International Journal of Research in Social Science and Humanities (IJRSS)

DOI: 10.47505/IJRSS.2025.8.6

E-ISSN : 2582-6220

Vol. 6 (8) August - 2025

Conceptualization of Public Health in India: An Evolutionary Perspective

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ABSTRACT

Public health is a wider and a complex concept. It is concerned with the health of the population. The very notion of what constitutes 'public' in public health has been subject to different interpretations across time and contexts. This paper traces the evolution of public health conceptualization in India through five distinct phases from independence to present. It examines conceptual transformations that have shaped governance approaches and continue to influence contemporary challenges.

Through historical analysis, the study identifies transformations: from nation-building focus (1947-1983) to pragmatic private sector accommodation (1983-1990) which was followed by market-dominated approaches during liberalization (1990-2005), rights-based reconceptualization (2005-2020), and emergency governance and digital surveillance during COVID-19 (2020-present). It was found that each phase added new perspective in previous ones rather than replacing them. As a result, contemporary framework involves contradictory principles such as market mechanisms alongside rights discourse, universal coverage with targeted programs, and digital surveillance amid privacy concerns. The COVID-19 pandemic governance highlighted the limitations of existing legal frameworks and introduced unprecedented dimensions of inter-sectoral coordination and digital health governance. It concludes that public health conceptualization is not merely a technical exercise but also addresses questions about state capacity, citizen rights, federal governance, and the relationship between individual and collective welfare. It reflected deeper tensions about state authority, federal governance, and individual versus collective welfare which needs coherent approach to reconcile accumulated contradictions while maintaining crisis adaptability.

Key words: Governance, Health policy, Public health.

1. INTRODUCTION

Health, a crucial aspect of human well-being, has been a prioritized agenda of a welfare state. As acknowledged by World Health Organization (WHO), health is not just the absence of diseases, it encompasses "a state of complete physical, mental and social well-being" (World Health Organisation, 2009, p. 1). It is not only an important indicator of quality of life but is also of economic progress at individual level and of societies. Thus it can be said that health is a foundation of prosperous societies.

Public health is a wider and a complex concept. It is concerned with the health of the population. The very notion of what constitutes 'public' in public health has been subject to different interpretations across time and contexts. For some, public health represents collective action to address population-wide health challenges. For others, it signifies state responsibility for ensuring basic health services. Yet for many, public health encompasses the broader social, economic and environmental determinants that shape health outcomes.

In India, this conceptual ambiguity takes on particular significance. The trajectory of public health development since independence reveals not just changing disease patterns or evolving medical technologies, but fundamental shifts in how successive governments have understood their role and responsibilities toward health of the people. Since,

independence, India has made progress in key health indicators like improvements in life expectancy and reductions in child and maternal mortality rates etc. For instance, India is experiencing an increase in life expectancy which is almost equal to the world average. Since 1990, life expectancy at birth in India has increased by approximately 13 years, rising from 58.6 to 72 years in 2023 (UNDP, 2025). However, as of the most recent National Health Accounts (FY2021-22) the total public expenditure on health in India was around 1.84% of GDP (GOI Ministry of Health and Family Welfare, 2024), the gravity of the challenge becomes manifold. In addition to this, 85-95% of the public spending is current in nature concentrating on wages and salaries (Hooda, 2013).

These contradictions are not merely an implementation failures or resource constraints. They reflect deeper tensions in how public health has been conceptualized and reconceptualized over different historical phases. The COVID-19 pandemic further exposed the limitations of existing frameworks and forced yet another reconceptualization. Understanding these conceptual shifts are crucial to understand the policy formulation as well as implementation approaches, administrative structures, and governance mechanisms.

This paper traces the evolution of public health conceptualization in India through distinct phases, focusing on the conceptual transformations that have shaped governance approaches and continue to influence contemporary challenges.

2. EVOLUTIONARY PHASES OF PUBLIC HEALTH CONCEPTUALIZATION IN INDIA

The conceptualization of public health has been determined by development in two areas - changing patterns of diseases and changing social, political and economic scenario. Public health is concerned with community and shared values of life, health, and security and governments play a crucial role in ensuring coordinated efforts and prioritizing allocation of resources (Beauchamp, 1983). In this way community is at the centre of public health while recognizing the tension between collective concepts and individual freedom.

