CHAPTER - II

EVOLUTION OF HOSPITAL ADMINISTRATION IN INDIA
Problems of poverty and disease haunts any developing country like India. On account of these problems, the government or the society has not been able to give adequate attention to a number of other vital aspects of socio-economic development. Therefore, the analysis of medical system, technology, patient's treatment and diseases in the Indian context assume great significance.¹

In the time of the Epics, Valmiki’s Ramayana advocated the principle that politics and warfare are irrelevant and have no place in the consideration of the doctor in treating the sick and the wounded. Treatment and medicine are above politics and warfare.

During the period of 2000 BC-1000 BC, Ayurveda, as a system of Medicine, was credited to sage- Atreya, and enriched by the works of other sages and practitioners. It emerged as a system of “Wholistic” medicine in India, viewing health as a "harmony" among body, mind and spirit.²

Ancient Indian physicians attached great importance to the role of cleanliness, appropriate diet, and regularity of habits and physical exercise to keep one healthy and free from disease. Ayurvedic texts such as the Charaka Samhita and the Sushruta Samhita contain chapters on this.

¹ M. Sankara Rao, "Health and Hospital Administration in India", Deep and Deep, New Delhi, 1992, p. 57.
The Sushruta Samhita prescribed the rules of conduct to be observed daily by an intelligent man seeking perfect health and a sound body. About cleaning the mouth, it states "A man should leave his bed early in the morning and brush his teeth. The tooth brush (danta-kashtha) should be made of a fresh twig of a tree or a plant grown on a commendable tract and it should be straight, not worm-eaten, devoid of any knot or at most with one knot only (on one side), and should be twelve fingers in length and like the small finger in girth. The potency and taste of the twig should be determined by or vary according to the season of the year and the preponderance of any dosha (humour) in the physical temperament of its user. The teeth should be daily cleansed with a paste consisting of honey, powdered tri-katu, tri-varga, tejavati (all medicinal herbs), saindhava (salt) and oil. Each tooth should be separately cleansed with this cleansing paste applied on (the top of the twig bitten into the form of ) a soft brush, and care should be taken not to hurt the gum during the rubbing. The use of thin, smooth and flexible foil of gold, silver or wood, ten fingers in length, is commended for the purpose of cleansing the tongue by scrapping."

The Sushruta Samhita then gives instructions for massage and anointing of the body, for physical exercise, for bathing, wearing clothes, going to bed etc. Among general rules of conduct it states: The first rule is that one should keep the nails and hair short always put on clean and white clothes, wear a light turban and a pair of shoes and carry an umbrella and stick in his hand".

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As regards taking food, Sushruta Samhita states: "Food which is wholesome and approved by one's physician and which abounds in articles of sweet and emollient properties should be taken at the proper (and regular) time (everyday) in a moderate quantity. It is forbidden to take any food in the house of trader (i.e. of a hotel – keeper), or a courtesan, nor in the house of a wily, degenerate or inimical person nor at a village assembly. The refuse of another's dishes, as well as articles of food infested with flies, insects etc. or possessed of an objectionable colour, taste, smell, touch or sound, or those which produce an unpleasant impression in the mind, or food of like nature as well as those served (handled) by many persons, should not be partaken of (inspite of repeated requests in that behalf). It is not advisable to sit down to a meal without washing one's hands and feet. One should never take anything by repressing a natural urging for stool and urine, nor sit down to a meal just at the break or the close of the day, nor in an unprotected situation (i.e. without any shade, or without something to sit down). One should not take his meal after the expiry of the (daily) appointed time nor in an insufficient or inordinate quantity.  

While Ayurvedic texts state rules which are meant for maintaining the health of an individual or group of individuals, the concept of public health as we understand it today, was not enunciated in these ancient medical texts. Kautilya's Arthashastra a non-medical text of the early centuries of the Christian era, contains some

references about public health. Regarding the flow of dirty water from the house into the street drain, the Arthashastra states: "From each house a water course of sufficient slope at a distance of 3 padas (foot-length) from the neighbouring site, shall be so constructed that water shall either flow from it in a continuous line or fall from it (into the drain). Violation of the rule shall be punished with a fine to panas (Copper coins)". About the cleanliness of the street it says: "Whoever throws dirt in the street, shall be punished with a fine of one eighth of a pana; whoever causes mire or water to collect in the street shall be fined one-fourth of a pana. Whoever commits the above offences in the King's road shall be punished with double the above fines. Whoever defecates in places of pilgrimage, reservoir of water, temples and royal buildings, shall be punished with fine of one pana or above". Unclean conditions inside one's house which caused annoyance to the neighbours or the passersby were also considered objectionable and were punishable. "If a pit, steps, water-course, ladder, dung-hill or any other parts of a house, offer or cause annoyance to outsiders, or in any way obstruct the enjoyment of others or cause water to collect and thereby injure the wall of a neighbouring house, the owner shall be punished with a fine of 12 panas". Selling rotten meat was punished very severely. Cutting off of his two legs and one hand or a fine of 900 panas was recommended.  


Early Indian rulers considered the provision of institutional care to the sick as their spiritual and temporal responsibility. The
forerunners of the present hospitals can be traced to the times of Buddha followed by Ashoka India could boast of a very well-organized hospital and medical care system even in the ancient times.\(^5\) Thus it is noteworthy to mention that, in India, the systematic account of origin and progress of hospitals are found during the era of Ashoka, who not only built hospitals for human beings, but also for animals with the motive and intention to spread Buddhist ideology of sympathy for the sick and every creature in his kingdom and should be healthful without 'Soka' (i.e. without lamentation and depression). But in modern sense, these hospitals could not be as matter of fact considered as places for diagnosis and treatment, because they were manned by indigenous medical practitioners based on a traditional knowledge of herbs and methods of healing wounds. Thus, in ancient period upto 18\(^{th}\) Century, system of medicine and practice known as 'Ayurveda's Siddha and 'Unani' were in practice. Except these practices and function the ancient hospitals did not cater to the acute and serious sickness as do the hospitals of modern times. But, they were mainly concerned with the care of the sick for the balance of their lives.\(^6\)

The writings of Sushruta (6th century BC) and Charaka (200 AD) the famous surgeon and physician respectively were considered standard works for many centuries with instructions (in Charaka Samhita) for creation of hospitals, for provisions of lying-in and children rooms, maintenance and sterilization of bed line with steam and fumigation, and use of syringes and other medical appliances.


