medico friend circle bulletin

15

MARCH 1977

Health Care Delivery Through ESIC

VIDYUT KATGADE*

FEBRUARY 24th, 1977 is a date that will be written in silver letters (if not golden) in the history of Employees State Insurance Corporation (ESIC) and the Corporation has quite a legitimate reason for this gesture. She has completed 25 years of her precious service to the working masses of Indian private sector establishments. The ESI scheme has been advanced as a social security scheme, almost the only of its kind in this country. What more could an indifferent industrial worker wish for himself and his family ? The benefits extended to the insured individual are in kind as well as cash covering him in times of short or long transient disabilities. Social security in form of disability benefits, pregnancy benefits, compensation benefits and funeral benefits are, by no measure, mean. But a bit of rethinking might be rewarding at this stage of a silver milestone in the history of the corporation.

Cash benefits : an illprojected incentive

The whole business of ESI has been to project their benefits in terms of hard cash which is a catchy lure for most workers. A glance over statewise or nationwide statistics of ESI functioning in the country shows how much has been done for the workers and at what cost, to what gain. It is said that our ESI is a mini model of nationalized Health Services (on the blue-print of U.K.). To speak of figures, it is said that the health services were nationalized in U.K. over a span of 125 years, while the population they took care of is only near 4 crores. Our ESI has extended its aids to some 6 million persons in organised sector of this country in just 25 years.

ESI began its activities in 1952 in Delhi and Kanpur. Adopting the ESI Act (1948) was not an unpleasant task for increasing number of establishments for many reasons. Firstly the implementation of act in itself was something with which the labour organisations felt content that they were doing something for their men. On the other hand the management or employer was relieved by throwing the baby of social security in the lap of the Corporation. The administrators felt that increasing attention was being paid to the needs of working class and the worker was happy that cash benefits were now well within his sight. Slowly and steadily ESI scheme gathered momentum in various states and union territories of India.

By 1965 the scheme covered some 2.8 million families (11.75 million persons). Its health activities (which renders the scheme of some relevance to us) were carried out through 11 hospitals, 226 centres and more than 5000 beds at that time. The scheme was applied to personnel in working, technical, supervisory, clerical and such other catagories in power using perennial factories with more than 20 employees on payroll. The scheme was applied with great vigour by certain states like Karnataka, Tamilnadu and Kerala while in states like U.P. it showed a very slow progress.

By the time another decade passed, ESI had further established itself, now (March 1975) it had 4.5 million families (some 18.6 million individuals) to look after, which they did through 56 hospitals, 365 centres and some 12.5 thousand beds. The activities were further extended in November 1975 by an amendment in the ESI act. In its present shape it envisaged to give a cover to persons working in smaller power using factories, non–power using factories, shops, hotels, restaurents, cinemas, theatres, news

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papers and transport undertakings also. Further there is provision of the act being extended to any other agricultural or commercial establishments. This might appear to be a provision too good to turn down. The ultimate aim may or may not be to simply magnify this picture a hundred folds and rest back in chairs that health care is doled out to all the 60 crore heads of this country. But to dream of such an extension in areas heitherto unattended is not a reality bound thinking. The magnanimity of the cost and manpower problem is probably ignored or unattended. True it is not customary to brood over darker side of the picture on such auspicious occasions as a Silver Jubilee Celebration. But only a look at present functioning will show us how unrealistic. expensive and fantastic the situation would be. The hazard is all the more alarming if one does not examine the present cost and benefit pattern in the health aspect of ESI scheme.

The concept of insurance and social security has two principles implicit in its form and philosophy. They are : (a) Sharing the cost on a general basis where both the employee and the employer put in their bit of resources. At present in general 2.5% of one's wages are directly deducted from worker's pay bill towards ESI and the employers give an amount equivalent to 4% to 5% of their total salary bill. The state too shares 1/8th the cost of health expenses of ESI. Thus here appears to be a system which is almost self-sufficient, without aids or grants, a kind of cooperative project for welfare of commenman, (b) —While the cost is uniformly shared by most insured persons the help and benefits go to the needy and temporarily indisposed persons and the healthy counterpart continues to pay for a security granted under the scheme. Here again is a healthy attitude of ' love thy fellowman, help the needy ' kind of sermon put into practice. It might appear that a ' third party ' has no business to be nosy about the activities of ESIC as far as her health programmes go.