The evolution of public health as a concept reflects its emergence as a product of modernity, which transformed the social and economic order of 18th and 19th century. Initially, public health emerged as a response to manage unhealthy urban environments, based on the notion that health is a public good and it is the duty of the government to deliver it (Gorsky, 2011). However, the later emergence of germ theory led to the ‘medicalization of public health’. This shift saw the earlier dimension of collective management of the environment being diluted and the focus shifted towards individual interventions emphasizing ‘personal hygiene’ and ‘personal prevention’.

During the early 20th century focus was on ‘national efficiency’ with emphasis on health of mothers, infants and children through antenatal clinics, welfare provisions for school children, and milk pasteurization. The interconnection between unemployment, poverty and health led to recognition of public health’s role in broader social justice. Later with the rise of evidence-based medicine emphasis shifted to biomedical rather than social solutions. Lifestyle and individual behaviour were recognised as health determinants, particularly as disease patterns shifted from infectious to chronic diseases (Berridge, 2011).

Thus, the different phases of public health development reflected competing conceptualizations, each shaped by prevailing crises and governance philosophies. The evolution of public health conceptualization in India can be examined through five distinct phases, each representing fundamental shifts in how the state understood its relationship to citizen health and its role in ensuring population wellbeing.

2.1 Phase I (1947-1983): Public Health as Nation-Building

The first phase of public health evolution in independent India was dominated by efforts to extend the reach of public health facilities to the masses, particularly in rural areas. However, concerns of population growth led to over emphasis on family planning, limiting the broader focus of public health. The lack of adequate resource commitment also ensured that even these limited policy objectives were not successfully achieved (Sen & Iyer, 2015).

The infrastructure framework that developed during this period emanated from the recommendations of the Bhore Committee, which advocated publicly funded health services delivered through a three-tiered public system of primary, secondary and tertiary care (Government of India, 1946). Yet the spirit of these recommendations was dampened by several structural issues. Most significantly, while health remained a state subject constitutionally,

DOI: 10.47505/IJRSS.2025.8.6

almost the entire governance framework emerged from the center, particularly because of resource dependence of states (Jeffery, 2021). This created a fundamental tension between federal principles and centralized control that persisted in the following years.

Health issues were approached on a campaign basis with externally linked aims, and when those aims were not realized, campaigns also waned. This campaign mentality reflected a particular understanding of public health as episodic intervention rather than sustained governance. The early years of the highly interventionist state saw the idea of health and well-being not getting enough space, for various political and geopolitical reasons. This neglect became the foundation on which the private sector would, in later years, dominate the arena of health (Amrith, 2009).

The regional and social variations in health outcomes during this period resulted from a top-down approach that made states dependent on the center despite health being a state subject. During this phase, public health was conceptualized primarily as a state capacity demonstration and nation-building exercise. The emphasis on extending reach to rural masses reflected the new state's attempt to establish legitimacy and presence across the territory, but it also revealed the limitations of viewing public health primarily through the lens of administrative expansion rather than health outcomes.

2.2 Phase II (1983-1990): Pragmatic Accommodation

The second phase marked a significant conceptual shift through introduction of private sector in health. Government acknowledged the complementary role of the private sector in the National Health Policy 1983. This laid the foundation for private sector dominance in healthcare in the following years (Sen & Iyer, 2015). This represented a fundamental reconceptualization from viewing public health as exclusively state responsibility to accepting mixed provision models.

Inadequate resources and fragmented focus had given space to the private sector to step in, which also changed utilization patterns in favour of private provision (Hooda, 2013). During this period, public health was no longer seen as a state monopoly but as requiring multiple actors and approaches. The pragmatic accommodation of private providers reflected both the state's recognition of its own limitations and the emergence of new ideas about efficient service delivery.

However, this shift also began to introduce tensions between public health as a collective good and market-based provision which became more pronounced later. The acceptance of private sector involvement represented not just a policy adjustment but a conceptual transformation that would have lasting implications for how public health responsibilities were understood and distributed.

2.3 Phase III (1990-2005): Market-Dominated Conceptualization

The third phase fundamentally altered public health conceptualization as health got caught up in broader economic reforms. Unregulated privatization became the dominant theme, resulting in increased costs and the emergence of household impoverishment due to health expenditure (Sen & Iyer, 2015). The health sector experienced comprehensive liberalization and privatization, leading to high costs and gradual impoverishment of vulnerable households.