Medicine based on the Indian system was taught in the ancient University of Taxila. Charaka Samhita, a treatise on medicine based on the teaching of Charaka was written around 600 AD and Sushruta Samhita, a treatise of Surgical knowledge, was compiled during 400 AD.\(^7\)

Fa-hein (405-411 AD) who was a contemporary of Chandragupta Vikramaditya, gives a description of the charitable dispensaries in Pataliputra. He states that, "The nobles and householders of this country have founded hospitals within the city to which the poor of all countries, the destitute, the cripple, and the diseased come. They receive every kind of help free of cost. Physicians investigate their diseases and according to their cases order them food and drink and medicines that may contribute to their ease. When cured, they depart, at their convenience.

Hiuen Tsang (629-645 A.D.) who visited India during the reign of Emperor Harsha stated: In all the highways of the towns and villages throughout India, he (the Emperor erected hospices (punya-shalas), provided with food and drink, and stationed there physicians with medicines for travellers and poor persons to be given without any stint.

Such institutions either regular hospitals for the poor and the needy, or clinics provided with stocks of medicines, were spread all over the empire. These were called punyasthanas, punyashalas, dharmashalas, the viharas and the maths. They were the Indian equivalents of the Western alm-houses, monasteries and infirmaries.

The wealthy, the princes, and the kings who built such hospitals and supported them with money, were considered by the public as great philanthropists, entitled for a high place in heaven.  

The institution of hospitals Bimaristan or Maristan in the modern sense of the term, though initiated first at Jundi Shapur by Sassanian Persians, was given a positive shape by the Muslims. These institutions were located in the Islamic world from Persia to Morocco, and from Northern Syria to Egypt and India. In the hospitals created in different cities and states in the medieval Islamic period, the treatment, the diet and other necessities were free. Patients suffering from mental disorders and infectious diseases were kept aloof from other patients. In many hospitals, patients were given special hospital clothes to wear in place of their own which were returned to them on being discharged.

Muslim rulers in India in the Delhi Sultanate period and the Mughal period, established hospitals in large numbers in the cities of their kingdom, where all the facilities were provided to the patients free of charge. Not only the kings and the princes but even the rich citizens gladly and voluntarily paid for the maintenance of the hospitals. In 1595, Sultan Mohammad Qutab. Shah IV built Daru-Shifa (the House of Cure) on the banks of river Moosi. The Mahanama journal describes Daru-Shifa and the attached inns in the following words: "Daru-Shifa had accommodation for 4000 patients. Arrangements on an elaborate scale were made to provide their diet, and many physicians were employed for their treatment".

8 O.P. Jaggi, "Indian System of Medicine", Atma Ram and Sons, New Delhi, p.87.
During the reign of Aurangzeb, there was a hospital built at Etawah by Nawab Khayr Andish Khan Kumbuh. The Nawab was himself well-versed in the science of medicine. He composed a book entitled Khayr-Ul-Tajarib. In the preface of the book, he stated: "This poor sinner named Mohammad Khan and entitled Khayr Andish Khan, for the sake of divine recompense, founded a hospital in the town of Etawah, and appointed several physicians like Abdur Razzaq Naysaburi, Abdul Majid, Isphahani, Mirza Mohammad Ali Bukhari, Mohammad Adil and Mohammad Azam, from among the practitioners of Greek system of medicine, and Kanwal Nain, Sukanand and Nain Sukh from among the Indian Vaidyas who were his old friends, so that they might keep in it valuable and easily available medicines of all kinds together with necessary diet and food for the poor patients. They should also keep in it everything else that might be required for the proper treatment and attendance of the patients.\(^9\)

However the age of Indian medicine started its decline from the Mohammedan invasions in the tenth century. The Mohammedans brought with them their Hakims who followed the Greek system of medicine which came to be known as "Yunani". This system and its physicians started to prosper at the expense of Ayurveda and its Vaidyas. However, the influence of Ayurveda continued in the South.\(^{10}\)

The first European hospital in India was the Portuguese Hospital at Goa founded by Albuquerque in 1510. The successive Portuguese

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Governors-General took great care to run it efficiently. In 1591 the administration of the hospital was placed in the hands of the Jesuits who made it one of the best run hospitals in the world.

By far the most detailed account of the hospital was provided by a Frenchman Pyrard de Laval. Cast away on the island monarchy of Maldives, Pyrard reached Calicut in 1607 from where he moved south to the Portuguese fortress of Cochin. He was arrested and imprisoned there because he did not produce proper papers and credentials. Sick and chained he was shipped to Goa in 1608.

Pyrard was taken to the Royal Portuguese Hospital for a three-week treatment. He found the Jesuits who ran the institution as the most cultivated and modern community in Goa, and the hospital superior even to the Hospital of the Holy Ghost in Rome or the Infirmary of the Knights of Malta, the two leading hospitals of Europe at the time. Pyrard wrote that the beds were beautifully shaped and lacquered with red varnish; the sacking was of cotton; the mattresses and coverlets were of the silk or cotton, adorned with different patterns, pillows of white calico. Provided with pyjama, cap and slippers, bedside table on which was a fan, drinking water, a clean towel and handkerchief, a chamber pot under the bed.

There were physicians, surgeons and apothecaries, barbers and bleeders, who did nothing else and were bound to visit each of the sick twice a day. The sick were sometimes very numerous and were as many as 1500 all of them either Portuguese soldiers or men of other Christian races of Europe of every profession and quality. Indians were not taken in there, having a hospital apart wherein were received only
Christian Indians. Two Jesuits, and more if need be, were in attendance, who did nothing else but go round confessing and comforting the sick, administering the sacrament, and giving them breads for saying prayers. No women were allowed to enter sick or sound. Nor were any householders received, neither men women nor children.

John Albert de Mendeslo of North Germany who visited Goa around 1638, described the hospital as a noble structure capable of accommodating over a thousand patients and fully equipped to meet the requirements of medical care.

