are provided exclusively for the family planning services. Laboratory services are available for simple medical tests. In some P.H.Cs. X-ray facilities are also provided.

The functioning of the P.H.Cs and sub-centres is limited by the following factors:

(a) There is a general shortage of doctors and of female para medical workers in the P.H.Cs.

(b) Over lapping of authority, pre-occupation of doctors with paper work, insufficient budget allocation for maintenance of vehicles - all these handicap the performance of the P.H.C. doctors.

(c) P.H.C. doctors do not, in general, visit homes in the area under their jurisdiction.

(d) There is shortage of medicines in the P.H.Cs. Therefore, patients have to purchase medicines from the market.

(e) Pathological testing and X-ray facilities are inadequate at the P.H.C.
In-patient facilities are not used in some P.H.Cs. However, the organisation of malaria work is generally satisfactory.

From the above limitations it is evident that the rural health infrastructure is not very impressive. Decision-making is confined to higher levels viz., State Department of Health and Family Welfare in respect of general health services and the Central Ministry of Health and Family Welfare in respect of family planning, a part of child welfare services, etc. This multiplicity of decision making bodies at higher levels create difficulties in a coordinated development of this multidimensional health programme. This explains the short falls and delays encountered by the P.H.Cs and sub-centres in timely recruitment of personnel, procuring equipments, medicines, drugs, allocation of enhanced finances, etc.

Another defect in the system is in regard to the population norms laid for P.H.Cs and the sub-centres. In applying the norms, the minimum that is required is to supplement the population criterion by geographical consideration (i.e., flexibility in applying the norms to hilly areas and parsely populated areas), including the existing transport and communication facilities made available at a particular

place. Adequate attention was not given to these factors. Another drawback is the location of the P.H.C. or sub-centres. It seems that the choice of location mostly compromised the need maximising accessibility to the services.\textsuperscript{19}

It is thus evident that the rural health services suffer from many limitations and shortcomings. The continuance of these shortcomings is attributable to the bureaucratic system and procedures that have characterised the evolution and functioning of the services. The performance of the rural health services has not been satisfactory. In other words, the existing set up is capable of solving only a small part of the health problems faced in the rural areas.

The task of providing primary health care to all who need it is, however, not going to be easy. The only way in which the health services can be organised rapidly and effectively is for the Government and the communities to make major efforts to develop primary health care services at the community level. The following basic principles should be followed if these efforts are to be successful:\textsuperscript{20}

(a) Primary health should be shaped around the life styles of the people to be served;

\textsuperscript{19} ibid., pp.120-122.

(b) The local people should be actively involved in planning health care so that it suits their needs and priorities;

(c) The health care offered should make maximum use of community resources, especially those which have hither to remained untapped, and should remain within limits of the funds available;

(d) Primary health care should not only deal with the prevention and care of disease but also promote health in the community, in the family and in the individual;

(e) All health interventions should take place in or as near as possible to the patients' home and be carried out by the trained worker to give the treatment in question;

(f) Other services in particular supplies, supervision and referral and technical support should be designed to support the needs at the local level.

The most important factor is that the health team should be an efficient one in health care delivery. The success of the team depends on its functional structure and its flexibility to adapt to different conditions. Responsibility
of each member of the health team should be clearly defined and there must be co-operation and mutual understanding among the members of the team to make the rural health services a success.

FAMILY PLANNING

Family Planning is primarily a preventive health measure i.e., prevention of unwanted births leading to the ill-health of the mother and the well-being of the family. It is thus a public health measure which along with other preventive measures help to improve the standard of living of the family. It is also a socio-economic welfare measure due to the restriction of the family size. In other words, it is actually a family welfare measure which limits or restricts the family size. The chief cause for the need to implement the family planning is the sudden rise in population, so much so that if the situation is not brought under control in a comparatively short period, it would become very difficult for all the people to live with peace and content in this world. Famines, epidemics and wars are the three important scourges of mankind. They have prevented undue growth of the population by bringing about sudden deaths during one of these episodes.

The discoveries and advances in the medical sciences have brought down the death rate enormously. Along with
this the introduction of preventive measures in the public health programme, has definitely improved the health of the people resulting in drastic reduction in the number of deaths every year. The birth rate, however, has remained high. The net result of this has been the sudden increase in the population.

Growth of population brings about an enormous strain on the economic status of a nation as it has got to provide for food, shelter, clothing, employment, etc., for the people. If the rising population were to keep pace with production of food and industrial development, the question of family planning would not have arisen. But while the population increases geometrically, the food production, etc., increases arithmetically. Such an increased population is a serious challenge to the country. Having already realised that the benefits accrued from all their projects and plans were neutralised due to increased population, the Planning Commission gave top priority to the family planning programme with a view to reduce the birth rate.

The advantages of family planning are:

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(1) It builds a happier family life;

(2) It protects the mother who is exhausted from bearing too many children and thereby leading to her ill-health;

(3) It protects the child with proper support for his future;

(4) It contributes to family stability;

(5) It seeks to avoid unwanted pregnancies and encourages the birth of children by design, by choice and not by chance.

India is the second populous country in the world, next to China. It has a meagre share of 2.4 per cent of the earth's land, housing a substantial share of 14.5 per cent of the total population of the world. The per capita land availability is minimal. The pressure on land reached almost a saturation point.

At the time of the 1891 census, India's population was 236 million. Thirty years later in 1921 it was 248 million i.e., an increase of 12 million. In the next thirty years 1921-‘51 the population increased to 257 million i.e., an increase of 109 million or 9 times the increase during the 30 year period between 1891 to 1921. Before 1921, one decade of rapid population growth was followed by another decade
of slow growth. This was primarily owing to frequent epidemics and famines. For example, it is estimated that India lost more than 60 million people at the time of influenza epidemic of 1918, and during the period 1898-1918, approximately half a million deaths were annually caused by plague. But since 1921 India has been relatively free from the ravages of epidemics and famines and the consequent decline in the death rate, rather than an increase in the birth rate, has resulted in a faster rate of population growth.22

Studies have brought out that each additional year of life expectancy at birth is associated with a decline in general fertility rate of 1.9 points. Effective literacy23 more particularly female literacy24 have been found to be strongly associated with family planning acceptance and high female age at marriage. Hermelin conducted an analysis which distinguishes urban from the rural areas and found that direct programme effects were more pronounced in urban areas. He


also found that programme has a significant additional effect where socio-economic factors were operating. It is undisputed that the casual analysis of fertility changes is extremely difficult to carry out with definitive results. Yet, several researches carried out in Asian countries have brought out that family planning programmes have contributed to fertility decline in those areas where modernisation was well underway and where the administrative, political and social setting was favourable to the implementation and diffusion of a family planning programme.

The population policy varies from country to country and has to be in conformity with the economic and social situation obtaining in a country. There are, however, certain measures which have, by experience, proved to be effective in controlling the growth of population in many developing


countries. These are: 28

(1) Spread of education among the population;

(2) Participation of women in gainful employment outside the home;

(3) Abolition of or reduction in the economic value of child labour;

(4) Reduction in infant mortality;

(5) Restraint on early marriage;

(6) Decline in traditional religious beliefs which support high fertility norms;

(7) Attenuation of the extended family;

(8) Adoption of social security measures like old age pension, unemployment relief, etc.;

(9) Provision of different birth control methods as alternative choices and as close to the homes of the people as possible;

(10) Increase in the per capita income of the economically weaker sections of the society.

Each of the above measures has stood the test of time by proving its efficiency and earned a world-wide recognition as a curbing influence on the growth of population.

HISTORICAL BACKGROUND

The family planning movement in India from its beginning in 1916 till the Government launched an official programme in 1951 was the result of the efforts of a few dedicated individuals and some voluntary organisations. The late Pyare Kishan Wattal drew attention to the population problem in his book The Population of India, published in 1916. The late Professor Raghunath Dhondo Karve faced a great deal of hardship and had to give up his official position for advocating family planning.