This period saw public health expenditure remaining very low, lingering around 1% of GDP despite government assurances towards realizing 2-3% of GDP as health expenditure. Moreover, this minimal spending neglected investment in physical infrastructure, medicine, equipment and research, with 85-95% of government health spending being current in nature, concentrating on wages and salaries (Hooda, 2013). Most importantly, there was meagre allocation towards drinking water, sanitation and nutrition - services that are preventive in nature and have the highest potential in determining long-term healthy life.

The highly skewed nature of public health expenditure during this period not only neglected capital investment but also the preventive aspects of public health. This reflected a fundamental conceptual transformation where public health shifted from being understood as a public good to being treated as a market commodity. High emphasis on multi-specialty, high-end tertiary care without adequate arrangements for prevention at lower levels distorted the very idea of public health (Raj, Dalal, & Gupta, 2025).

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During this period, market logic began to dominate not just service delivery but the fundamental understanding of what public health meant and who was responsible for ensuring it. The consequences of this shift - including household impoverishment and increased health inequalities - would eventually force another conceptual rethinking in the subsequent phase.

2.4 Phase IV (2005-2020): Rights-Based Reconceptualization

This phase was characterized by mixed approaches that attempted to reconcile market mechanisms with renewed state responsibility under a rights-based framework. During this period, the private sector continued flourishing and the public sector was redefined through a rights-based approach to overcome earlier failures and challenges (Sen & Iyer, 2015).

More comprehensive and integrative approaches were developed to revive public health from its incapacitated state. The National Health Mission and the National Health Policy 2017 emphasised on equitable access, decentralised planning and community participation (Gupta, 2005). Further, the Ayushman Bharat initiative, gave a renewed push towards promotive care and improved access. These represented important steps to move focus of health sector initiatives beyond curative care (Raj, Dalal, & Gupta, 2025).

In attempts to reconcile market mechanisms with rights discourse, a new role of the state as guarantor rather than direct provider emerged. The focus shifted towards ensuring access while allowing diverse providers (public and private) to deliver services. However, this created three key tensions: between universal entitlements and targeted beneficiary approaches, between rights discourse and limitations.

The rights-based conceptualization represented an attempt to restore public health as a collective responsibility and accommodate the market realities that emerged during the previous years. This hybrid approach highlighted both the political necessity of addressing health inequalities and the practical challenges of reversing market dominance in healthcare provision.

2.5 Phase V (2020-Present): Emergency Governance and Digital Surveillance

The COVID-19 pandemic has fundamentally reshaped public health conceptualization in India, introducing entirely new dimensions that transcend traditional frameworks. India witnessed its first coronavirus case on 30th January 2020, in Kerala, in a student returning from Wuhan (Kumar, Kumar , Christopher, & Doss, 2020). The government's response revealed both the limitations of existing conceptual frameworks and the emergence of new paradigms for understanding public health governance.

2.5.1 Emergency Legislative Framework and Governance

The pandemic exposed significant gaps in India's legal preparedness for health emergencies. For the first time since independence, India faced a major health emergency that required extraordinary measures. The government's response relied on two primary legal instruments: the colonial-era Epidemic Disease Act (EDA) of 1897 and the Disaster Management Act (DMA) of 2005. However, the application of these frameworks revealed fundamental limitations in addressing modern pandemic challenges.

The EDA, enacted during the British colonial era to tackle the bubonic plague in Bombay State, contained only four sections and was described as "extraordinary" but "necessary" during its original discussion in 1897 (Rai, 2020; The Law Commission of India, 2024). While the Act had been vital in containing other outbreaks like Cholera (1910), Spanish Flu (1918-20), Smallpox (1974), Swine flu (2014), and Nipah Virus (2018), it proved inadequate for the complexity of COVID-19. The Act was silent on technical and operational mechanisms of epidemic control and management. It lacked provisions for testing, contact tracing, isolation protocols, and modern transportation screening (Patro, Tripathy, & Kashyap, 2013; The Law Commission of India, 2024).

The nationwide lockdown was declared on March 25, 2020, under the Disaster Management Act (DMA) 2005, not the EDA. This decision raised constitutional questions about whether pandemic could be considered "disaster" as per the DMA's definition. Section 2(d) of the DMA defines disaster as "catastrophe, mishap, calamity or grave occurrence" but the interpretation of health emergency under this framework created legal ambiguities. The lockdown was

DOI: 10.47505/IJRSS.2025.8.6

extended multiple times until May 31, 2020, demonstrating the government's reliance on disaster management rather than health emergency frameworks (Gowd , Veerababu, & Reddy, 2021).

