Vol 9, Issue 5, 2026 **Impact Factor: 8.535** DOI: https://doi.org/10.31426/ijamsr.2026.9.5.9319

IJAMSR

International Journal of Advanced Multidisciplinary Scientific Research (IJAMSR) ISSN:2581-4281

Public Health Emergency Laws and Its Impact on India's Economy

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ABSTRACT

Public health emergency legislation for the protection of the health of the general population and for the successful management of health emergencies such as epidemics and pandemics. In India, we have the Epidemic Diseases Act, 1897 and the Disaster Management Act, 2005, which give legal framework for addressing public health emergencies. However, the implementation of emergency measures like lockdowns, travel restrictions, and the closure of businesses may have major impacts on the economy. This study aims to investigate the role of public health emergency laws in India and to analyze the effect of these laws on economic growth, employment, company activities and government expenditures. Besides this, it seeks to comprehend the challenges faced by workers, small firms and vulnerable sections of society in the time of public health emergency. Secondary data was collected from many sources such academic papers, government reports, books and other publications related to the topic. This underlines the necessity of striking a balance between safeguarding public health and the economy through the adoption of efficient legal systems, prompt support of the government, and appropriate economic policies. The study could help in identifying strategies to raise India's preparedness for future health catastrophes, while also reducing the negative economic impacts of such events.

Keywords: *Public Health Emergency Laws, Indian Economy, COVID-19, Economic Growth, Employment, Government Policies.*

Introduction

The roots of India's central public health emergency laws go back to the colonial era, with the key piece of legislation in this regard being the Epidemic Diseases Act of 1897. Therefore, this Act is a fairly simple, but peculiar, piece of legislation, which is crucial in the event of epidemics. It has only four components. It was adopted to combat the bubonic plague in Bombay state within the state. In

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contrast, the EDA may not be enough to deal with modern public health disasters, such as the COVID-19 pandemic, since it is antiquated and narrow. In the latter half of the 19th century and the early 20th century public health emerged in British India.1 It was a time of transition from polling to microscopic medical research, which helped build the foundation for new healthcare systems. Colonial administrations promoted both the proliferation of infectious diseases and the development of tropical medicine. In the backdrop of colonialism and the ecology of infectious disease, most of which still persist in the countries classified as undeveloped or third world today, it is conceivable to draw a link between the history of the sickness and precaution. The first ship to land in India was in 1600, carrying medical experts of the British East India Company. Western medicines have since gained a foothold in India.2. In recent years there have been initiatives to draft more comprehensive public health legislation. For example, the Public Health (Prevention, Control and Management of epidemics, bio-terrorism and catastrophes) Bill, 20173 was drafted by the Ministry of Health and Family Welfare, Government of India. This law was aimed at improving local government organizations and filling loopholes in the Emergency Declaration in the Emergency Declaration. Note that this proposal has not yet been introduced in Parliament and the Epidemic Diseases Act of 1897 continues to be in force. The Constitution of India empowers the President of India to announce three categories of emergencies, viz. national, state and financial emergencies. Yet, the Indian Constitution's provisions on emergency do not refer particularly to health issues. To be able to provide medical aid to all the citizens in case of health emergency, it is very important that the government at all the three levels i.e. union, state and local should participate.

The article is devoted to the evolution of public health services in developed countries.

The need for effective public health care was partly motivated by military considerations in industrialized nations. This was because the tally of army casualties from disease greatly exceeded those from combat. Moreover, elites had a vested interest in controlling illness because there was no guaranty before the discovery of antibiotics in the middle of the 20th century that a remedy could be found. And there was a danger to commercial interests, as demonstrated by the considerable financial losses suffered by Hamburg enterprises in 1892 due to a cholera epidemic.

Scientists, throughout the last decades of the nineteenth century, began to be able to identify germs and to understand how they cause disease. Therefore, the "sanitary movement" appeared, which made important changes in the health behaviors and private lives of the people, such as the decision to abandon the practice of keeping animals in the urban areas. There were all kinds of demonstrations, ranging from the big ones to an irate butcher chasing a sanitary inspector down a street in Chicago with a knife. Reforms had to be carried out rigorously (often by force), but also with a great deal of work to convince the populace that better cleanliness meant better general well-being.

There was much attention and aid given to the development of the organizational and technological infrastructure of public health services and public health engineering. By the middle of the twentieth century, the industrialized world had reached a stage at which the institutions and processes for the prevention of exposure to communicable diseases were well developed. Their initiatives had lowered

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the rates of mortality and morbidity dramatically. There was a substantial rise in the incidence of non-communicable diseases and this led to the growth of public health services to address these diseases by implementing lifestyle adjustments and managing environmental pollutants. Despite this, public health services are still quite effective in preventing and controlling communicable diseases and are often reviewed to better adapt to the ever changing environment.