In 1923, Professor N.S. Phadke started the Birth Control League in Bombay and about the same time Shri G.D. Kulkarni formed a similar organisation in Poona.29 The great poet Rabindranath Tagore supported birth control. In a letter to Mrs. Margaret Sanger in 1925 he expressed his gratitude to her for championing the cause and stated: "I am of opinion that birth control movement is a great movement not only because it will save women from enforced and undesirable maternity, but because it will help the cause of peace by

lessening the number of surplus population of a country scrambling for food and space outside its own rightful limits. In a hunger stricken country like India it is a cruel crime thoughtlessly to bring more children into existence than could properly be taken care of, causing endless suffering to them and imposing a degrading condition upon the whole family".30

For the first time The All India Women's Conference took a stand on birth control in 1931. A birth control clinic was started in 1936 in Bombay. In 1936, Dr. A.P. Pillai conducted a family planning training course. In 1937, Dr. Raina started the 'Help our Mother Society' in Ujjain which included birth control advice among its services. Mrs. Palmer of the Birth Control World Wide made notable attempts to propagate family planning in the United Provinces during 1939. In 1939, some birth control clinics were opened in the United Provinces and Central Provinces. In 1940, Shri P.N. Sapru successfully moved a resolution in the Council of States for the establishment of birth control clinic.31

An instance of the Government action during the entire period was the step taken by the Mysore Government to open a family planning clinic in the State during 1930. Two years


later in 1932, the Government of Madras agreed to open birth control clinics in the Presidency. The National Planning Committee appointed by the Indian National Congress in 1935 under the Chairmanship of Jawaharlal Nehru, strongly supported family planning. 32

The Health Survey and Development Committee appointed by the Government of India in 1943 under the Chairmanship of Shri. Joseph Bhole recommended that provision should be made to open birth control clinics in various Government hospitals for reasons of health of mothers and children. In 1949, the Family Planning Association of India was formed in Bombay under the Presidency of Shrimathi Dhanvanthi Rama Rao. 33 This was the situation just before the country became independent, a situation in which the interest in the population problem waxed and waned periodically. The efforts of these people lacked public support. However, these were the individuals and organisations who deserved recognition as the pioneers of birth control.

The planning development of the country was taken up after Independence. The Government of India appointed the Planning Commission in 1950. Soon after, a Committee was appointed to go into the health programme and a separate

33 S.L. Ogale, et.al., p.114.
Committee was asked to report on population growth in India. As a result, family planning was given a place in the First Five Year Plan (1951-'56). Subsequently, in 1952, family planning was officially accepted as a national programme because of the magnitude and the urgency of the problem. The factor which weighed heavily in favour of the family planning programme was the gap between the birth rates and the death rates arising out of ever increasing high population growth rates. In the First Five Year Plan, a provision of Rs.65 lakhs was made by the Government of India for a family planning programme designated to discover effective techniques of family limitation and to suggest methods by which knowledge of technique could be widely disseminated. Considerable progress was made in the opening of family planning clinics, both in the urban and rural areas. At the end of the First Five Year Plan there were only 147 such clinics, 21 in the rural areas and 126 in the urban areas.

In this connection it may be pointed out that desperate attempts to limit the family size and in the absence of proper facilities, women used to turn to quacks, dais (midwives) and paramedics. The indigenous, illegal providers of abortion services still dominate the scene. Their numbers outstrip that of qualified medical practitioners. The methods they use range from vacuum aspiration to use of twigs and other
foreign bodies including herbal concoctions. These abortion methods were studied in depth and well documented by the Indian Council of Medical Research (ICMR). Mr. Chhabra, a journalist and activist specialising in population, health and women's development issues has commented that it is sobering and heart breaking to note that sizable number of women remain vulnerable to primitive manipulations of this kind.  

In the beginning there was active resistance to the family planning programme. The reasons were:

1. Some people were convinced that practicing family planning is a contravention of the popular belief that children are gifts of God;

2. There was the feeling that the family planning movement would lower moral standards and the community would face with yet another problem;

3. Recourse to contraception is not only against well established religious practices but would invite the disapproval of elders as well as religious heads;

4. The general impression was that only a middle class


family accepts the philosophy of family planning with the result that the intelligentsia in the country was being whittled which would ultimately create an imbalance in the composition of the society:

(5) The fear of insecurity in old age and the hope of dependency on sons prompt people to covet more sons. Surveys have proved that this desire for many sons has been a very real compulsion that has led to over large families:

(6) Community leaders and religious heads have mooted a possible likely imbalance in the population strength community-wise, thus giving a communal facet to the element of fear;

(7) A family planning work does not bring in quick and speedy results. As such political parties remain indifferent to the movement;

(8) As regards the methods of family planning, prejudices and misunderstandings still linger in certain quarters.

Through a process of motivation and education, the Indian family planning programme depends for its success on voluntary acceptance by the people. The philosophy behind
the programme is as follows:36

(i) The community must be prepared to feel the need for the services in order that those may be accepted when provided;

(ii) Parents alone must decide the number of children they wish to have;

(iii) People should be approached through the media they respect and through their recognised and trusted leaders;

(iv) The services should be made available to the people as near to their homes as possible;

(v) The services will have greater allowance and effectiveness if they are made an integral part of medical and public health services, especially of the mother and the child health programme.

The family planning programme in India was adopted as an official programme. The programme was made time-bound and target oriented. It was only in 1962-'63 that the Government indicated the objective of the family planning

programme to reduce the birth rate from the level of 41 to 25 per 1,000 of population by 1973. As a result of the family planning efforts, there has been a marked decline in the level of birth rate. Between the years 1971 and 1981 the birth rate had declined by about 4 points. During 1965-'71 there was a decline of 2 points. Thus, in 1981 the birth rate of India was around 35.

The decline was attributed to family planning. More efforts will have to be made if the birth rate is to be reduced to the level of 21 per 1000 population by the year 1996.37 To assist in the family planning programme, the Government brought in the Abortion Act i.e., Medical Termination of Pregnancy (MTP) Act, in 1972. The implementation of the Act proved a success.38

STATE LEVEL POSITION

The family planning programme is a Centrally Sponsored Scheme and the State Governments get 100 per cent assistance from the Central Government. The States, however, are responsible for administering the programme. An organisation has been set up to provide family planning information and

37 S.N. Agarwala, _et al._, pp.221-224.
38 _ibid._, p.231.
service to the people - the Primary Health Centres and Sub-Centres as units in rural areas and the Urban Family Planning Welfare Centres as the unit in urban areas.

In the rural areas, the family planning programme has been integrated with public health and maternity and child health programmes at the P.H.C. Generally one P.H.C. is located in each Community Development Block. The P.H.C. has a number of sub-centres which operate as the primary functional units. These sub-centres have been organised on the basis of population (5,000 to 10,000) coverage. The P.H.C. has medical, paramedical, extension and statistical staff. Sub-centres are manned by an ANM and an attendant. In the urban areas, the family welfare centres are run by local bodies and voluntary organisations. At the district level, a District Family Planning Bureau forms a part of the district medical and health organisation and supervises the work of the urban and rural centres in the district. At the State level, State Family Planning Bureau is provided as a part of the Directorate of Public Health. At the Government level there is a Department of Health and Family Welfare under the control of a Commissioner and Secretary to Government who heads the family welfare structure.
The population policy measures of the Government of India as applicable to State Governments are: 39

(1) Freezing of people's representation in the Lok Sabha and State Legislatures on the basis of 1971 population till 2001;

(2) Devolution of taxes, duties and grants-in-aid to State Governments to be made inter alia on the basis of 1971 population figures until 2001 (this is where population is a criterion);

(3) Eight per cent of Central assistance to State Plans to be made against performance in family planning;

(4) Introduction of such other measures as the States consider necessary and desirable for promoting family planning also left to the choice of the States.