The medical benefits which are freely delivered almost at the doorsteps of an employee are : out patient care, supply of drugs and dressings, pathological and radiological investigations, special services, domiciliary and emergency services, family planning, antenatal, natal and postnatal services, inpatient care, immunisation and health education. The list is comprehensive and has not left any lacuna for further improvement. Overcrowding is no problem in ESI clinics. In the direct care every 1000 or more employees family units insured have a full time, part time, or mobile dispensary of their choice. In the indirect care system an Insurance Medical practitioner is allowed no more than 750 employee family units. The doctors at dispensaries see roughly 80 patients and carry out one house visit on an average working day. The ESI doctor population ratio is 1:585 as against the national doctor population ratio of 1 : 4370. The insured employees have 2.62 beds per thousand as against the national figure of 0.49 beds per thousand. Prescriptions are profuse and wholesome, sickness leave is their privilage and facilities range from dressing to denture, spectacles to surgical and hearing aids to hernia belts. Above all periodic cash benefits are paid to insured persons in case of sickness duely certified by Insurance Medical Officer to the time of 50 days' continuous absence in a year. This cash payments are calculated at the rate of 7/12 daily wages. (Besides these of course there are specified special extended sickness benefits with absence upto 124 and even 309 days in conditions mentioned in the list of ailments. But we shall suppose that they are not of usual occurance). This brings the cost of such services to an understandably high figure. The per capita expenditure on ailing individuals for the years 1961–62, 1969–70 and 1973–74 were Rs. 23.79, Rs. 58.91 and Rs. 67.53 respectively. It is unethical, though tempting, to compare these figures with national per capita expenditure on health and social security. The solution to the problem does not lie in pinching off bits of the aforesaid expenditure or trying to evenly spread the butter however thin the layer be. The Corporation also realizes that she cannot go escalating the ladder of cost. They thought of a short cut instead. They put a ceiling of Rs. 50 and said that all the extra expenses shall be met by the state. The shortcut has by-passed the major issue which is of prime concern to us.

Evaluation

The organised private sector establishments have done their bit by sharing the Insurance Premium, the insured persons have given their share but are the resources thus collected spent in a rational and effective method ?

Tackling health problems in a working population engaged in industrial and business world is in fact an occupational hygiene activity. Occupational health work has to have a consideration for environmental factors in causation, perpatuation and complication of health problems. It is well known that communicable diseases are more prevalent in industrial workers than in general population. Besides, special occupational diseases like Fibrotic Pneumoconiosis in miners, Byssinosis in cotton workers, high lead absorption in batteries and smelting industry, Dermatoses in workers in cement and mineral oil industries pose

problems specific to their worksite and environment. But a major organisation like ESI does not see that these facts have any relevance to the service they have been giving. ESI hospitals and centres as a whole function only as General Medicine Practice Centres in the vicinity of an industrial setting. Practice of Industrial Medicine is a job of 'plant physician' according to ESIC. There is no need for a physician engaged in ESI dispensary to know the immediate environment of the patient who visits him. An ESI doctor deals with insured individuals with a registration number, his chief concern is symptoms, signs and diagnosis. He is often bullied to refer these insured workers to special clinics for investigations or treatment. It might appear that at times he functions a little better than a medical receptionist or a post office of health problems. To remain in his seat he has to write certificates of ailments and copious prescriptions which a paying worker thinks he has a right to obtain. The records mantained over year are nothing but separate medical histories on individual workers and thus are in no way different from records in a practicing physician's chamber. The all too important enquiry about worksite is just never engaged into. The folders mantained in the ESI dispensaries have no provision at all if one wishes to systematically gather parallel data about conditions of work and health of the worker. Individually when a doctor make such observation he has to keep his impressions 'up his sleeve' rather than record it on a folder. This brings in subjective elements and their confirmation becomes almost impossible.