The use of emergency powers raised fundamental questions about the balance between collective health security and individual rights. The lockdown restrictions impacted fundamental rights enshrined under Article 19(1)(d) regarding free movement and Article 19(1)(e) regarding the right to reside anywhere in India. The formation of Inter-Ministerial Central Teams (IMCT) under Section 10(2) of the DMA to conduct field visits in states instead of using constitutional mechanisms like Inter-State Council under Article 263 created federal tensions (The Law Commission of India, 2024).

The establishment of a COVID-19 Economic Response Task Force and the directive for Central Armed Police Forces to enter battle mode demonstrated how health emergencies now required whole-of-government responses that transcended traditional sectoral boundaries. This represented a new understanding of public health as inherently inter-sectoral, requiring coordination across health, labour, education, transport, digital infrastructure, and economic sectors simultaneously.

This experience demonstrated that the invocation of colonial-era and disaster management legislation proved insufficient for managing a modern pandemic, highlighting the need for comprehensive health emergency legislation specifically designed for contemporary public health crises (Gowd , Veerababu, & Reddy, 2021; The Law Commission of India, 2024).

2.5.2 Digital Health Governance Revolution

Beyond legislative frameworks, the most significant conceptual innovation was the introduction of digital surveillance as a core component of public health governance. This transformation reflects broader trends toward digital health governance, which emphasizes integrating technology with governance structures to enhance healthcare delivery and policy implementation (Kar & Ram, 2024). The Aarogya Setu contact tracing app represented a fundamental shift from physical infrastructure-based health monitoring to digital network-based surveillance. By July 2020, it had been downloaded 127.6 million times, making it one of the world's most widely adopted contact tracing applications. The app collected demographic data including age, gender, phone number, travel history etc. and stored it on central servers. It also frequently collected GPS coordinates of the users along with continuous access of Bluetooth data about nearby users. This phase marked a significant shift in public health practice that combined individual behaviour monitoring with population-level surveillance in unprecedented ways. The centralized storage of data and its use for surveillance represented the authority of state in health governance.

The digital transformation and its use in health sector led to rethinking about legal frameworks governing health surveillance. The absence of specific legislation for health data collection resulted in handling of personal data through executive orders rather than comprehensive legislation. This created accountability gaps. These gaps highlighted the absence of robust digital health governance frameworks necessary for balancing technological innovation with democratic safeguards (Kar & Ram, 2024). In this regard, the Law Commission of India (2024) also recognised the importance of digital surveillance for epidemic management and emphasised the need of proper legal framework with clear privacy protections and data collection standards.

Thus, this phase faced the tension between emergency health needs and constitutional privacy rights which was not addressed in previous public health frameworks. A number of concerns were raised: firstly, personal data collected through Aarogya Setu could be shared with government agencies, public health institutions, and research organizations. This altered the relationship between individual privacy and collective health security. Secondly, the government made the app mandatory for all private and government sector employees. This led to the concern regarding unprecedented state surveillance capabilities in the name of public health. Thirdly, the app was developed through opaque public-private partnerships with tech industry volunteers participating in management. This questioned the design decisions possibly made by employees of companies with conflicts of interest.

Later Arogya Setu App was transformed into a National Health App under the Ayushman Bharat Digital Mission. This was an important step for institutionalization of digital health surveillance beyond the pandemic period (GOI Ministry of Health and Family Welfare, 2023). This digital transformation introduced new questions about the

DOI: 10.47505/IJRSS.2025.8.6

boundaries of public health intervention and the role of technology in mediating state-citizen relationships during health emergencies.

2.5.3 Healthcare System Transformation Under Crisis

While legal and digital innovations addressed governance challenges, the pandemic exposed severe limitations in India's healthcare infrastructure. The total number of public hospital beds, ICU beds, and ventilators - 713,986; 35,699; and 17,850 respectively - proved inadequate when active COVID-19 cases crossed the one crore mark (The Law Commission of India, 2024; Kumar & Singh, 2021). Most government hospitals were overburdened, unequipped, and understaffed during the peak period in September 2020 (Indian Express, 2020; Naik, 2020).

This crisis forced rapid innovation in healthcare delivery models that went beyond traditional hospital-based approaches. Converting public buildings into COVID-19 care centers, increasing domestic production of medical supplies, and developing telemedicine capabilities all represented new approaches to healthcare provision (The Hindu, 2021; India Today, 2020). The emphasis on home isolation, community care centers, and digital health monitoring reflected a more distributed and technologically mediated understanding of health service delivery.