In addition to the above measures, the Government of Madras has introduced a number of incentives which applied to public servants. These measures were taken by the State Government on its own initiative.

The other important features of the population policy

were (a) the decision to raise the minimum legal age of marriage from 15 to 18 years for girls and from 18 to 21 years for boys and (b) increase in the amount of monetary compensation for sterilization to a substantial amount both for male and female acceptors. 40

The State-level Coordination Committee aims at securing coordination amongst the various Government departments and also with the non-official agencies. The State Grants Committee, advises the Government about the disbursement of funds amongst voluntary and local bodies engaged in the family planning work. 41

The media used for family planning programme propaganda are: film shows, mass meetings, group meetings, camps, home visits, exhibitions, posters and pamphlets. The District Bureau of Family Planning was provided with the necessary basic audio-visual material such as films, film strips, film projector and audio-visual van. The District Bureau were required to arrange the film shows, etc., in rural and urban areas in their jurisdiction. The family welfare programme is also projected through a number of programmes of All India Radio and Doordarshan. Apart from these the person-to-person

40 ibid.
41 ibid., pp.68-69.
approach is also being utilised with emphasis on group meetings. The involvement of the community is sought through the participation of local leaders and voluntary workers. The Government of India has instituted a scheme of award in order to inculcate a spirit of healthy competition amongst States. The Government of Madras received the awards a number of times.

The Urban Family Welfare Centres which are generally attached to district and other hospitals where primary attention is made to medical work and family planning work generally receives only secondary attention. The area of operation of a P.H.C. is too large. The resources, both human and physical, at its disposal for handling the task are very limited. Secondly, the P.H.C. is ill-equipped for extension work for family planning. Most of the audio-visual equipments are located at the district headquarters and are available to the P.H.C. once in a while. Thirdly, the sub-centres are understaffed and ill-equipped for the job. There is generally one ANM and attendant. Being women, the interior and distant villages are generally neglected. Moreover, they were generally not able to reach the menfolk of the villages. Another important matter is that the attitude of the State Government towards voluntary organisations is generally indifferent. These organisations often find it difficult to
get the assistance normally admissible to them in time. The educational and motivational aspect of the programme has not received adequate attention from the concerned authorities. However, inspite of all these drawbacks, the Government of Madras does not find it difficult to achieve the targets fixed for the family planning programme. In fact, the targets are generally exceeded.

SCHOOL HEALTH SERVICE

The School Health Service is one of the most important modes of basic health delivery. A child of today is the future adult citizen of the country. Therefore, the health and well-being of the children should receive the highest priority in any scheme of national development. Therefore, care of the child while at school is an important part of the comprehensive health services of any welfare state. The health status of a country depends to a large extent on the care taken of the health of the children, particularly when they are in schools. The expenditure incurred on the improvement of the health of the children would pay rich dividends in raising the standard of health of the future generation.

The child in the school is placed in an environment
different from the family unit. In the school the child comes into contact with a mixed groups of children coming from different layers of community life. The child exposes itself to the hazards of a new environment. School health service should, therefore, provide for promotion of mental health and detection of psychological problems in the school children at an early age when they are likely to respond to treatment.

Primary responsibility for the health of the child rests with the parents. The school cannot substitute for the parents. But, the idea behind the school health service is to plan, fortify and supplement the efforts of the parents. The objectives of the school health service are:

(a) Periodical medical inspection of children;

(b) Institution of remedial measures to correct the defects observed during the medical inspection and follow up;

(c) Preventing communicable diseases through immunisation programmes such as vaccination against smallpox, typhoid and tuberculosis;

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(d) Ensuring proper environmental sanitation in the schools including attention to housing facilities, protected water supply, drainage and disposal of waste;

(e) Health education to impart knowledge and develop healthy attitudes and habits;

(f) Improvement of nutritional status through supplemental feeding;

(g) Promotion of appropriate social and emotional behaviour.

The School Health Committee constituted by the Government of India had recommended that since the P.H.Cs form the basic health unit in rural areas, it would be advantageous that school health services were carried out as part of the activities of the existing P.H.Cs. In the alternative, the Committee recommended to examine the possibility of enlisting the services of private practitioners to attend to the medical inspection of school children on a part time basis.

The school teacher is also expected to play an important role in the school health programme due to his daily close contact with the students. In order to enable him to fulfil this role, adequate training in the field of school health and health education would be necessary. This training should
form part of the programme of the teacher-training. With such training the teacher would be in a position to attend to the following functions connected with school health scheme: 43

(i) Daily observation of children with a view to note any change from normal health;

(ii) Testing the vision and recording the height and weight;

(iii) Maintaining of the health records of the children;

(iv) Giving first-aid during emergency;

(v) Assisting the doctor while examining the children;

(vi) Follow-up action with a view to see whether the recommended remedial measures are adopted.

One of the defects found in the school health service programme is the absence of a satisfactory system for taking remedial measures and follow-up. In other words, there should be facilities for correction of observed defects. The following procedure should be followed:

(a) If the defects observed are of a routine nature treatment should be arranged in the P.H.C. itself:

43 ibid., p.175.
(b) If the defects require specialised attention, arrangement should be made to send the pupil to the nearest hospital;

(c) Beds should be reserved in hospitals for admitting the pupils referred for treatment.

It should be possible for the teacher with some training to spot common communicable diseases among the pupils and take appropriate action immediately. One of the important items in the school health programme should be immunisation of the children against preventable diseases such as smallpox, tuberculosis, etc. During epidemics appropriate preventive inoculations should be administered in the school. It is essential that healthy environmental conditions prevail in the school. Faulty construction of building, poor ventilation and lighting, lack of washing facilities, insanitary toilets and other deficiencies will obviously contribute to the ill-health of the pupil. Also the need for providing protected water supply and a satisfactory system of disposal of wastes cannot be over-emphasised.⁴⁴

POSITION IN MADRAS STATE

A periodic examination is arranged during their studies

⁴⁴ ibid., pp.116-118.
at school for which the students are charged a special fee. Physical 
examination of the teachers and other employees 
of the school is done for the safety of the pupils. The usual 
defects found among the school children are:

(a) Nutritional deficiencies which are corrected by midday 
meals or supplementary feeding programme;

(b) Other defects are eye defects, ear, nose, throat 
problems, round worms, thread worms, amoebiasis, 
tonsils, skin diseases etc. In towns and cities student 
clinics or separate wards for students are established 
in large hospitals where separate facilities for 
specialised examinations and investigations are 
available. In rural areas both the primary and 
subsidiary health centres act as integrated health 
care centres of the people including the school 
children. For ordinary ailments, the students get 
medical assistance from the P.H.C. If the defects 
found are complicated, the students are referred 
to the nearest Government hospital for specialised 
attention. Some of the private schools have their 
own medical officers and nurses, etc., and a clinic 
attached to their schools. Some of the schools have 
first aid rooms where a trained teacher attends to 
the emergencies.
The school medical inspection has been almost a total failure as far as its concrete benefits are concerned. The examination has been cursory, too many pupils examined in a day in a superficial way. The follow up of the defects found in the pupil during health inspection has been poor. This is the most important drawback of the system which is inevitable when the medical officer visits the school for a short period, only usually at the beginning of the school year.

The schools also verify whether the young pupils are immunised against diphtheria, whooping cough and tetanus by triple antigen, against smallpox by vaccination, against tuberculosis by HCG vaccine and also against other diseases. A better way of imparting health knowledge to the students is by organising health practices and holding frequent inspections. Proper exercise, games and plays supervised by the teachers should be encouraged. This improves not only the health, but also mental and moral health as well. The co-operation of the parents, students, teachers and the school medical officer is absolutely necessary for an efficient health service in schools.