Needless to say that true preventive medicine plays a marginal role, if at all it does. It amounts to saying that at present there is no comprehensive occupational health service in India inspite of the fact that 'Health Insurance' is practiced in a misunderstood or misinterpreted sense of the terms involved. The ESI health services function in a way that does not insure health per se and instead what is assured is probably an immediate and adequate (at times even an exaggerated) attention to the illness in the families with insured employees. Environmental monitoring is not possible and even if practised can not be measured as a team approach by physicians and hygienists. The ESIC could infact shoulder a part of the environmental monitoring by involving her doctors in viewing problems of masses rather then individual cases. The very pattern of organisation of health care delivery through ESI could be used to achieve more ends than just theraputic practice.

A well organised medical team is already functioning in the neighbourhood of these work site purely at a diagnostic and curative level of practice. A fresh endeavour would only require opening their minds to one more aspect of health and illness of workers. As ESI doctor could look at the health status from a different and yet a relevant angle so that expenditure now incurred is better utilised. This could also do away with the need for a full-fledged department for research and basic data collection for implementing environmental monitoring in future. At least the ESI doctor would not have to await reports and communication about basic data from Central Labour Institute or Occupational Health Research Institute. If it could be made mandatory to record some basic demographic, ergonomic, chemical and psychosocial observations in the folders of ailing workers, just within a year's time they (ESI doctors) could have the basic data to go ahead with.

At present the environment of a worker is either totally ignored or its scrutiny is entrusted in the hands which have failed to deliver the goods. The Corporation has her own Factory Inspectors but the kind of work they do has no direct impact on employee's health. He goes visiting factories counting heads employed as against heads insured, checking contents of first aid boxes, water in tap, number of urinals, spitoons and lavatories in the plant, inspecting ventilations and illumination within the workshops. He has to count the masks, crash helmets, gloves and aprons and above all the entries in the accident registers which are better mantained now that the employer does not feature in the compensation business. The Factory Inspector from the local office of ESIC is more a census man or a little bit of an account officer who checks registers of the weekly paid premimum etc.

The Directorate General, Factory Inspections which has been functioning as the Government's instrument in this field has a history which antedates ESIC itself. But it functions 'as an integrated service to advise Government, Industries and others in the matters relating to helth, welfare and safety of workers. The Central Labour Institute which has been functioning since 1960 with three other regional labour institutes at Kanpur, Calcutta and Madras seems to be geared into a more global and comprehensive work but its impact on health care pattern through ESIC is obscure. Like most educational and research centres these institutes mantain museum of industrial health safety and welfare, industrial hygiene laboratory, library cum-imformation centre, sections for training, industrial physiology and industrial psychology. At state level, department of health and labour, through chief inspectors of factories and industrial health inspection services,

are known to be 'rendering assistance by making studies and undertaking studies at plant level and imposing acts'. Whether these bodies function in harmony with ESIC or in a competitive spirit is not clearly understood as the latter seems hardly to be influenced by them. ESIC has the resources which it collects from both the employees and the employers. It is conceivable that they have some amount of control over them and thus over the whole scene. It is only fit that they step in the environmental monitoring aspect of worker's health.

Future of health care delivery through ESIC

It is learnt that the corporation has set up a high powered committee for suggesting comprehensive amendments to the ESI Act. It is also likely to suggest steps for extending its coverage in seasonal industries such as sugar and other agrobased industries. It is now that a bit of rethinking, ordering and improvement on present pattern of expenditure on medical benefits is required. The corporation has crash programmes to build more hospitals, annexes and dispensaries all over the country. It is also noteworthy that after a period of relative stagnation, industrial production has recently shown unmistaken signs of growth. This calls for some more benefits to the workers. An improved health programme is a proposal which sounds promising but there is also a need for cost oriented planning. Two announcements (which need confirmation) to mark the silver jubilee celebration are awaited. The first is regarding the extension of sickness benefit period under the scheme from 50 days to 90 days. And other which arouses concern is further increase in expenditure on medical benefits. One is left wondering about the wisdom in such incentives. An ever-rising cost of medical benefits does not necessarily mean better working conditions or better health for the workers. If at all it reflects anything it is the failure of tools heitherto employed in Occupational Health Work. And hence some amount of soul-searching is prescribed to the healing organisation on its silver jubilee. 'Physician, heal thyself' is the simple advice.