These innovations represented not just emergency adaptations but new conceptual approaches to healthcare organization that challenged traditional boundaries between institutional and community-based care, between clinical and non-clinical spaces, and between professional and technological mediation of health services.

2.5.4 Federal Governance Challenges and Coordination

The pandemic highlighted fundamental tensions in India's federal structure regarding health governance. While health remained a state subject under the Constitution, the central government's invocation of emergency powers and coordination of national responses revealed the limitations of decentralized health governance during crisis situations. The decision to impose nationwide lockdown using central powers while health and public order remained state subjects created constitutional controversies.

Different states adopted varying approaches to lockdown implementation, testing strategies, and economic relief measures, creating a patchwork of responses that sometimes conflicted with central directives. States like Odisha brought ordinances providing imprisonment for 2 years and fines of Rs. 10,000 for violating epidemic regulations, replacing the EDA's original provision of 6 months imprisonment and Rs. 1,000 fine. Telangana invoked the EDA by issuing "Telangana Epidemic Disease (COVID-19) Regulation 2020" which empowered multiple officials and brought all hospitals under regulatory purview while prohibiting misinformation spread on social media (The Law Commission of India, 2024).

Karnataka's regulations barred private laboratories from conducting COVID-19 testing and made District Disaster Management Committees the main authority for containment strategies. These variations demonstrated how federal structures could both enable innovation and create coordination challenges during health emergencies.

The lack of fiscal and monetary support from the central government to states during lockdown became a major federal concern. The central government's formation of Inter-Ministerial Central Teams (IMCT) to conduct field visits in states, instead of using constitutional mechanisms like Inter-State Council under Article 263, was criticized as unconstitutional overreach (The Law Commission of India, 2024; Joshi, 2025). This forced new thinking about the appropriate balance between central coordination and state autonomy in health governance, particularly during crisis situations requiring rapid, coordinated responses.

The variation in state responses - from Kerala's early success in contact tracing to Mumbai's struggles with healthcare capacity - demonstrated the complex interplay between federal governance structures and health emergency management capabilities.

2.5.5 Legal and Constitutional Innovations

The pandemic forced several legal innovations that reflected new conceptualizations of public health authority. On April 22, 2020, the Union Cabinet issued an ordinance to amend the EDA following incidents of attacks on healthcare workers. The ordinance significantly enhanced penalties - property damage could result in imprisonment for 3 months to 5 years and fines of Rs. 50,000 to Rs. 200,000, while violence against healthcare workers carried imprisonment for

DOI: 10.47505/IJRSS.2025.8.6

6 months to 7 years and fines of Rs. 100,000 to Rs. 500,000, plus compensation obligations (Law Commission of India, 2024). However, these amendments addressed only specific aspects and broader structural gaps were left unresolved.

Various states issued their own regulations under the EDA. The Ministry of Health and Family Welfare, as the nodal agency, actively directed and advised states on COVID-19 measures while holding regular press briefings. The delegation of Home Secretary's powers to the Secretary of Ministry of Health and Family Welfare under Section 69 of the DMA represented unprecedented authority transfer for health coordination.

The pandemic also highlighted the need for health emergency provisions in the Indian Constitution. Unlike national emergency (war, external aggression, armed rebellion), state emergency (constitutional breakdown), or financial emergency (financial stability threats), health emergency does not have constitutional recognition. Due to this gap disaster management framework that was not designed for health crises had to be applied (Law Commission of India, 2024).

The experience highlighted the need for a comprehensive public health legislation. Although governments have made attempts earlier like the National Health Bill (2009) and Public Health Bill (2017), but these were unsuccessful as states opposed these in the context of constitutional division of powers (Law Commission of India, 2024). The pandemic demonstrated that health emergencies transcend traditional federal boundaries and require new legal frameworks that balance central coordination with state autonomy and also protect fundamental rights during crisis situations. The Law Commission of India (2024) concluded that either the existing EDA needed substantial amendments or entirely new comprehensive legislation was required to address modern epidemic management needs.

2.5.6 Institutionalization of New Paradigms

The pandemic response has created new institutional arrangements that introduced a new paradigm in health governance. On the one hand, the transformation of Aarogya Setu into a National Health App under the Ayushman Bharat Digital Mission represents the institutionalization of digital health surveillance. On the other hand, the establishment of emergency response protocols, development of telemedicine guidelines, and creation of health technology assessment capabilities brought changes in the way public health is conceptualized and organized.