PORT HEALTH (QUARANTINE)

The introduction of the quarantine procedure by the
Government is one of the modes of health delivery. International quarantine requires that each country should take effective measures to see that travellers from and to other countries by ship or aircraft do not carry into or out of country any infections or communicable diseases and in particular the six quarantine diseases viz., plague, cholera, smallpox, yellow fever, typhus and relapsing fever. Now-a-days due to quick transit facilities, no country is free from the import of the above deadly communicable diseases. By quarantine arrangements the ports of entry in each country are now well guarded against the influx of these diseases. These are governed by the rules made under the International Sanitary Regulations which were adopted by the World Health Assembly in 1951. The Government of India adopted these rules and issued rules and regulations under the Indian Aircraft (Public Health) Rules, 1954 and the Indian Port Health Rules 1955. They came into effect on the 17th October 1955 and 27th February 1956 respectively.

All the quarantinable diseases are present in India except the yellow fever. The Government of India, therefore, concentrated their attention on taking strict precautions against the entry of yellow fever infection into India. Passangers arriving in India by air or sea from a yellow fever infected area who are not in possession of international certificates
of vaccination against yellow fever, are detained in quarantine till such time as they cease to be a source of risk. Isolation arrangements have been made in various airports. The Government has established health organisations in all important sea and airports in India to exercise the necessary vigilance and control over international traffic and to ensure the application of International Sanitary Regulations, Indian Port Health Rules and the Indian Aircraft (Public Health) Rules. Health organisations directly under the control of the Central Government are functioning in all the important ports and airports to attend to the health clearance of international traffic.

The quarantine procedure adopted is both simple and effective. A list of all places in India, against which foreign countries have imposed quarantine restrictions on account of any of the quarantinable diseases, is maintained and notified every week. Information regarding the imposition of such restrictions is received from the Director, External Intelligence Station, WHO, Singapore. This is given wide publicity in the press for the information and guidance of the general public. Due publicity is also given to international health requirements for the passengers going abroad.45

Under the International Sanitary Regulations, India's obligation is to strictly observe certain minimum standards for keeping major ports and airports free from rats and mosquitoes. Anti-mosquito and anti-rodent measures are taken at airports. Hitherto, the Port Trust - Port Administration Authority were doing this work. The Government of India have, however, has gradually taken over the functions from these local authorities.

The Government of India takes responsibility in respect of the health arrangements on pilgrim ships and the observance of health requirements by Haj Pilgrims in order to save them from any inconvenience on their arrival at Saudi Arabia. Reports regarding health conditions on outgoing and incoming pilgrim ships are forwarded to the Ministry of External Affairs with whom a close liaison is maintained in all health questions pertaining to pilgrim traffic. The Bombay Airport (Santa Cruz) was declared as a first port of entry into India from the West. An emergency isolation hospital and a modern yellow fever isolation hospital function at the airport. The Eastern Traffic touches at Calcutta and Madras. Small isolation hospitals and yellow fever isolation hospitals are functioning at Calcutta, Madras and in other important airports. It is, therefore, clear that quarantine procedure (Port health)

46 ibid., p.178.
is one of the very important modes of health delivery. Lack of adoption of such procedure by a country would entail influx of communicable diseases into the country from abroad.

**MEDICAL CARE**

Medicine is a social science and medical care programme is a social action. Any social action continuously changes with cultural patterns of any society and as such medical care programmes has always been dynamic. In the Madras State there is a wide range of medical care programmes. These can be classified as below:

1. **State Government Programmes in Rural Health Centres and urban hospitals and dispensaries for the public including the State Government employees;**
2. **Central Government health services providing hospital and dispensary services especially for Central Government employees in the State;**
3. **Railway Medical Service for the benefit of railway employees;**
4. **Armed Forces Medical Services for the Defence Service employees;**
5. **Employees' State Insurance Hospitals and dispensaries;**
Other services under the indigenous systems of medicines such as Siddha, Ayurvedic, etc.: 

Private hospitals, dispensaries and clinics:

Hospitals run by voluntary organisations.

The health centres established in rural areas provide integrated curative (medical) and prevention (public health) services. The services include in-patient and out-patient services, family welfare, maternity and child health, health education, environment, prevention of communicable diseases, etc. Apart from this, the Government maintains hospitals and dispensaries in towns and cities. Specialised medical institutions exist for tuberculosis, leprosy, infectious diseases, maternity and child welfare, eye hospitals, mental diseases etc.

The total number of medical institutions that were functioning in the State during 1940 was 1336. These include subsidised rural dispensaries, State Government hospitals and dispensaries, medical institutions of local bodies and private bodies, institutions of railways and special institutions for T.B., leprosy, ophthalmic, etc. In 1952 the total number of institutions came down to 1224. The reason for the decrease in strength was due to the closure of the subsidised rural
dispensaries and conversion of some of them into institutions of indigenous medicines. The Government opened some additional medical institutions in the urban areas. Therefore, the total urban institutions had increased to 320 to 1952 from 269 in 1940. Based on the recommendations of the Bhore Committee, the State Government opened Primary Health Centres in the rural areas during the First Five Year Plan. Later, these institutions were expanded to cover each Block and to serve as integrated medical public health centres to the entire rural population. Sub-centres were also opened and they functioned under the PHCs. The out-patients and in-patients treated in all the medical institutions had increased. In the matter of allocation of funds the curative side got preferential treatment over the public health side. At times the curative side got funds, three or four times more than the preventive side. The colonial regime was reluctant to allocate the minimum funds needed during the pre-Independence period. Only after Independence and especially starting from the First Five Year Plan more funds were allocated for medical and public health, even though the curative side continued to get preferential treatment. Government's desire to allocate more funds was limited by the needs of other sectors and the resources constraints.
HEALTH INSURANCE

One of the leading patterns of health insurance in the country is the Employee's State Insurance Scheme providing coverage to the industrial workers in the registered factories and their families. Under the health insurance schemes, employees, employers, State and Central Governments contribute according to the prescribed schedules. But the schemes generally provide traditional types of medical care in the form of out-patients and in-patients treatment. In addition, E.S.I. provides cash and disablement benefits.

More than 40 per cent of the doctors in the State are private practitioners. They are concentrated in the urban areas and are providing mostly traditional types of general practitioner's service. In addition, specialist care and hospitalisation are also provided through private practitioners. In big towns and cities, polyclinics where a number of specialists share a common building are also provided. Similarly, private nursing and maternity homes provide adequate hospitalisation for those who can afford. A number of privately sponsored charitable dispensaries and a few charitable hospitals are also available for the medical care of the poor.

One of the modern developments in medical institutions is the medical social service. It is the application of the
methods of social service work in the sphere of health and more especially in the hospital setting within the last few decades i.e., after the Second World War the philosophy of rehabilitation of the physically disabled has become widely accepted and understood. Rehabilitation has now become the concern not only of the Government but also of the general public, voluntary health agencies and organised medicine. The concept is now fully reflected in the planning of comprehensive medical care which has outstripped even the preventive and social medicine by including in its fold all the fine aspect of medical care namely curative, preventive, promotive, social and rehabilitation.

The medical colleges in the State impart education on both medical and surgical sides. The objective of medicine is to raise the level of the health of the people. Modern medicine has to be adjusted to meet the physical, biological, social and psychological needs of the community where it has to be practiced in order to achieve this objective. It is imperative, therefore, that medical education should provide such opportunities at the under-graduate level as to enable them to study the man in his environment whether at home, in school or at work and also both in sickness and in health. Medical education should aim at fulfilling these basic objectives in training the doctors.
INDIAN SYSTEMS OF MEDICINE

Ever since the dawn of history man has evolved several ways of coping with illness. Different societies have looked for different substances and ways that may ease pain and elevate spirits. All ancient civilisations have thus developed their own medicinal systems which reflect not only specific philosophies but also appear to be influenced by the then existing social beliefs and practices. Thus, was born the Indian systems of medicine like Siddha and Ayurveda. Unani was developed during the 8th Century A.D. by the Caliphs of Bagdad. Siddha, Ayurveda and Unani systems are fundamentally similar in their approach to health and disease. India occupies even today one of the top positions in the use of herbal drugs and drug extracts for the treatment of diseases. It was during the British rule the allopathic system of medicine was introduced in India. Several medical schools and hospitals based on this system were opened. This effectively prevented the development of the indigenous systems of medicine.