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(Turn to Page 8)

Dear friend,

Needed–New Managers for Medical Colleges

I. Received the 14th issue of the printed MFC bulletin a few minutes ago. While rolling my eyes hastily over the pages, I got them stuck on the 1st column of the 5th page, on " Dear Friend ". Uudoubtedly, the point raised in it, and the manner in which it has been raised, deserve praise. It's a pity that the destiny of thousands of ailing patients and innocent students and doctors, is being controlled in a 'puppet–on–a–string' fashion by these incompetent players.

To me, the article is an incomplete one. It had the scope of discussing the problem to its fullest extent, instead it has been concluded in a fugitive style. Difference also exists regarding the remedy posed by the author.

It is obvious that in the moribund society of ours, we can't get anything better than these worthless 'managers'. The article would have reached the zenith or perfection, if it could throw some light on this aspect–the 'soil' and 'crop' aspect. I can't restrain myself from labelling the solution 'futile' (I apologize). With my very little understanding ability I realize that, the " cadres " adopted on the " lines of Indian Administrative Services " will be of the same competency as the existing ones; and nothing better can be expected from them (though some thing worse can, even very pessimistically, be–expected), because they will also be the fruits of this system, which has yielded these so called 'Deans', at its best.

—Shyamal Kumar Dey, Calcutta

II. Being a junior I know very well to what extent our big hospitals are inefficient; they do not lack money but administration. I was working in few wards having fourty patients. There were many sophisticated equipments which were never used or sometimes nobody knew how to operate with those instruments. But for fourty patients there were only three syringes, two forceps and two scissors. And due to want of these instruments; I used to waste many hours daily.

Above mentioned is one example but from top to bottom today's administration is full of lacunae. A lot of money is wasted in the things of minor importance while there is no money for things of vital importance which strikes everyday. In recent past there were hubble bubble in health ministry about idea of starting Indian Medical Services like I.A.S. It is need of the hour.

—Tejpal Jindal, Sevagram

DOCTORS' CAMP AT KISHORE BHARATI*

A PROBE INTO THE CYCLE OF POVERTY AND DISEASE

The initial stimulus for Kishore Bharati to hold a camp for young doctors and medical students was provided by the Medico Friend Circle. The aims of the camp were threefold :

(a) to expose young doctors and medical students to the conditions determining village community health and to deepen the perception of their future role,

(b) to stimulate the inhabitants of one village to explore issues arising broadly out of the state of health, and

(c) to make Kishore Bharati's workers more perceptive of the barriers with holding community initiative in solving health problems.

The camp did **not** aim to do any preplanned work or service of presumed use to the community because campers armed with preconceived service goals and work targets cannot be sufficiently perceptive of the underlying needs and problems of the community. Nor can villagers undergo the process of working out and deciding exactly what they need, and why, but remain passive uncommunicative acceptors of such services.

Methodology

Given the stated aims, it was possible to approach the problems in two ways : (a) a survey-questionnaire approach or (b) an informal conversational approach using free-association techniques.

The former method, if employed by skilled surveyors fluent in local language and customs, may elicit a mass of useful quantitative data. But the data remain limited in depth. In studying single-village communities, where depth of understanding is critical and where exceptional single-family incidents can influence the whole village, it was felt an informal conversational approach was more appropriate. This technique would, moreover, involve both campers and villagers in the important experience of active communication.

This aproach was put into practice by arranging for campers to stay overnight, in pairs, with families chosen from a socio-economic and caste cross-section of the village. The preparation of villagers and prospective campers was undertaken gradually, over a period of a month preceding the camp.