In 1701 a French hospital was established at Pondichery which had become the colonial headquarters of the French in India. The necessity to have a hospital there was felt in 1700 to treat the French soldiers, topas and other civilians employed by the French East Indian Company.

The construction of a small hospital began in May 1701 and completed in August 1704. The building consisted of three big halls, four wards, a kitchen and a big store.

Jacque Thedore Albert (1675-1721) was the first chief surgeon of the hospital.11

The Construction of another building for a big hospital commenced in the south-west corner of the town in 1734. The site of the above hospital was close to the Pondicherry railway station, and

presently the area is covered by Old Hospital Road. This hospital was a rectangular building with a number of wards and two great halls. It is reported that this hospital was not only meant to treat sick French soldiers but also served as a lodge for European orphans. There were special wards for admitting violent maniacal cases. A French Capucien missionary was in charge of the hospital and under the direction of the chief surgeon, administered medicines etc. to patients.

On an average there were 30 to 40 soldiers as in-patients and there was a chronic scarcity of bread for them.

When the French left, the hospital was upgraded by the Government of India into Jawaharlal Nehru Institute of Post Graduate Medical Education and Research.¹²

Hospitals in Madras Presidency:

The Modern system of medicine in India was introduced in the 17th Century with the arrival of European Christian missionaries in South India. In the 17th Century, the East India Company - the forerunner of the British Empire in India established its first hospital in 1664 at Chennai for its soldiers and in 1668 for Civilian population.¹³ The English hospital which was opened in 1664 at Madras was enlarged in 1679.

The second hospital was built at Madras by public subscription at a cost of 838 pagodas (nearly Rs.3,000) between 1679 and 1688. It

was a large two-storey building, the property of the Church and Vestry. In 1688 during the Governorship of Elihn Yale, the Madras Council decided to acquire this hospital building, paying its full value to the Vestry, and directed that a new hospital be built near the river.

The third hospital seems to have been built soon after the Company acquired the second, perhaps before that building was actually vacated. The third hospital seems to have been consuming more money than was earmarked.

Towards the end of the year, the Madras Council took over the charge of maintenance of the hospital from the Church and vestry.

Another hospital was built through collection of subscription. The Company contributed 1,500 pagodas (about Rs. 5000). In 1714 a house at Fort St. David was bought for a hospital for 400 Pagodas. In 1728, however this hospital was reported to be in a ruinous condition, and orders for re-building it were passed.¹⁴

In 1772, another new and bigger hospital was completed which later became the Madras General Hospital. The Madras Medical Board described the General Hospital as an institution for the reception of the sick, both European and native, civil and military in 1842. In 1859, the entire building was reconstructed and the new building were occupied in 1861, whose eastern part was assigned to British troops, the western used as a civil General Hospital of which the upper storey was occupied by the Europeans and Eurasians and the lower by the native sick.¹⁵

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¹⁵ Public Despatch to England, dated 15th October, 1772.
In March and September 1797, Assistant Surgeon John Underwood applied for the grant of a piece of land at Pursewakam, a suburb to the south of Madras, as a site for a hospital for indigent native sick. The Superintendent of the Company's lands objected to the site mentioned, where upon Underwood applied for any piece of waste ground for a site. About 40 acres of land was allotted to him for the purpose. In 1798, the Court of Director, gave him a letter and stated that all necessary assistance would be given to him in erecting and maintaining a hospital for native poor. Dr Underwood, paid 304 pagodas (about Rs.1000) for the land and he put up buildings which cost him about 9,813 pagodas (about Rs 35,000).16

Dr Underwood estimated that annually 2,500 pagodas may be needed for maintenance of this institution and this amount could be received by public subscription. The Chief engineer inspected the buildings which consisted of two substantial blocks with verandah all round besides detached blocks for 'caste' Hindus and a terraced dispensary. On the report of the Chief Engineer, the Government decided to take over the hospital for the reception of indigent poor. Mr Underwood who erected it was allowed 150 pagodas per month in lieu of all demands for rent and expenses of repairs, and as Attending Surgeon 100 pagodas per month. The hospital was placed under the immediate control and superintendence of the Medical Board.17

A Medical Board consisting of Mr. Willian Webb, Nathaniel Kindersley, Charles Baker, Henry Sewell and John Defires was

17. Letter from Fort George, dated 18th October, 1799.
appointed to advise in the administration of the hospital and to inspect the institution regularly. To start with, over 80 in-patients and over 100 out-patients were looked after and the annual subscription totalled upto 3,200 pagodas.

The demands on the hospital had increased because of the popularity of the institution and the increase in the population of the area while its revenues were decreasing. In 1807, the Committee of the Native Infirmary requested the government for financial assistance pleading that revenues from a village may be gifted to the Infirmary. In the following year, it was even suggested to the Government to merge the Monegar Choultry and the Native Infirmary (Monegar means village headman). The Government therefore resolved to purchase the grounds of the Infirmary from Underwood.\(^{18}\)

The Government then, expanded the Monegar Choultry lands and building so as to accommodate the patients from the Infirmary. The Capital of the infirmary amounting to Rs.54,645 was also transferred to the Monegar Choultry Fund and in 1809 the combined institution was named "The Madras Infirmary and Native poor Asylum". This merger took ten years after the Infirmary was started.

In 1908 the Board of Directors requested the Government to take over the management of Monegar Choultry and the Infirmary. The expenditure had gone up enormously due to expansion of its humanitarian activities – the care of the sick, the insane and the destitute – which was beyond the means of the sponsoring body. The Government accepted the proposal and took over the control of these

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institutions in 1910. As the old buildings had become unsuitable, Lord Carmichael, Governor of Madras in 1912 disapproved the whole place and ordered the construction of a new Royapuram Hospital. Pent land Wards with 162 beds and Bryson Wards with 104 beds with an auditorium were soon built. After that the hospital rapidly expanded. In 1940, its name was changed to Government Stanley Hospital. With a bed strength of about a thousand now, it caters to the needs of the thickly populated area of north Madras.\(^{19}\)

**Hospitals in Bombay Presidency**

The first hospital in Bombay was opened towards the end of 1676.