SIDDHA SYSTEM

The Siddha Systems of Medicine is said to have been in existence in South India especially in Tamil Districts of Madras Presidency for the last many centuries from the time of the famous first Tamil Sangam. The word 'Siddha' means to be ever sure and true, ever ready and ever lasting. The
literature of this system has been written in Tamil and mostly in the form of verses, the interpretation of which is indeed difficult for the average man.

Siddha system is said to have originated from the Sage Agastiar. The Tamil verses in the Siddha system of medicine are attributed to 18 saints, the famous two among them were Bhoga and Sattainatha. The Siddhas were famous for handling all kinds of herbal plants, poisons, salts, metals, other organic and inorganic products and all the other things connected with the extraction and preparation of these for medical purposes.

AYURVEDA

Ayurveda is the name which the ancient Indians gave to one of their systems of medicine. 'Ayuh' means life and 'veda' to know or attain. Ayurveda, therefore, is the science by the knowledge of which life can be prolonged or its nature understood. This system of medicine is similar to the Siddha system of medicine. The physician Dhanvantri is said to be the founder of Ayurveda. In the beginning this system was given much importance in the Travancore-Cochin States only. Subsequently, it spread throughout India.

UNANI

As stated earlier, Unani system of medicine is
fundamentally similar to Siddha and Ayurveda systems of medicine. This system has also been held in great regard by all classes of medicalmen for its proved utility and excellence of theory. Avicienna, commonly known to the orient as "Shaik-UR-Raees" wrote many books on Unani system of treatment. He was the author of the famous book Khanoon (Canon).

HOMOEOPATHY SYSTEM

The system of medicine evolved and practiced in the West is today known as 'Allopathy', a word coined by Dr. Samuel Hahnemann who lived in Germany during the 18th and 19th Centuries. The father of Homoeopathy is the said Dr. Samuel Hahnemann. He discovered that quinine which was thought to be capable of curing malaria was also capable of producing malaria or to put it correctly a condition similar to malaria on healthy individuals if such healthy people took large doses of it. This is the first basis of Homoeopathic Law. The Law says that 'any drug or agent which is capable of producing symptoms similar to the symptoms of a disease will cure the same symptoms in disease provided the said medicine is administered in smaller quantities, than the quantity required to produce symptoms. Therefore, Homoeopathy is actually a 'Law of Similars' and the slogan for homoeopathy is 'similar is cured by similar'.
The conception of sickness in homoeopathy is quite different from the conception of it in any other system of medicine. Here is the starting point of the division between homoeopathy and all other systems of medicine. All other systems take only the changes in the tissues and organs of the body and their functions i.e., the result of sickness as the disease proper. Infact what they consider as the disease is not the actual disease, nor the cause attributed by them but the real cause of it. Disease is something prior to these results. One is able to see only the results and if he wishes to know more about the disease, he has to see with his mind's eyes.

After Independence, the Government of India and the State Governments encouraged the development of the Indian systems of medicine. The ICMR took up research on indigenous drugs and therapies for certain diseases. The Central Drug Research Institute at Lucknow was engaged in research on plants. Several more institutes like the Central Council for Research in Ayurveda and Siddha, were set up to further research in Ayurveda and Siddha.

POSITION IN MADRAS STATE

In 1921 the Government of Madras had constituted a special committee to examine the possibilities of improving
the indigenous system of medicine on a scientific basis. The Committee felt that it was only through the promotion of indigenous systems of medicine that the State can hope to achieve the ideal of bringing medical relief within easy reach of all people, especially in the rural areas. It recommended the establishment of a medical school or college for turning out qualified medical practitioners. The Government accepted the recommendations of the Committee and a School of Indian Medicine was opened in 1925. A Government Hospital of Indian Medicine was started in 1926 and it was attached to the School of Indian Medicine.

In 1930 the Government started a Post-graduate course in Indian systems of medicine for the graduates of Western Medicine called Fellow of Indian Medicine, (Subsequently renamed as Associate in Indian Medicine) and a course for practitioners of Indian systems of medicine in modern medicine named as Associate Licentiate in Indian Medicine (Subsequently abolished in 1941).

The State Government encouraged the opening of hospitals and dispensaries for the Indian systems of medicine. At present the Siddha, Ayurveda, Unani and Homoeopathy units are functioning in many Government hospitals. Two Government Siddha Medical Colleges at Madras and Palayankottai, one Government Homoeopathy Medical College at Madurai, one
Government Unani Medical College at Madras are functioning at present in the State under the control of the Department of Indian Medicine and Homoeopathy. Besides, a few private hospitals, dispensaries and colleges are also functioning. Now-a-days some of the allopathic practitioners have started prescribing Indian medicines for specific diseases like jaundice, rheumatism, arthritis, etc.

The indigenous systems of medicine can regain their glory only if the efficacy of its remedies is proved and they are put to use by the medical community as a whole. For this purpose research would have to be more purposeful and well directed.

VOLUNTARY ORGANISATIONS (INCLUDING INTERNATIONAL AGENCIES WORLD HEALTH ORGANISATIONS [WHO])

The existing agencies under the United Nations for international health work are the W.H.O., UNICEF, FAO, UNESCO and the ILO. The WHO was established in 1948. Its functions are epidemic warning, standardisation of biological and direct services to its member Governments (mostly advisory) including eradication of diseases such as malaria, tuberculosis, maternal and child health, nutrition, environmental sanitation and mental health. Governments accepting a programme of WHO aid should undertake to carry on the programme after
the help is withdrawn. The aim of WHO assistance is to help people to help themselves. The education and information side of the WHO includes training of doctors, nurses, sanitary engineers and other professional auxiliary staff, studies and surveys and stimulation of research, courses, symposia, seminars and other educational meetings, popular fellowship programmes and publications of various types, for example, Bulletins, Technical Report Series, etc. World Health Organisation liaisons with other international organisations such as UNICEF, ILO, FAO, UNESCO, International Refugee Organisation (IRO), Voluntary Organisations, Relief Societies, Religious or Missionary, Medical and Public Health Organisations, World Medical Association, International Council of Nurses, International Non-governmental Organisations, etc. The UNDP (United Nations Development Programme) provides funds for member countries for specific projects. The UNICEF provides funds for health programmes approved by the Joint Council of WHO-UNICEF.\textsuperscript{47}

\textbf{UNICEF}

\textit{United Nations International Children Emergency Fund} was established in 1946. It receives contributions from all

Governments and gives assistance to all Governments that work together in harmony to give their children better life. Three-fourths of the children of the world, live in the economically backward countries where poverty, hunger and diseases are widespread and most children lack adequate food, clothing and protection. They constitute the most vulnerable group and deserve special consideration and treatment.

UNICEF aid falls under the following major categories:

(a) Basic maternal and child health services;

(b) Disease control which includes campaigning to eradicate diseases such as malaria, tuberculosis, yaws, trachoma and leprosy affecting large number of children, supplying vehicles, insecticides, sprayers, drugs and laboratory equipments;

(c) Nutrition;

(d) School services for children including teaching of home craft and mother craft;

(e) Emergency aid for the relief of mothers in time of disasters such as earthquake, floods, drought and famine;

(f) Training of all categories of personnel;
(g) Environmental sanitation through improvement of village water supply and sewage;

(h) Specialised projects such as for physically handicapped children;

(i) UNICEF aid to health centres includes simple technical equipments, midwives' and nurses' kit, drugs, milk, vitamins, etc.;

(j) UNICEF has supplied teaching and demonstration equipments for nurses' and midwives' training school.