Selection And Preparation

A group of fifteen participants was selected. They were sent relevant background material by post, before the commencement of the camp. Five Kishore Bharati (KB) workers, including a doctor, joined them to facilitate communication with the villagers. Half this group were medicos drawn from nearby medical colleges so as to open up possibilities for their long-term involvement in local health problems. The rest were doctors and rural workers with some special experience outside the immediate region. Local doctors were too busy with their practices to join the camp. In response to a wish expressed by some villagers, the Joint Director of Veterinary Services (Bhopal) obligingly deputed the newly qualified Assistant Veterinary Surgeon-in-charge of the Block Veterinary Dispensary at Bankhedi. The Veterinarian, however, failed to participate.

The village Palia Piparia was chosen partly for its proximity to Kishore Bharati and for the familiarity of Kishore Bharati's staff with several of its families. More important was the fact that its existing socio-economic conditions, with its mixture of tribals and non-tribals, are representative of medium-sized village communities in Madhya Pradesh.

In order to arrange a doctors' camp of this kind, there was a lot of work to do to soften some barriers of fear and misunderstanding. Beginnings were made in homes where a special personal contact had arisen either through the various activities of KB or through the illness of a family member when medical help had been sought. The most challenging sections of the village were those of landless and the marginal farmers where frequent illness and death are coped with indigenously and outside help shunned for fear of exploitation. Here the contact was tenuous through a handful of agricultural labourers who Work at KB.

Slowly the idea of the doctors' visit to the village was introduced. The villagers were told that the doctors would come to learn, not to teach or practice medicine upon them. Familiar examples were discussed, such as the lack of appreciation of doctors for village medicines or beliefs about sickness and health, the emphasis of doctors on expensive foreign-looking medicines and injections, and their insufficisnt knowledge of the food consumed by villagers. Slowly it was assessed in which homes two medicos might be welcome for a night or two.

Then about a dozen families were approached to be hosts to the doctors. They were reassured that no special preparations need be made in the way of food and comforts as the young medicos wanted

* P. O. Malhanwada, Via Bankhedi, District Hoshangabad, M. P. 461 990. From December 21 to 24, 1976.

to experience the everyday life of villagers. Care was taken to assess that the family could at least afford to share a total of two ordinary meals of any composition with their guests.

Orientation

Most of the campers arrived by early afternoon on December 21. In the first orientation session, a background talk about KB was given outlining its work and past experiences. and its present thinking. It was explained why KB, despite the presence of a qualified doctor, had decided **not** to launch a dispensary or health care programme of its own. Rather, KB had adopted a dual approach to stimulate and raise the awareness of the people about what they could do to improve and protect their health while simultaneously promoting the improvement and optimal utilization of the services of the government Primary Health Centre and its subcentre system. KB's doctor explained some of the ways in which her MBBS training had been put to test by village conditions in the last two years. In fact, her motivation in arranging this camp was largely to share of this educational experience with other young doctors.

An afternoon tea was arranged to get the village hosts and their guests acquainted. It was surprising to observe that the shy hesitation to initiate or sustain friendly conversation was nearly equally distributed between illiterate farm labourers and physicians with MD degrees. The exchange allowed the medicos a foretaste of the type of people they would be living with. To the KB staff, it yielded a few tips to communication snags that might develop, and a couple of minor rearrangements were made. A second orientation session was held to review what was to be observed during the next two days in the village. The next morning, some final instructions along with a cyclostyled set of socio-medical case histories in simple Hindi were given to stimulate the discussion of relevant health problems with the villagers.

The Stay In The Village

The experience cannot be described easily as it was multifocal and different for each of the twenty campers. They created quite an impact on the village. Everywhere the villagers were standing out looking curiously and trying to talk to some of the doctors. The campers on the whole found the villagers eager to tell their views (right or wrong) and get the doctors' opinions. Many of the doctors were asked to examine ill persons and they tried to prescribe medicines or some other cure. Here they came face to face with the underlying problems of the village. For some it was a shock to realize what poverty meant or did to people. Others were stumped : " What to do with patients who don't have any money ? " Quite a few took the way out by stressing preventive medicine.