Another hospital in Bombay seemed to be built in 1737, near the Marine Yard. The Consultation of June 30th, 1738 contained regulation for the hospital which stated that the patients admitted were to be divided between the two surgeons, those who admitted, in one week went to the first surgeon, and the next week, to the second surgeon. The pay of the Hospital Assistants was fixed at six rupees, and Outdoor Assistants, eight rupees per month.\(^{20}\)

Plans for a big new hospital at a cost of Rs.5,15,025 were prepared in 1781, but were found too expensive. The hospital was to be made bomb-proof.\(^{21}\)

A native hospital existed in 1809 and treated about twenty patients daily. It was supported by the Government. During the later

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20 . Ibid., pp. 84.
21 . Consultations of June 20th and September 26th, 1781
half of the nineteenth century, a number of large hospitals were constructed and opened in Bombay. They owed their existence to the charity of the wealthy inhabitants.

**Hospitals in Bengal Presidency.**

The first hospital in Calcutta was opened towards the end of 1707 or early in 1708. Although the cost of personnel and medicines were paid for by the East India Company, and the cost of diet was supposed to be covered by the fee charged from the patients yet the monthly expenditure of the hospital was often suspiciously high, and in 1752, the Court of Directors ordered a member of the Council to inspect the place every week and report to the Board. In his visit to the hospital in September, Mr Frankland found the surgeons in attendance but the building needed repairments. This hospital seems to have been destroyed in 1756 during the battle between the Company and Nawab Siraj-ud-Daulah.

The second hospital was a temporary building erected inside the old fort on the recovery of Calcutta by the Company.\(^{22}\)

In 1769 the third hospital which came to be known as Presidency General Hospital was built. All the three hospitals were primarily intended for the Company’s soldiers and sailors but admitted all Europeans, of all Classes and all callings.

The first hospital for the native poor in Calcutta seems to have been opened during 1792-93.\(^{23}\) In a meeting held for the purpose, it was decided 1) to institute a hospital for natives, 2) to vest the

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22. Ibid., pp. 85-87.
23. Calcutta Gazette of 18th October, 1792 and 1st November 1792.
management in an equal number of European and native Governors, residents of Calcutta and 3) to appoint a Committee to raise subscriptions and prepare a plan. The Government granted a subsidy of Rs 6,000 per month on 6th July 1793. Twelve Governors were appointed. The first hospital was opened in a house on the Chitpur Road. Subsequently a house in Dharamtola was bought, and opened as a hospital on 1st September, 1794. This native hospital of 1792 was the precursor of the later Medical College hospital. The Calcutta Gazette of 20th September, 1806 gave the statistical records of the hospital for the year 1805-06, the year running from 1st September to 31st August. During the year 220 in-patients and 2,874 out-patients were treated, and 1,286 vaccinations were performed. There were 53 deaths, 4,265 were relieved and discharged; while 62 patients, 19 in-patients and 43 out-patients, remained under treatment at the close of the year. An Eye Infirmary was established in Calcutta in November 1824. In 1825, two branch dispensaries were opened and attached to the Native Hospital.

The Calcutta Medical College Hospital had its beginning on 1st April, 1838, when a small clinical hospital with thirty beds and an out-patient dispensary, was opened to provide clinical instruction to the students of the new college. A Lying-in Hospital was opened in Calcutta early in 1840, with an out-patient dispensary and a training class for dais. The foundation stone of the Medical College Hospital was laid by the Governor-General Lord Dalhousie, on 3rd September, 1848, and the hospital was completed early in 1853. It contained 500 beds in twenty-four wards, one being reserved for women and children
and absorbed the old Eye Infirmary and Lying-in Hospital. This hospital admitted both European and native patients.\(^\text{24}\)

Thus, from 18th century onwards, unlike indigenous medicine, modern western medicine was increasingly applied for preventing the occurrence of illness. Thus, there was a great development of hospital administration in structure, size and functions with the introduction of new methods like operative surgery and medical treatment. Gradually and in course of time, the hospitals began to admit any type of case and obtained better results like reduction of mortality and morbidity rates and also the improvements of standards in nursing functions.

There was no proportional and potential accomplishment in the preventive health field on the basis that there was a population growth due to reduction of death rate; but increase of diseases due to poor financial aid to the hospitals as well as administering them for the development of health. The officials of the hospitals and British Government were reluctant in their attitudes and behaviour patterns towards the Indian people because the people were entwined or obsessed with religious and traditional practices.\(^\text{25}\)

Fairly detailed descriptions of the working of hospitals in the nineteenth century have been given by the surgeons themselves who were working therein. More interesting are the accounts of the beginning of the anti-septic era. While some doctors believed in the germs as the causative agents of different diseases and suppuration in the ordinary and post-operative wounds, others did not.\(^\text{26}\)

As the British spread their political control over the country, many hospitals and dispensaries originally started to treat the army personnel were handed over to the civil administrative authorities for treating civil population. Local government and local self government bodies (municipalities, etc.) were encouraged to start dispensaries at tehsil and district level. In 1885, there were 1250 hospitals and dispensaries in British India. But the medical care scarcely reached 10 per cent of the population. 27

However, by the end of 19th century, the attitude of public towards hospital system began to change. As a result of this, importance was given to the hospitals and the volume of work increased and the whole picture, (i.e., structure, administration, etc.) greatly changed.

In the early years of 20th century, more efforts were made to remove the stigma on the performance and a bad image of the hospitals by transferring their administration from 'Public Assistance powers of Local Authorities' to the 'Health Committees' and these hospitals, later, were named as 'Public Health Hospitals'.

Under this new direction and set-up, the local authority hospitals made considerable advancement structurally and functionally and some hospitals were also upgraded as teaching hospitals. 28

Military Hospitals :

In 1910 a committee appointed by the British Government recommended the establishment of Station Hospitals for Indian troops of the British Army and the raising of an 'Indian Army Hospital Corps'

for the menial staff. These proposals were approved in 1918. All the 148 hospitals thus established were to be administered by Indian Medical Service (IMS) which had begun as a military service. A few years later the name was changed from station hospitals to military hospital, separately for British and Indian troops (BMH, IMH) and at some places combined (CHM). The advent of second World War (1939-45) saw some modifications. After the end of the War most of the hospitals created to cater for the needs of war casualties became surplus to the requirement and were disbanded in the two year following the end of the war, only some military hospitals were retained.29

However, a systematic Public Health Administration was introduced under the British rule in our country. Later, the British Rulers appointed several committees and enacted a number of Acts in order to develop the system. The following are some of the important Acts and Committees relating to the health administration in India.