FAO

Food and Agricultural Organisation is concerned with the problem of increased food production and banishment of hunger. It works in collaboration with other international organisations and with the Ministries of Food and Agriculture and Health and Family Welfare in the Government of India.

UNESCO

It is concerned mainly with educational, social and cultural programmes and training for such programmes.

ILO

International Labour Organisation helps in industrial
health and occupational health programmes. 48

OTHER GOVERNMENTAL AGENCIES

They are the Colombo Plan, Technical Co-operation Mission, U.S.S.R. Aid, Norwegian Aid and others. The Colombo Plan is a cooperative enterprise of member Governments of the Commonwealth countries in order to further economic and social programmes and to make these countries self-reliant. It has contributed to the higher training of a large number of medical and auxiliary personnel in all fields. The Indo-US Technical Co-operation Programme is based on an agreement signed between the Government of the United States of America and India with a view to promoting and accelerating integrated economic development of India; Under this agreement, projects of technical co-operation mutually agreed upon between two countries are executed. A separate agreement is again signed for each of the projects in question. The schemes are jointly financed by both the Governments. The contribution of the TCM is for meeting overall cost of equipments and materials, freights, exports and training facilities.

The U.S.S.R. has made valuable contributions to India

in the field of paediatrics and physiotherapy. Some projects have also been started in India, to make large-scale manufacture of drugs, antibodies and medical and surgical equipments in collaboration with the U.S.S.R. Financial and technical assistance given by Norway to India under the Indo-Norwegian Agreement was signed under the auspices of the United Nations for the development of fishing industry on modern lines.

Other international voluntary bodies are the Rockefeller Foundation, Ford Foundation, CARE, etc. The Rockefeller Foundation has been operating in India since 1920. It was associated with several health and medical programmes in India. Its programme included the training of competent teachers and research workers in selected medical colleges. It included training abroad of Indian candidates through fellowships and travel grants. The programme also included the adoption of research as an integral part of the medical course and the sponsoring of visits of a large number of medical specialists from the U.S.A. Due to co-operation and collaboration of this Foundation, a number of institutions were established in India. For example, All India Institute of Hygiene and Public Health, Calcutta, the Virus Research Centre in Pune, All India Institute of Medical Science, New Delhi and a number of medical colleges have also received help either for purchase of equipments or for construction work.
The Ford Foundation contributed mainly in the public health field, towards the implementation of some of our national health programmes. For example, it has helped in the establishment of Public Health Orientation Training Centre, Research-cum-Action Projects in environmental sanitation, pilot projects in rural services at Gandhigram and family planning programme.49

The Co-operative for American Relief Everywhere (CARE) is a non-profit, non-sectarian and non-governmental organisation of the United States, created in 1946 with the primary object of sending food from American donors to people of war devasted Europe. Today this organisation serves many countries, including India, and supplies food packages and kits for use in vocational training, agriculture, health and education programmes.

ASSISTANCE TO THE GOVERNMENT OF MADRAS

The assistance earmarked by the international agencies, other governmental agencies and international voluntary bodies to the Government of Madras and its departments and institutions are generally passed on to them through the Government of India.

49 ibid.
INDIAN VOLUNTARY ORGANISATIONS

The voluntary organisations doing leprosy work at present are:

(a) Hind Kusht Nivaran Sangh, New Delhi;
(b) Mission to Lepers - Purulia;
(c) Gandhi Memorial Leprosy Foundation, Wardha;
(d) Gandhi Samarak Nidhi, New Delhi;
(e) Ramakrishna Mission, Belur;
(f) Belgian Leprosy Centre, Chingleput;
(g) Mother Teresa's Anti-leprosy Relief work and several other smaller organisations.

So far as India is concerned the Christian Missions voluntarily took up the work out of compassion. Their organisations concerned with this work are:

Schieffelin Leprosy Sanatorium at Kargiri,
The Belgian Leprosy Centre at Polambakkam (Chingleput),
The Danish "Save the Children" Organisation at Pogri (Andhra Pradesh),
The Swedish Mission at Katpadi (Madras State),
The Mission Hospital at Vellore.

ROLE OF VOLUNTARY TUBERCULOSIS ORGANISATIONS

The Voluntary Tuberculosis Organisations which were leaders in the field of tuberculosis treatment in the past are still actively engaged in the programme. The Tuberculosis Association of India and various other social welfare organisations have helped to mobilise public opinion in support of the programme. Thus, they play a very important and commendable role in the fight against T.B. by supplementing the governmental efforts in organising treatment and training programmes and in imparting education with the public and leaders of the society and by providing social assistance to patients and their families. They also hold scientific conferences and raise funds through T.B. seal sales. 51

There is no substitute for self-help and unless the recipient countries work for development through dedication and determination no amount of external aid would help. Education, social equality and social justice, are the basic requisites of progress.

To sum up, some of the important modes of health delivery are the school health service, port health (quarantine), family planning and rural health services. The school health service scheme has not proved a success so far as its concrete

51 ibid., p.242.
benefits are concerned. As regards port health it is clear that the Government strictly follows the international laws and procedure in this regard. Therefore, the question of influx of any communicable disease into the country in large scale was not there. The family planning targets were achieved by the Government of Madras and it even gets awards from the Government of India. However, the educational and motivational aspect of the programme has not received adequate attention from the authorities concerned. The Subsidised Rural Medical Relief Scheme which was in force upto the end of the 1930s was a cheap mode of health care delivery for the rural population by the colonial regime. The excessive concern of the then Government to minimise the financial commitments prevented the proper functioning of the health care system. Based on the recommendations of the Bhoje Committee the Government started establishing Primary Health Centres in the First Five Year Plan. In course of time PHCs were established in all Blocks. Sub-centres were also established under the control of each PHC. The PHC is an integrated health service which deals with both preventive (Public Health) and curative (Medical) services including family welfare programme. However, the performance of the rural health services has not been very satisfactory due to the reason that medical officers and others are not prepared to work
willingly in the rural areas. As a result, the posts remain vacant very often. Many of the problems faced by the PHCs are the creation of the bureaucratic system and procedures that have evolved as the primary health services. The pattern of expenditure on the preventive (Public Health) as well as the curative side (Medical) shows the Government's preference for the curative side.
CONCLUSION
C O N C L U S I O N

Life is man's most valuable possession, and next in order of value is health. Without health, life is deprived not only of much of its usefulness, but also its joys and pleasures. If the nation is concerned with the health and happiness of its citizens, then it is necessary to have a well-developed programme of vital statistics which would be one of the hallmarks of civilisation. It has been said that more a civilised nation is, the more highly developed is its social accounting procedures.

The social accounting procedure followed in the Madras State lacked accuracies in the demographic and epidemiological statistics. To overcome these drawbacks the best course would be to strictly enforce the provisions of the Madras Registration of Births and Deaths Act and impose severe punishments to the defaulting Registrars who failed to submit their returns in time. As regards the inaccuracies in the registered causes of death especially in the rural areas the law should be so amended as to insist on the production of death certificates incorporating the causes of death from a qualified doctor by the relatives of the deceased person before the body is allowed to be disposed of. This would ensure cent per cent accuracy in the recorded causes of death. Now that all the villages are covered by the Primary Health Centres and sub-centres
(where the services of qualified doctors are available) it may not be difficult for the rural population to follow this procedure. However, every effort was made by the State Government to obtain and record the statistics of births and deaths correctly as far as possible. As already pointed out elsewhere in this thesis it is relevant to mention here that Madras was probably the Province which was least faulty in respect of vital statistics.