Some doctors went to the fields to see the working conditions and crop patterns. Most of the campers talked at length with their host families and their neighbours. They also walked about the village where people called out to them to come and talk. But the villagers on the whole were rather puzzled and kept asking them, "What good will your coming here do to us ?"

At night spontaneous gatherings grew around slow-burning fires at several places in the village. Three big ones were in the Gond, Rajhar and Kotwal homes. In most cases discussions started from health problems but quickly shifted over to poverty and land distribution. Quite a few solutions to these problems were explored by the villagers in a couple of these meetings. At the meeting in the Rajhar community, some old people told a story of how their lands had been snatched away by the manipulations of the landlord family. In all the meetings the villagers kept saying: we are illiterate - you tell us the way; we are poor – nobody listens to us; **you** can do something. Some doctors took this as an invitation to lecture the villagers on preventive health care and hygiene, which the villagers listened to with equanimity, never pointing out the flaws in the arguments.

Discussion at Kishore Bharati

The campers returned to KB form the village on December 23. Two long discussion sessions were then held that afternoon and night. Some villagers participated intermittently. The campers decided to discuss under the following headings :

I Problem Identification
(1) Economic, (2) Social, (3) Health
II Opinions of the Villagers about KB
III Relevance of Medical Education and Research
IV Possible Solutions.

Herewith follows a point-wise summary of what the discussions yielded :

I Problem Identification

(1) Economic Problems. The following were listed :
- (i) Disproportionate land distribution. Some families own large tracts, the majority have little or no land.
- (ii) Absence of alternative sources of income, like cottage industry.
- (iii) Low agricultural output and poor knowledge of new agricultural techniques. This often leads to frequent misapplications.
- (iv) Low wages of agricultural labour. Rates range from Rs. 2 to 2.50 per day for 6–8 months

per year or 4 quintals of wheat for 6 months.

(v) Low storing capacity of the poor. This leads to distress sales of agricultural produce.

(vi) Lack of credit facilities for the landless and for marginal farmers.

(vii) Large numbers of children produced. Considered as economic assets, they are needed for security under conditions of high child mortality.

(2) Social Problems. The most outstanding were :

(i) The all-pervading influence and rights enjoyed by six to eight high-caste families to the exclusion of others. This is reinforced by interlocking relationships with influential powers in the area, including the police and government officials.

(ii) Untouchability. The basoards have to bring water from the river, a distant and unclean source.

(iii) The purdah system in the upper caste. This cuts off their women from the outside world.

(iv) Lack of relevant education for poor children. Villagers perceive school education as something that takes children away from home and livelihood (" सत्यानाशी विद्या है"). As a result more than half grow up illiterate. Incidentally people educated outside the village do not receive a very high intelligence rating within the villagers' framework of realistic common sense.

(v) Early marriages of boys and girls.

(vi) Children burdened early with adult responsibilities such as child care and earning.

(vii) Lack of a spirit of cooperation for projects of community health. This is due to :

(a) opposition from the upper class
(b) lack of free time
(c) lack of motivation
(d) anxiety over intercaste mixing
(e) money involved
(f) lack of organising skill
(g) lack of information and guidance
(h) failure of previous efforts.

(3) Health Problems. These mainly included :

(i) Intestinal amoebiasis. It is so common that it is accepted as a normal discomfort.

(ii) Malaria. It takes a high toll from peoples' ability to work.

(iii) Skin infestations, infections and abscesses. These are very common and are treated with local applications.

(iv) Colds, coughs and nondescript fevers.

(v) Water contamination. The campers felt it to be a major problem but as there were few cases of acute gastro-enteritis during the camp, the villagers were not much interested in it.

(vi) Finance. Many people had no money to spend on medicine or preventive health.

In the context of the need for " preventive medicine ", it was pointed out that the high mortality rate of children under five years is not attributable to diseases preventable by immunization programmes. It is due, rather, to the complex of malnutrition, gastro-enteritis and infectious respiratory diseases which characterize the rural poor. Major changes like the provision of a safe and convenient water supply would have to come from sources sufficiently powerful, probably the Government.