1. The Quarantine Act (1825) was the first Act enacted for the purpose of improvement of people suffering from communicable diseases and from contact with such people.

2. A Public Health Committee was appointed in 1864 for surveying the public health needs of Bengal, Madras and Bombay Presidencies.

3. The Birth and Death Registration Act (1873) was introduced to have a record of Births and Deaths.

4. Vaccination Act was passed in 1880 for the immunisation from contagious diseases.

5. A Plague Commission was appointed in 1886 and in the same year Local Bodies Act was made for transferring and entrusting the responsibility for the health and sanitation of the people to the local authorities.

6. In 1887, the Epidemic Diseases Act was passed for the purpose of providing the basic framework for the growth of Public Health Policy and its administration.

7. In the down of devolution of authority from Center to the States under 'Minto-Morlay' (1909) and 'Montague-Chelmsford' (1919), the subject of 'Public Health and Medical Relief' was included in the transferred subjects of the State list.

8. With the introduction of provincial autonomy under the Government of India Act, 1935, the ministries in the States were made totally responsible for health policy and administration.

9. Drugs Act was enacted in 1940 as a central legislation.

Though the above steps were taken by British Administrators for the development of health of Indian people, the living conditions of the people and health administration could not be restored on account of out-break of Second World War and partition of our country. During this period, the death rate from Malaria, Small pox and T.B. etc. was higher.  

Between the World Wars I and II much thought had been given to the reorganization of hospital services by the constitution of number of Commissions of Inquiry on the subject.

Further, after the Wars, the civilian hospitals were encouraged to adopt the methods of 'rehabilitation' or 'fitness' centres as a means of restoring the lives of patients to working capacity. Thus, these centres, really and undoubtedly did valuable work, not only in surgical conditions, but in a wide range of medical treatment as well.\(^31\)

**Bhore Committee**

The need to take stock of health care status of the country and plan appropriate measures was felt by the government in the early forties. Thus was born the "Health Survey and Planning Committee", better known as Bhore Committee (by the name of its Chairman, Sir Joseph Bhore), in 1943. The Committee was asked to survey the then existing health care organization resources and to advice on the development of health care services in the country. The recommendations of the committee are considered the blue print of health care delivery system in independent India which laid the foundations for the development of health care delivery system in development plans in independent India. The infrastructure for the delivery of medical and health care system was laid down on this Committee's recommendations.\(^32\)

The committee made extensive recommendations which can be classified into five broad headings.

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31. Ibid., p.59.
1. Provision of adequate preventive, promotive and curative services to all in the form of comprehensive health care (integration of services).

2. Delivery of this comprehensive health care through an infrastructure of hospitals, dispensaries and by opening primary health care (PHC) centres at block level and taluka level hospitals.

3. Development of adequate communications in rural areas.

4. Demarcation of health services into two groups, viz. personal and impersonal.

5. Fitting the above concepts into a short-term plan and a long-term plan.

The short-term plan envisaged a provincewise organisation for the combined preventive and curative health work through establishment of a number of primary, secondary and district health units. The impersonal health services were to include town and village planning, housing, water supply, drainage and general sanitation. The bed: population ratio was planned to be raised from 0.2 in 1946 to 1.03 per 1000 population at the end of ten years in 1956. The long-term plan envisaged a PHC for every 40,000 population with a 30 bedded rural hospital to serve four PHCs with a provision to double this number after ten years. Raising of hospital accommodation to 2 beds per 1000 population was also an important long-term goal, with creation of 12 more medical colleges in addition to 43 established during the first ten years. The Committee recommended high priority to be given in the health development programme to reduction of sickness and mortality.
among mothers and children, with emphasis on nutrition, health education, school health services, housing, water supply, industrial health and legislation for environmental health.\textsuperscript{33}

Emergence of Health care Delivery system and Hospitals in Independent India

When the country became independent in 1947, the health scenario was, to say the least, unsatisfactory. The bed to population ratio was 1:4000, doctor to population ratio 1:6300 and nurse to population ratio 1:40,000. Although the population was distributed in urban and rural areas in the proportion of 20:80, a great disparity existed in the facilities available in urban and rural areas. The medical resources were polarised in the ratio of 80:20. The indicators of health spoke of poor state of health of the people as indicated in the Table II.1.

\textbf{Table II.1}

\textbf{Health indicators in India during 1947}

\begin{tabular}{|l|l|}
\hline
1. Crude death rate & 27.2 per 1000 \\
2. Infant mortality rate & 162 per 1000 live births \\
3. Death less than 10 years of age & 48 per cent of total deaths \\
4. Expectancy of life at birth & 30.9 years \\
5. Infectious disease accounted & Over 50 per cent of total deaths. \\
\hline
\end{tabular}

On the eve of independence in 1947, there were 7,400 hospitals and dispensaries in the country with 11,000 beds giving a bed to

population ratio of 0.25 per 1000. There were 47,000 doctors, 7000 nurses, 19 medical schools and 19 medical colleges in the country.\textsuperscript{34}

The Homoeopathic Enquiry Committee\textsuperscript{35} (J.N. Mukerji Committee 1948-49) recommended for the establishment of the Central Council of Homoeopathic Medicine. The committee not only recommended for a system of registration of practitioners of the homoeopathic system of medicine but also to take immediate steps by the Central and provincial government and states to declare illegal use of bogus degrees.

Model Public Health Act Committee\textsuperscript{36} (Das Gupta Committee, 1953-55) recommended a unified and integrated health organisation at various levels to be operated through the Director of Health services, District Headquarter's Organization, Thana Health Center organisation in urban areas.