The health status of the people in Madras State during the period 1940-'52 as revealed by the various indicators of health shows that the birth rate and the death rate had declined. The expectation of life had increased. These were attributed to the wide use of antibiotics, insecticides, sulpha drugs, control of endemic diseases, extension of medical care by the Government, etc., besides partly due to under registration. The maternal mortality rate showed an appreciable decline in 1952. The infant mortality rate which was 160.09 per thousand live births in 1921 and was 146.76 in 1947 recorded a rate of 108.20 in 1952, a reduction of 38.56 in six post-Independence years. This is about three times the decline in 26 years from 1921 to 1947. The main reason for this marked decline was the expansion of maternity and child welfare services by the State Government, Municipal Corporation, Municipalities, some Panchayat Unions and Voluntary Organisations. The implementation of the schemes such as the Maternal and Child Health Services, Family Welfare Services and later the Integrated
Child Development Scheme (ICDS) contributed much for the care of the expectant and nursing mothers and undernourished children. Only if the above services are continued with greater vigour the advantages of the declining trend in mortality can be maintained. It is, therefore, clear that only through well planned health programmes the health of the mother and child could be protected and thereby achieve the objective of complete physical, mental and socio-economic development of the people.

The welfare of mother and child continues to get increased care from the Government and other organisations even now. Even the 15 Point Programme announced by the Government of Tamil Nadu in 1993 lays greater emphasis on the welfare of the women and children. One of the goals set in this programme is an infant mortality rate of 30 live births and a crude birth rate of 10. It hopes that at this low level of fertility, the birth and death rates will be about equal, resulting in almost zero population growth. Apart from the above goals, it would seem desirable to set goals for life expectancy and full registration of births and deaths.

Apart from his efforts to protect the health of the mother and child, man has to face the various challenges posed by the communicable diseases such as cholera, smallpox, plague, tuberculosis, leprosy and malaria. The point whether he has
made progress in his fight against these diseases and the Government's approach towards prevention and control of the diseases have been examined. It was found that of all serious diseases, only smallpox has been eradicated. Other serious diseases like cholera, malaria, etc., are under control. At present both the developed and developing countries are concerned very much with the eradication of cancer and AIDS. Plague does still occur from time to time in India. The Beed (Maharashtra State) - Surat (Gujarat State) plague of India is a recent (1994) example. This made the public health authorities worrying whether there is a resurgence of communicable diseases in India. The sudden spurt in the incidence of some of these diseases is due to the lack of a surveillance mechanism, which is central to any public health policy. Surveillance helps to keep tabs on the diseases, its occurrences, disappearance, recurrence, incidence, causes, cure and spread. Surveillance would make it easier and possible to source the disease and to investigate why the disease spread in a severe form. The breakdown of the public health and civic amenities contribute much to the spread of the diseases.

Some important factors which contribute to the health of the population are nutrition, environment, water supply and sanitation. Undernutrition and malnutrition contribute greatly to ill health of the people, especially the prevalence of
protein-calorie malnutrition, anaemia of pregnancy in expectant and nursing mother and high incidence of vitamin deficiencies among the pre-school and school age children. The important factors contributing to this situation are ignorance, poverty, under-feeding, faulty practices of weaning and cooking, infections, etc. The solution lies in increased production of cheap nutritious foods and their improved storage, preservation, processing and proper education of the people. Poor maternal nutrition increases the likelihood that the infant will be of low birth weight, which puts it at higher risk of death. Protein-calorie malnutrition leads to growth retardation, impaired learning and lowered immunity to diseases among young children. Adults suffer from severe fatigue and lowered work capacity. Lack of adequate food is not the only reason leading to malnutrition, which is also caused by the physiological toll taken by diarrhoea, worms and childhood diseases.

The country's large grain reserves have encouraged some people to believe that there is little or no hunger in India today. The truth is that majority of Indians do not get adequate food to eat. Having surplus of food does not mean that the food reaches the people or that the people have the capacity to buy food. But the most important reason for the lack of concern is the increasing disconnection between hunger and death. In earlier years hungry people attracted attention by dying. But the link between hunger and death
in India has been weakened by the spread of vaccines and antibiotics. These effectively protect malnourished children and hungry adults from diseases caused by malnutrition. This is one of the reasons why infant and child mortality rates have come down in India despite only marginal improvement in malnutrition.

Nutrition Programmes were first introduced in the Corporation of Madras and in some Municipalities. Later the State Government implemented several programmes such as the Special Nutrition Feeding Programme for pre-school children, Applied Nutrition Programme, Midday Meals Programme, etc. Subsequently, a new scheme viz., the Chief Minister's Nutritious Meal Programme which brought under one umbrella all the different types of feeding programmes was implemented in the rural areas from 1st July, 1982. It was extended to cover children in the urban areas from 15th September, 1982. This programme was further enlarged to cater to the children in the age range upto 15 years from 15th September, 1984. The children are fed 365 days in a year. Tamil Nadu is the first State in India to introduce such a feeding programme. These measures were taken by the Government as part of its overall objective of developing the health care of the people.

The basic reason for most nutritious problems is poverty. With health care or nutrition programmes the position cannot
be changed much. The permanent solution lies in all round development including industrial, agricultural, educational, etc., which alone can provide employment to all and consequently improve their economic condition. But this task is probably beyond the Government's capacity. If so, the country may have to remain the land of hunger and want, decades into the future.

Apart from nutrition, the environment can be considered to be an integral part of health development, since any impact on man's environment also influences his state of well-being or welfare. India confronts severe environmental constraints due to its limited natural resources combined with high population pressures. The expanding industrial sector is producing new environmental problems, including toxic chemicals and radioactive waste. Air pollution in the cities and towns continues to increase. The country thus confronts a double burden of environmental health problems, the old problems of water, sewage and waste disposal and other forms of pollution related to poverty and infectious diseases along with the new problems of industrial pollution, chemicalisation of agriculture, etc.

The Government has become very conscious of the growing environmental problems and therefore, the Government responded by enacting various laws. A new Department of Environment
has been created besides the constitution of a Pollution Control Board. The Five Year Plans give special allocations for the control of environmental pollutions. However, Government alone cannot solve this problem without the active involvement of the people and the private sector organisations.

Although the country has many environmental laws and regulations, their implementation has been fraught with problems. As the current environmental monitoring arrangements are weak, there is very little reliable information on the status of environmental quality in various regions and state. Creating a monitory network to assess environmental conditions will help in identifying areas of degradation and in planning administrative action for improvement.

Another strategy to improve implementation is through strengthening the organisational structure at both Central and State levels. The Government should also encourage the development of private sector organisations in areas such as environmental impact assessment, environmental quality analysis and design of pollution control systems.

Poor awareness of environmental problems persist among industrial executives, Government bureaucrats, politicians and engineers. Elite attitudes are changing to some degree, due to the combined efforts of the mass media, environmental
action group and international agencies. To support and accelerate this process of attitudinal change, major efforts at environmental education need to be introduced in schools, colleges and professional education.

There is a need to create incentives for developing cleaner technologies and fostering cleaner industries. There is a need to make politicians and bureaucrats aware of the linkage between economic and ecological aspect and between health and environmental aspects, especially because of the tight connections between poverty and the environment in the Indian context. There is also a need to develop expertise within political parties and incorporate environmental issues into political competition. Organisationally, the combination of national and grassroots organisations have helped to place the problems of deforestations, dam building and other environmental issues on the political and policy agendas in India. All steps should be taken to reduce the element of hazard or risk to the community by locating such chemical and other hazardous industries in an area where risk or danger to the community is minimum. Every care must be taken to see that large human habitations does not grow around them. Instead there should be a green belt around such industries.

Now a race is on all over the world to protect the ozone layer. Scientists found a layer over the Antarctic in
1985. Since the ozone layer protects the earth from the sun's radiation, higher rates of skin cancer and a potential global warming were blamed on the gas that had been escaping into the air from millions of airconditioners and discarded home refrigerators. Over the years, scientists have been trying to develop alternatives to these gases which affect the environment.