The villagers had several complaints to make, the major of which were :

(a) Ineffectivity and remoteness of Government health service
(b) Exploitation by private practitioners
(c) Expensive and over-charged medicines
(d) Prescriptions and drug-labels in English
(e) Loss of wages incurred to reach doctors
(f) Unavailability of transportation for the poor.

Most of the campers could realise by now that the practice of hygiene, especially personal hygiene, was largely determined by availability of leisure time and facilities, both of which are aften in short supply among low income groups.

There was a lot of fear associated with the heavy drive for vasectomy operations. Stories of coercion, abuse and even death were being circulated.

Most communities, especially the poor, had strong beliefs in spirit medicine and magic. There was also a feeling that indigenous medicines were more suited to the village people. Villagers, thus, often felt closer to unqualified practitioners who have strong communication advantages.

II Opinions of the Villagers about KB

This part of the discussion was offered by the campers for the benefit of the KB workers and was not directly related to health.

III Relevance of Medical Education and Research

" The things we learned in college are not reaching the people ", remarked one camper. " It has not been made sufficiently clear as to what is the role of poverty, and the removal of poverty, in Preventive Medicine " said another. Poverty is, indeed, listed in textbooks among the causes of ill-health. It is, however passed over in sections on preventive action. The words of a villager underscored this deficiency succinctly " बीमारी का सब से बडा कीटाणु गरीबी है। "

The campers generally realized that much of college medicine and research is not applicable to the present unbalanced socio-economic set-up, especially in rural areas. It is based largely on urban upper and middle class conditions, values and environment. High quality training and research are necessary in the most basic areas of rural medical and health practice, heretofore unexamined in college classrooms.

IV Possible Solutions

(i) Launching a hospital or dispensary. This view was still expressed by a few doctors. Some disagreed. Several remained silent. Most seemed to sympathise with the aim of building up and utilising the Government health system, through the active initiative of the villagers.

(ii) Improving the economic conditions of villagers through the development and promotion of cottage industries. The campers could not, however, suggest a suitable cottage industry for this village. Also, it was realised that the benefits accruing tend to be siphoned off by the rich.

(iii) Maximising the use of local resources, including the culture and energy of the people themselves.

(iv) Exploring ways by which the benefits of higher agricultural production reach the weaker sections.

Most campers eventually realised the inadequacy of their own understanding of the complexity of rural problems. They observed soberly that there were no ' quick and easy ' formulae to be offered. A deeper study is, therefore, necessary.

Follow-up

It is being assessed whether there is any change in the awareness level of the village as a result of the camp. This feedback has already helped KB in planning future activities. KB's workers have decided to share their own newly gained perception of health problems with the people of this region through informal discussions, meetings, exhibitions and special activities with school children.*

The doctor-campers are also being followed up to find out what impact this camp has had on their perspective of medical work. A change in perspective would prove the utility of the camp. If so, this method of raising awareness among young doctors must be repeated and developed.

–Mira Sadgopal **– Vasanthi Gupta**

Contd. from page 4

4. Sunday Standerd, News item in the issue dated 30–1–77, New Delhi.
5. WHO (1967): Tech. Report Ser. 354; ILO/WHO Joint Expert Committee Report on Occupational Health, Geneva.
6. WHO (1973): Tech. Report Ser. 535; Environmental and Health Monitoring in Occupational Health, Geneva.
7. Personal communication with officials at various levels of functioning within ESIC.

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I, Ashvin J. Patel, hereby declare that the particulars given above are true to the best of my knowledge and belief.

A. J. Patel

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*1. An audio-visual exhibition portraying the cycle of poverty, malnutrition and ill health was put up by KB at the Vasant Panchami Mela organised by the Bankhedi Panchayat in January. The Mela was attended by several thousand people from roughly 100 villages.

2. About 150 eighth class students from 11 middle schools of Bankhedi Block spent a full day at KB in early February participating in exhibition, tape-recorded drama (composed and recorded with villagers), and competitions on the themes of poverty, food production, nutrition and health.

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