Dayasankar Trikamji Dave Committee\textsuperscript{37}(1955) recommended that two councils should be created similar to the Indian Medical Council which will have control over the maintenance of uniform teaching standards in all institutions; one for Ayurvedic and Unani systems of medicine and the other for Homoeopathic system. Separate Directorates for (a) Ayurvedic and Unani and (b) Homoeopathic systems of medicines should be created in the Central Ministry of Health, Government of India, and also in the States as far

\textsuperscript{34} Ibid.,


\textsuperscript{36} National Health Policy, Lok Sabha, Secretariat, New Delhi, 1985, pp. 5-6.

as possible. All the teaching institutions should have indoor hospital beds and the ratio of students to beds should be 1:5. Refresher courses in Ayurveda, Unani and Homoeopathy should be organised in teaching institutions.

Udupa Committee\textsuperscript{38} (1958-59) recommended that the Central and State Governments should make an unequivocal declaration of policy recognising the training and practice of Ayurvedic. The Government should provide adequate finances to improve the position in Ayurvedic training and setting up drug firms and museums and should start training courses for Ayurvedic pharmacists. Governments should open as many Ayurvedic hospitals and dispensaries as possible at the State, District and Tehsil levels.

\textbf{Mudaliar Committee :}

To provide guidelines for further national health planning in the context of the five-year plan, a fresh look at the health structure and resources was called for by the year 1959 to survey the progress made since the implementation of Bhore Committee report and to make recommendation for the future development. The Health Survey and Development Committee (also known as Mudaliar Committee for the name of its chairman) thus came into being in 1959. It was found by this committee that the implementation of the Bhore Committee recommendations was slow and the progress not as expected. Among others, it recommended consolidating the gains rather than going in for more services, the District hospital envisaged to play key role in the

referral services from PHCs and taluka hospitals, mobile service
teams, suggestion for a small fee for service in public hospitals,
practical bed : population ratio of 1:1000, 50 bed Taluka hospitals, and
district hospital with 300 beds, and long-range health insurance policy
for all citizens.39

Contributory Health Services Scheme Assessment Committee40
(1961-1962) opined that the highest priority should be given to provide
separate permanent building for all dispensaries. And the dispensaries
should be adequately stocked with the general and specialists and all
the staff should reside within the premises of the dispensaries. The
committee was also of the view that the contributory health service
administration should periodically meet different categories of staff,
arrange for talks on personnel management, doctor-patient
relationship, community health and corporate life.

Other Committees:

There were many committees and study groups appointed from
time to time. The following two were notable among them for the
conceptual changes in the hospital services.

1. The Hospital Review Committee (Dr. K.N.Rao Committee) 1968
while reviewing Delhi Hospitals made the following general
recommendations.

   a) That the hospital should function as an integral part of the
      comprehensive health service, both curative and
      preventive.

39. Report of Health Survey and Development Committee, Government
b) That the office of the medical superintendent should be a full-time appointment with administratively qualified doctor with no clinical responsibilities.

c) That the administrative structure should be tripartite:
   i) clinical
   ii) nursing, and
   iii) business administration.

2. The Study Group on Hospital (1968) appointed by Central Government had recommended the following:
   a) By 1971 the following bed capacity should be attained:
      Teaching hospitals At least 5000
      District hospitals At least 200
      Tehsil/ Taluka hospitals At least 50

   b) The projected bed capacity of 4.2 lakh beds in 1976 should be raised to 6.3 lakhs bringing the bed : population ratio to one bed per thousand population by 1976.

   c) A regular system of giving liberal grants-in-aid to voluntary organisations to open institutions for giving medical care on non-restrictive basis.

   d) In difficult areas and in areas where distances are long and communications difficult, such as hilly districts, certain tehsil/ taluka hospitals should be developed as full-fledged referral centres.\footnote{Report of the study group on Hospitals [Jain Committee], 1968, Ministry of Health, Government of India, New Delhi, quoted in B.M. Sakharkar, Op cit., pp. 7-8.}
The three major Seminars\(^{42}\) conducted by the Indian Institute of Public Administration, New Delhi during May 1971 to August 1971 mainly focused attention on Family Planning in the country – the policy involved and administration of the various Family Planning Programmes.

The Srivastava Committee\(^{43}\) (1974) suggested the following measures:

1) A nationwide network of efficient and effective services suitable for our conditions, limitations and potentialities should be evolved.

2) Steps should be taken to create bands of para-professional or semi-professional health workers from the community itself to provide simple protective, preventive and curative services which are needed by the community.

3) Between the community and the primary health centre, there should be two cadres; health workers and health assistants.

4) The Primary Health Centre should be provided with an additional doctor and a nurse to look after the maternal and child health services. The possibility of utilising the services of senior doctors at the medical college, regional district or taluka hospitals for brief periods at the primary health centre should be explored.


\(^{43}\) Report of Study Group on Medical Education and Support of Manpower (Chairmanship of Dr. J.B. Srivastava). The Director General of Health Services, Government of India, New Delhi, 1974, quoted in G. Rameshwaram, "Medical and Health Administration in Rural India", Ashish, New Delhi, 1989, pp. 8-9.
5) The Primary Health Centre as well as taluka tehsil district, regional and medical college hospitals, should develop living and direct links with the community around them, as well as with one another within a total referral services complex.

The Government of India should constitute under an Act of Parliament a Medical and Health Education Commission for co-ordinating and maintaining standards in medical and health education on the pattern of University Grants Commission.

The Medical Policies and Programmes of India, by and large, conform to such policies and programmes of the other Developing and Developed countries. India is a party to the International Cooperation for achieving the goal of "Health for All" as prescribed by the World Health Organisation (WHO). India is committed to provide a range of public health services to all its citizens to keep them reasonably healthy and free from diseases. The aim of the policy is to provide every Indian citizen, the needed medical treatment which are appropriate and effective for the purpose irrespective of his/her status or position. However, the priority areas are population stability and maternity and child welfare.44

Access to good health, health care and hospital services may thus be treated as an inalienable right of every individual, every family and every nation. A sound health care system is a critical requirement for the 'sustainability of development and poverty alleviation'.45

Hospitals, Beds and Medical Manpower

There is an ongoing race between the medical resources and increasing population. Even though there has been a tremendous growth in the medical resources, they have not been able to cope up with increasing demand due to unchecked growth of population. The hospitals, beds and medical manpower is depicted in Tables II.2 and II.3.