Another important factor which contributes to the health of the population is adequate protected water supply and good sanitary habits. The Government has implemented various priority schemes such as Rural Water Supply and National Water Supply and Sanitation Schemes during the period of this study.

During the period of this study and also subsequently major changes did take place in Government's policy and approach in the delivery of health care to the people. What follows is an analysis of some of the important schemes introduced.

During the pre-Independence colonial period the rural areas were very much neglected in the matter of medical assistance. The few dispensaries which were functioning were scattered at long distance. Therefore, the rural population had no opportunity to get the services of qualified medical men. They largely depended on unqualified indigenous medical
practitioners. The Government realised the position and introduced a cheaper method of bringing medical relief to the rural population through the Subsidised Rural Medical Relief Scheme (SRMRS). Due to various drawbacks the SRMRS though expanded initially, came to a halt beset with constraints of finance. The attitude of the colonial Government was not encouraging for continuing the scheme.

The Primary Health Centres were established for making medical and health services available to the rural population near their homes. The PHCs as they are at present constituted and staffed are not equipped to give the integrated health service expected of them. Public health orientation of the PHCs activities was not in evidence in the manner and to the extent to which it is necessary. The reasons for this are not far to seek. One of the foremost is the quality of the personnel. Rural service has not been popular and where the positions are not actually vacant, the incumbents with rare exception, look upon it as a period of forced labour until they can manage to find their way to a more congenial posting in a city hospital or a health department. Another factor, responsible for the functioning of the health centres is the lack of orientation of the medical officers and the other staff in the public health methods. If the medical officers are themselves not seized of the importance of the maternal and child health work, of environmental sanitation and vital
statistics, it would be in vain to expect from them the leadership expected of them in these fields. The most serious drawback is that the responsibility of providing integrated health care to a large population is too heavy for the team of medical officers and other staff. Under these conditions it is perhaps not unnatural that even a medical officer suitably oriented to public health is precluded from engaging in preventive work by the sheer weight of curative work that he has to shoulder. There is lack of adequate guidance and supervision of the work of the PHC staff. In some cases dual control of curative and preventive functions resulted in an unhappy state of affairs. Lack of sufficient financial allocation is another important constraint to the proper functioning of the PHCs.

The task of providing primary health care to all who need it is, however, not going to be easy. The only way in which the health services can be organised rapidly and effectively is for the Government and the communities to make major efforts to develop primary health care services at the community level. The following basic principles should be followed if these efforts are to be successful:

Primary health should be shaped around the life-styles of the people to be served. Active involvement of the local people in planning health care is necessary so that it suits
their needs and priorities. Maximum use of the community resources, especially those which have hitherto remained untapped would strengthen the health care offered. It is appropriate that primary health care not only deals with the prevention and care of the disease but also promotes health in the community, in the family and in the individual. It must also be ensured that interventions take place in or as near as possible to the patients' home and carried out by the trained personnel to give the treatment in question. Other services like supplies, supervision, referral and technical support will have to be suitably designed to support the needs at the local level.

The most important factor is that the health team should be an efficient one in health care delivery. The success of the team depends on its functional structure and its flexibility to adapt to different conditions. Responsibility of each member of the health team should be clearly defined and there must be co-operation and mutual understanding among the members of the team to make the rural health services a success.

Family planning was one of the public health schemes introduced during the period of this study. There is no gainsaying that family planning offers complete solution and relief for the numerous problems and ills that plague India at present.
But, family planning is suggested as one of the remedies. This method would bring down the birth rate.

High population growth is due to fast declining death rate. The main reason for lack of appreciable decline in birth rate is the emphasis placed on sterilisation and the poor attitude adopted towards spacing methods. Measures such as promotion of literacy, especially female literacy, increase in age at marriage of females, creation of gainful employment opportunities for females, enhancing the status of women, etc., would help in the reduction of birth rate. More vigorous efforts should be taken to promote them. The demand for spacing methods should be increased substantially without neglecting sterilisation. The targets for various states should be set in terms of reduction in birth rate. Only then will it be possible to bring down the birth rate.

The other approach to family planning is the maternal and child health (MCH) approach. This approach is a package of services which emphasise as to how to have the desired number of healthy children at the desired periods, while safeguarding the mother's health. On the other hand, the contraception approach gives a single message as to how not to have a baby. The maternal and child health approach is far superior when compared to the purely contraceptive method due to its sustainability in the long run and acceptability to the people. The State Government has already taken steps to change over
to the MCH approach. As an initial step only the Health and Family Welfare Staff alone are now allowed to deal with family welfare schemes. This system eliminates unhealthy competitions among various departments. At the same time there is no short fall on the part of the State Government in achieving the targets fixed by the Government of India.

The School Health Service is one of the important modes of health care delivery to the students. The scheme does not work successfully due to the reason that medical inspection is done once in a year, and that too many students are examined in a day in a superficial manner. The follow up action taken on the cases detected is very poor. Better way of improving the system is to organise frequent medical inspection and impart health knowledge to the students. For this, cooperation of the students, parents, teachers and the medical officers is absolutely necessary. The enforcement of the quarantine procedure by the Government is also a health care scheme. India follows strictly the international laws and procedures in this regard.

As regards medical care it is noticed that during 1940 a total number of 1336 medical institutions were functioning and giving relief to the people. These include subsidised rural dispensaries, State Government hospitals and dispensaries including local bodies and private bodies institutions, railways
and special institutions. In the course of ten years their strength gradually came down and the total number stood at 1,224 in 1952. The reason for the reduction was mainly the closure of a large number of subsidised rural dispensaries. Some of these dispensaries were converted as dispensaries of indigenous medicine. The number of medical institutions in the urban areas alone had increased from 269 in 1940 to 320 in 1952. The Government actually concentrated more on opening additional institutions in urban areas which were prone to various diseases. Subsequently, a large number of PHCs were opened in rural areas to serve as an integrated, curative and preventive services to the rural population. The in-patients and out-patients treated in all the medical institutions had also increased. The honorary medical service which was financially very beneficial to the Government was also continued.

The Indian systems of medicine viz., Siddha, Ayurveda, and Unani received encouragement both from the Central as well as from the State Governments after Independence. Homeopathy also received much impetus. The ICMR took up research on indigenous drugs and therapies for certain diseases. Several more institutes like the Central Council for Research in Ayurveda and Siddha were set up to further research in Ayurveda and Siddha. The State Government encouraged the opening of hospitals and dispensaries for the Indian systems
of medicine and also for homoeopathy. Units of these systems are functioning in many Government hospitals. The State Government has also opened separate medical colleges for the Siddha, Unani and Homoeopathy systems. Apart from this, a few private hospitals, dispensaries and colleges are also functioning in the State.

As regards the relative share of expenditure on preventive care to curative care in the overall expenditure of the Government, it is found that the curative side (medical) got preferential allocation of larger share of expenditure than the preventive side (public health). At times the expenditure on curative services was more than three or four times than on the preventive services.

Though Government's desire to allocate more funds for the health care services was handicapped by financial resources, it is necessary to examine the overall policy and approach of the Provincial Government in a larger frame work; that the policy of the colonial regime was such that it was reluctant to provide adequate funds for meeting the minimum needs of the health care system and that during the post-Independence period covered by this study i.e., 1947-'52 and thereafter various health care schemes were implemented successfully inspite of the financial constraints.
At present the health care system is mainly perceived as a Governmental function. It is, therefore, not surprising that the health care programmes, though showed much progress, have not produced the results to the extent desired. To make the health care system a people's system, health care delivery should aim at community involvement and participation. It is time to realise that the people constitute the solution. Only then will the quality, accessibility, efficiency and accountability of health care system improve from the public point of view.