The COVID-19 phase or the pandemic introduced the new features in the concept of public health, these include digital-physical hybrid governance that need real-time surveillance, inter-sectoral coordination, emergency response capabilities, and multi-scale coordination from local to global levels. This phase marked the most significant reconceptualization of public health in India since independence and included dimensions that had not been anticipated or addressed earlier. The Law Commission of India (2024) recognized this transformation as necessitating fundamental legal reforms to institutionalize these new paradigms while addressing their governance challenges

3. CONCLUSION

The evolution of public health conceptualization in India reveals several important patterns that transcend individual policy changes. Each phase has been triggered by crisis moments that forced fundamental rethinking - population growth anxieties in the first phase, fiscal constraints in the second, economic crisis in the third, inequality concerns in the fourth, and pandemic response in the fifth. These conceptual shifts have rarely replaced previous understandings completely. Instead, they have layered new logics on top of older ones, creating hybrid systems that often embody contradictory principles.

Contemporary Indian public health simultaneously embraces market mechanisms and rights discourse, preventive rhetoric and curative spending, universal coverage and targeted programs, digital surveillance and privacy concerns, centralized coordination and federal autonomy. These are not only implementation challenges but also represent deeper conceptual tensions that accumulated over decades. Each phase has contributed institutional practices and conceptual understandings that continue to shape the way public health challenges are understood and addressed. The federal structure has further contributed in this complexity as different states interpret and implement different approaches and pursue diverse strategies. This besides creating opportunities for innovation has also made it difficult to develop a national approach to public health governance.

DOI: 10.47505/IJRSS.2025.8.6

Understanding the evolution, provides insights into the way foundational concepts shape governance approaches and administrative structures. Each phase in evolution of public health conceptualisation represented policy changes along with fundamental shifts understanding of state about its relationship to citizen health and its own role in ensuring population wellbeing. The COVID-19 pandemic caused the most significant conceptual change since independence. It introduced digital surveillance, inter-sectoral coordination, emergency governance, and multi-scale coordination as new dimensions of public health. These innovations created new capabilities along with new tensions between understandings of public health responsibility, individual rights, and collective security. The major concern in contemporary public health governance is in developing coherent approaches that can contribute in reconciliation of the accumulated conceptual tensions and address health challenges.

The Indian experience demonstrates that public health conceptualization is not merely a technical exercise but also addresses questions about state capacity, citizen rights, federal governance, and the relationship between individual and collective welfare. Future developments will likely continue this pattern of crisis-driven conceptual innovation and require governance systems that can adapt and maintain coherence across the multiple logics that characterize Indian public health.

REFERENCES

Amrith, S. (2009). *Health in India Since Indenpence*. Manchester: Brooks World Povery Institute.

Beauchamp, D. E. (1983). What is public about public health? *Health affairs (Project Hope), 2*(4), 76-87. doi:https://doi.org/10.1377/hlthaff.2.4.76

Berridge, V. (2011). Public health in the twentieth century II: 1945–2000s. In V. Berridge, M. Gorsky, & A. Mold, *Public Health in History* (pp. 195-210). McGraw Hill.

GOI Ministry of Health and Family Welfare. (2023, July 21). *Update on Digital Healthcare Mechanism.* Press Information Bureau. Retrieved July 16, 2025, from https://www.pib.gov.in/PressReleasePage.aspx?PRID=1941463

GOI Ministry of Health and Family Welfare. (2024, October 4). *National Health Account (NHA) Estimates 2020-21 and 2021-22: A comprehensice Overview*. Press Information Bureau. Retrieved July 10, 2025, from http://pib.gov.in/PressNoteDetails.aspx?NoteId=153237&ModuleId=3

Gorsky, M. (2011). Public health in the West since 1800: The context. In V. Berridge, M. Gorsky, & A. Mold, *Public Health in History* (pp. 23-41). McGraw Hill.

Government of India. (1946). *Report of Health Survey and Development Committee*. Delhi: Manager of Pubications. Retrieved from https://nihfw.ac.in/Doc/Reports/bhore%20Committee%20Report%20VOL-1%20.pdf

Gowd , K. K., Veerababu, D., & Reddy, V. R. (2021). COVID-19 and the legislative response in India: The need for a comprehensive health care law. *Journal of Public Affairs, 21*(4), e2669.