Table II.2
Hospitals and beds

<table>
<thead>
<tr>
<th>Sl.No.</th>
<th>States</th>
<th>No. of Hospitals</th>
<th>No. of Beds</th>
<th>No. of Hospitals</th>
<th>No. of Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Andhra Pradesh</td>
<td>608</td>
<td>33,871</td>
<td>615</td>
<td>36,400</td>
</tr>
<tr>
<td>2.</td>
<td>Arunachal Pradesh</td>
<td>22</td>
<td>922</td>
<td>18</td>
<td>1,091</td>
</tr>
<tr>
<td>3.</td>
<td>Assam</td>
<td>111</td>
<td>9,645</td>
<td>207</td>
<td>14,460</td>
</tr>
<tr>
<td>4.</td>
<td>Bihar</td>
<td>228</td>
<td>22,574</td>
<td>298</td>
<td>28,137</td>
</tr>
<tr>
<td>5.</td>
<td>Goa</td>
<td>89</td>
<td>3,400</td>
<td>108</td>
<td>3,383</td>
</tr>
<tr>
<td>6.</td>
<td>Gujarat</td>
<td>828</td>
<td>32,081</td>
<td>1,563</td>
<td>46,374</td>
</tr>
<tr>
<td>7.</td>
<td>Haryana</td>
<td>86</td>
<td>7,310</td>
<td>78</td>
<td>7,003</td>
</tr>
<tr>
<td>8.</td>
<td>Himachal Pradesh</td>
<td>54</td>
<td>2,800</td>
<td>65</td>
<td>4,274</td>
</tr>
<tr>
<td>10.</td>
<td>Karnataka</td>
<td>233</td>
<td>29,829</td>
<td>288</td>
<td>34,477</td>
</tr>
<tr>
<td>11.</td>
<td>Kerala</td>
<td>758</td>
<td>45,078</td>
<td>2,924</td>
<td>70,049</td>
</tr>
<tr>
<td>12.</td>
<td>Madhya Pradesh</td>
<td>276</td>
<td>16,827</td>
<td>362</td>
<td>22,103</td>
</tr>
<tr>
<td>13.</td>
<td>Maharashtra</td>
<td>1,085</td>
<td>76,777</td>
<td>2,104</td>
<td>1,11,420</td>
</tr>
<tr>
<td>14.</td>
<td>Manipur</td>
<td>21</td>
<td>1,266</td>
<td>25</td>
<td>1,460</td>
</tr>
<tr>
<td>15.</td>
<td>Meghalaya</td>
<td>11</td>
<td>1,577</td>
<td>15</td>
<td>1,754</td>
</tr>
<tr>
<td>16.</td>
<td>Mizoram</td>
<td>10</td>
<td>710</td>
<td>14</td>
<td>1,154</td>
</tr>
<tr>
<td>17.</td>
<td>Nagaland</td>
<td>34</td>
<td>1,078</td>
<td>31</td>
<td>1,114</td>
</tr>
<tr>
<td>18.</td>
<td>Orissa</td>
<td>304</td>
<td>11,491</td>
<td>287</td>
<td>13,988</td>
</tr>
<tr>
<td>20.</td>
<td>Rajasthan</td>
<td>229</td>
<td>18,023</td>
<td>267</td>
<td>21,815</td>
</tr>
<tr>
<td>21.</td>
<td>Sikkim</td>
<td>5</td>
<td>477</td>
<td>5</td>
<td>525</td>
</tr>
<tr>
<td></td>
<td>Tamil Nadu</td>
<td>376</td>
<td>40,651</td>
<td>408</td>
<td>48,780</td>
</tr>
<tr>
<td>---</td>
<td>------------</td>
<td>-----</td>
<td>--------</td>
<td>-----</td>
<td>--------</td>
</tr>
<tr>
<td>22.</td>
<td>Tripura</td>
<td>16</td>
<td>1,235</td>
<td>23</td>
<td>1,531</td>
</tr>
<tr>
<td>23.</td>
<td>Uttar Pradesh</td>
<td>733</td>
<td>46,245</td>
<td>735</td>
<td>47,278</td>
</tr>
<tr>
<td>24.</td>
<td>West Bengal</td>
<td>403</td>
<td>49,321</td>
<td>410</td>
<td>53,977</td>
</tr>
<tr>
<td>Union Territory</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Andaman and Nicobar</td>
<td>13</td>
<td>597</td>
<td>8</td>
<td>735</td>
</tr>
<tr>
<td>26.</td>
<td>Chandigarh</td>
<td>2</td>
<td>1,120</td>
<td>2</td>
<td>1,500</td>
</tr>
<tr>
<td>27.</td>
<td>Dadar and Nagar-Haveli</td>
<td>1</td>
<td>50</td>
<td>2</td>
<td>62</td>
</tr>
<tr>
<td>28.</td>
<td>Daman and Diu</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>150</td>
</tr>
<tr>
<td>29.</td>
<td>Delhi</td>
<td>63</td>
<td>13,291</td>
<td>80</td>
<td>18,241</td>
</tr>
<tr>
<td>30.</td>
<td>Lakshadweep</td>
<td>2</td>
<td>50</td>
<td>2</td>
<td>70</td>
</tr>
<tr>
<td>31.</td>
<td>Pondicherry</td>
<td>12</td>
<td>2,267</td>
<td>10</td>
<td>2,608</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6,901</td>
<td>4,86,805</td>
<td>11,254</td>
<td>6,19,433</td>
<td></td>
</tr>
</tbody>
</table>

Source: Health Information of India: Directorate General of Health Services, 1991

Table II. 3

Medical Manpower

| Population | 900 million (1993) |
| Hospitals | 11,254 Urban: 7,286 Rural: 3,968 |
| Dispensaries | 27,994 Urban: 15,710 Rural: 12,284 |
| Hospital Beds | 6,19,433 |
| Bed: Population ratio | 0.69 per thousand |
| Doctors | 3,65,000 |
| Nurses | 2,64,500 |
| ANMS | 1,41,200 |
| Dental Surgeons | 11,010 |
| Doctor: population ratio | 1:2470 Urban: 1:500 Rural: 1:16,000 to 20,000 |
| Nurse: population ratio | 1:3410 |
| Doctor: nurse ratio | 1:4:1 |
| Medical colleges | 128 |


In 1977, the Government of India launched a Rural Health Scheme, based on the principle of "placing people's health in people's hands". It is a three tier system of health care delivery in rural areas based on the recommendation of the Shrivastav Committee in 1974. Close on the heels of these recommendations an International Conference at Alma-Ata in 1978, set the goal of an acceptable level of Health for All the people of the World by the year 2000 through primary health care approach. As a signatory to the Alma-Ata Declaration, the Government of India is committed to achieving the goal of Health for All through primary health care approach which seeks to provide universal comprehensive health care at a cost which is affordable.

Keeping in view the WHO goal of "Health for All" by 2000 AD, the Government of India evolved a National Health Policy based on primary health care approach. It was approved by Parliament in 1983.\textsuperscript{47}

The five year plans were conceived to re-build rural India, to lay the foundations of industrial progress and to secure the balanced developments of all parts of the country. Recognising "health" as an important contributory factor in the utilisation of manpower and the uplifting of the economic condition of the country, the Planning Commission gave considerable importance to health programmes in the five year plans. The broad objectives of the health programmes during the five year plans have been:

(1) Control or eradication of major communicable diseases;

(2) Strengthening of the basic health services through the establishment of primary health centres and subcentres.

(3) Population control; and

(4) Development of health manpower resources.\textsuperscript{48}

Today India has a vast network of governmental, voluntary and private health infrastructure manned by large number of medical and paramedical persons. During the Ninth Plan (1997-2002), efforts were intensified to improve the health status of the population by optimising coverage and quality of care by identifying and rectifying the critical gaps in infrastructure, manpower, equipment, essential diagnostic reagents and drugs.\textsuperscript{49}

\begin{table}[h]
\centering
\begin{tabular}{|l|c|c|}
\hline
 & 1st Plan & 9th Plan \\
 & (1951-56) & (1997-2002) \\
\hline
1. & Primary Health Centres & 725 & 22,807 \\
2. & Subcentres & NA & 137,292 \\
\hline
\end{tabular}
\end{table}


3. Total beds 125,000 596,203 (1997)
4. Medical Colleges 42 187
5. Annual admissions in 3,500 19,000
6. Dental colleges 7 105
7. Allopathic doctors 65,000 410,800 (1997)
8. Nurses 18,500 776,643
9. ANMs 12,780 411,220
10. Health visitors 578 35,890
11. Health workers (F) – 134,086
   30.6.1999 (in position)
12. Health Workers (M) – 73,327
   30.6.1999 (in position)
13. Village Health Guides – 3.23 lacs

World Health Organisation (WHO) in a survey of public health systems of 191 countries in 2000 placed India at the 112th position. The criteria included "fairness of access to health care and fairness of contributions to the cost". India suffers from an acute shortage of medical facilities. It had 0.4 doctor per 1,000 people and 0.8 hospital bed per 1000 people compared to 1.6 doctors and 2.4 hospital beds per 1000 people in China. It may in this context be mentioned that people in the rural areas do not enjoy any health insurance. And there are marked differences in health care facilities between the urban areas where you have a relatively developed health infrastructure and the villages which are deprived of such services.

Millions of the Indians are not able to afford health care because of their poverty and rising cost of health services. The National Health Policy (NHP) 2007 aims at achieving an acceptable standard of good
health for the people in India. A number of states including Orissa and West Bengal have been implementing the "State Health System Development Programme" with the funding provided by the World Bank.\textsuperscript{51}

The National Rural Health Mission (NRHM), 2005-2012, is a perspective health development plan, to give a calculated boost to the national health security concerns.

It covers all the 28 States in India, of which 10 are "Focus" (F) states, 10 more are "High Focus" (HF) States, and the rest 8 North-Eastern States are the "Special High Focus" (SHF) states as shown in Table II.5.

\textbf{Table II.5}

\begin{center}
\begin{tabular}{|l|l|l|l|}
\hline
Sl. No. & Focus States & Sl. No. & High Focus States & Sl. No. & Special High Focus States \\
\hline
1. & Andhra Pradesh & 1. & Bihar & 1. & Arunachal Pradesh \\
2. & Gujarat & 2. & Chhatisgarh & 2. & Assam \\
3. & Goa & 3. & Himachal Pradesh & 3. & Manipur \\
4. & Haryana & 4. & Jammu & Kashmir & 4. & Meghalay \\
5. & Karnataka & 5. & Jharkhand & 5. & Mizoram \\
6. & Kerala & 6. & Madhya Pradesh & 6. & Nagaland \\
7. & Maharashtra & 7. & Orissa & 7. & Sikkim \\
8. & Punjab & 8. & Rajasthan & 8. & Tripura \\
9. & Tamil Nadu & 9. & Uttar Pradesh & & \\
10. & West Bengal & 10. & Uttarakhand & & \\
\hline
\end{tabular}
\end{center}

\textsuperscript{51} Sudhakar Panda, Op cit., pp. 35-36.
Even though the mission is described as the National Rural Health Mission, it does not exclude the urban areas for several consideration: (1) Firstly, most of the District Headquarters Hospitals, which are the "apex" of the District health care system, cover the rural areas, as well as the urban areas, (2) Secondly, quite a substantial rural population stay in the neighbouring urban areas or continue to move to and fro between the villages and the towns and cities, (3) Thirdly, most of the preventive health care schemes of inoculation, vaccination, immunization etc. make their first starts and significant achievements in the District Headquarters.52

Now-a-days many countries are progressively entering into the era of "Telemedicine" and "Electronic", "medicine". Many hospitals and medical services centres in the advanced countries are having and using the electronic system of consultation and prescription of drugs and medicines. The system facilitates the patients getting their prescriptions without physically running from place to place, or from pillar to post, to get the same. This has also very significantly reduced overcrowding of the premises of the hospitals and the medical services centres, by providing "immediate connectivity" of the patients with their Doctors. Telemedicine has become popular in the Western countries. It is also being practised in India by some of the renowned hospitals and agencies in our Metropolitan cities.

India has become increasingly a destination of health care from the neighbouring and the other foreign countries.53

53 . Ibid., p.126.