Gupta, M. D. (2005). *Public Health in India: An Overview*. World Bank.

Hooda, S. K. (2013). *Changing Pattern of Public Expenditure on Health in India: Issues and Challenges.* New Delhi: Institute for Studies in Industrial Development.

India Today. (2020, March 30). AIIMS to convert Trauma Centre into Covid-19 hospital. *India Today*. Retrieved September 13, 2024, from https://www.indiatoday.in/india/story/aiims-to-convert-trauma-centre-into-covid-19-hospital-1661255-2020-03-30?utm

Indian Express. (2020, September 23). To ease flow of patients to overburdened Pune, more health facilities set up in other districts. *The Indian Express*. Retrieved from https://indianexpress.com/article/cities/pune/to-ease-flow-of-patients-to-overburdened-pune-more-health-facilities-set-up-in-other-districts-6606655/

Jeffery, R. (2021). Health policy and federalism in India. *Territory, Politics, Governance, 10*(1), 67-85. doi:https://doi.org/10.1080/21622671.2021.1899976

DOI: 10.47505/IJRSS.2025.8.6

Joshi, C. (2025, July 28). *Legal Framework for Health Emergencies in India: Post-COVID-19 Analysis and Reform Recommendations*. Retrieved July 31, 2025, from https://bhattandjoshiassociates.com/legal-framework-for-health-emergencies-in-india-post-covid-19-analysis-and-reform-recommendations/

Kar, M., & Ram, S. (2024). Digital governance in transforming health systems and health policy in India. *The Journal of Community Health Management, 11*(1), 6-12. doi:https://doi.org/10.18231/j.jchm.2024.003

Kumar, A., & Singh, R. (2021). Public Health Policy of India and COVID-19: Diagnosis and Prognosis of the Combating Response. *Sustainability, 13*(6), 3415.

Kumar, S. U., Kumar , D. T., Christopher, B. P., & Doss, C. G. (2020). The Rise and Impact of COVID-19 in India. *Frontiers in medicine, 7*, 250. doi:https://doi.org/10.3389/fmed.2020.00250

Naik, A. (2020, September 12). Resource Constraints Hamper Hospital in Remote Nandurbar District of Maharashtra. *Moneylife*. Retrieved from https://www.moneylife.in/article/resource-constraints-hamper-hospital-in-remote-nandurbar-district-of-maharashtra/61500.html

Patro, B. K., Tripathy, J. P., & Kashyap, R. (2013). Epidemic diseases act 1897, India: Whether sufficient to address the current challenges? *Journal of Mahatma Gandhi Institute of Medical Sciences, 18*(2), 109-111. doi:10.4103/0971-9903.117796

Rai, S. K. (2020, April 2). *How the Epidemic Diseases Act of 1897 Came to Be.* Retrieved May 20, 2023, from The Wire: https://thewire.in/history/colonialism-epidemic-diseases-act

Raj, J., Dalal, S., & Gupta, A. (2025). Evolution of the Healthcare Policy Framework in India. *Indian Public Policy Review, 5*(6), 36-110. doi:https://doi.org/10.55763/ippr.2025.05.06.0035

Sen, G., & Iyer, A. (2015). Health Policy in India: Some Critical Concerns. In E. Kuhlmann, R. Blank, I. L. Bourgeault, & C. Wendt, *The Palgrave International Handbook of Healthcare Policy and Goovernance* (pp. 154-170). Palgrave Macmillan.

The Hindu. (2021, May 21). Residential hostel converted into COVID Care Centre. *The Hindu*. Retrieved September 12, 2024, from https://www.thehindu.com/news/national/karnataka/residential-hostel-converted-into-covid-care-centre/article34615424.ece

The Law Commission of India. (2024). *A Comprehensive Review of Epidemic Diseases Act 1897, Report No. 286.* Retrieved from https://lawcommissionofindia.nic.in/report_twentysecond/

UNDP. (2025, May 6). *India's human development continues to make progress, ranks 130 out of 193 countries*. Retrieved July 12, 2025, from UNDP India: https://www.undp.org/india/press-releases/indias-human-development-continues-make-progress-ranks-130-out-193-countries

World Health Organisation. (2009). *Basic Documents, 47th ed.* Retrieved from https://iris.who.int/handle/10665/44192

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DOI: 10.47505/IJRSS.2025.8.6