As Japan prepared to become a world power it studied the public health systems of Europe, and rapidly copied them. Similar policies were also adopted in its colonies Korea and Taiwan. Johansson and Mosk (1987) found that reducing the incidence of communicable diseases in Japan raised the productivity of the work force and the life expectancy of the population, even when there was no rise in income or consumption. This is consistent with the observation that in 1940 the life expectancy in all three East Asian countries was around 50 years, well above the life expectancy in India, which was 32 years, although the availability of calories per capita was relatively similar in all three.

Public Health Services in Colonial India

Many of the public health measures introduced during the colonial era were aimed at the protection of British people and military cantonments. There is a lot of dispute about the topic whether it was due to a lack of concern for the well-being of Indians or a fear of provoking animosity by imposing behaviors that were widespread in other cultures. In any case, a variety of safeguards were made to ensure that the British were kept in residential areas which were segregated from each other and had proper sanitation facilities. Municipal areas were given gear which is specifically meant to ensure that the sanitary conditions in the municipal areas are good including the management of water, solid waste and liquid waste. These services were mainly aimed at the early detection and containment of outbreaks of fatal epidemic diseases such as cholera and the plague before they could spread to affect even the more privileged societies. This was true in both urban and rural locations. “Yet for such limited ends, the colonial authorities created an impressive capacity for the provision of services associated with public health: Institutions for public health education and research; among the greatest in the world. Among the most renowned are the All-India School of Public Health and Hygiene and the Calcutta School of Tropical Medicine. These organizations were engaged in original research on many subjects, from determining the transmission of malaria to making and testing immunizations, as well as providing technical leadership and assistance and teaching public health authorities.

Public Health in Accordance with The Constitution

It is not guarantyd specifically by the constitution of India. This means that it is not protected by the legislation of India. This indicates that right to health is not protected by Indian law. In comparison, the Constitution makes several references to public health and to the obligation of the state to treat its inhabitants and to provide them with medical care. The Right is based on section IV of the Indian Constitution which specifies the essential basis of the governmental policy. For example, Art. 39 (E) of Constitution lays down that the state shall defend the health of the employees, while Art. Article 42 provides for equal pay for equal labor. Article 47 requires the State to promote better health raising the nutritional and dietary standards of its population. Article 243G provides that

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municipalities and panchayats have powers other than those of the states (read with Entry 23 of the 11th Schedule). The interpretation of a number of major judgments shows that the right to life guarantyd by Article 21 is also a guaranty to right to health and healthcare provision. Furthermore, in September 2019, the 15th Finance Commission recommended that healthcare be recognized as a fundamental right and moved from the State list to the Concurrent list. In the Indian cooperative federalism, the VII Schedule has a place for the term "public health and sanitation; hospitals and dispensaries". The constitution requires state authorities to develop, apply, and enforce laws that are relevant to public health. In 2019, a review was carried out by NITI Aayog and it was seen that public health systems in different States of India were not up to the mark. The main reasons for this gap were the absence of technical skills and lack of financial resources. While the financial dependence of the states on the national government is still a major problem, the addition of health care to the Concurrent List will add to the amount of paperwork, institutional limitations and bureaucracies. Such centralization would result in a loss of constitutional rights of the states, yet the political ideology of the federal government would still be felt in the policy decisions of the states. What is equally important is that every state in India requires specialized attention, which a comprehensive plan would also not be able to provide. Cooperative federalism is an essential ingredient of the Indian Constitution but it should not be an impediment to the Center and the states working together on an issue as vital as health.

Public Health System in India After Independence

And, save from a marvelous capacity to suppress outbreaks after they have happened, there is very little left of the public health arrangements that existed throughout the colonial period. The capacity to halt outbreaks from happening hasn't worked as well as it once did. Till 1950 much had happened in the world and in India which had led to this atrophy. The following are among these contributors:

In the 1940s, techniques were developed to make antibiotics on a large scale. This allowed the local elites to protect themselves from dying from contagious diseases without the need to maintain strict environmental hygiene to prevent exposure to disease for both rich and poor. The industrialized world also became better at protecting themselves from the potential spread of epidemics from the poor world and the focus of medical research turned away from finding new technology for controlling infectious diseases. The sole exception was when they were endangered by newly-emerging diseases, against which they had no protection, such as the avian flu.

In the industrialized world, the leading causes of death have shifted from communicable to non-communicable diseases such as cancer and cardiovascular diseases, between the 1940s and the present. This change was driven by the results that were achieved in public health. At the same time, advances in medical technology held up the promise of treating these illnesses by clinical and surgical interventions. The glow and honor which used to be the property of the public health authorities now belong to the general practitioners of medicine. At the center of intellectual endeavor were no longer ways to improve public health systems but ways to develop therapeutic technologies and ways to fund health care.

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To help clearly identify project inputs and outputs, multilateral and other donor organizations have promoted the establishment of specialized institutional structures and programs to control various communicable illnesses. But they have opposed the building of health systems that attempt to utilize resources in the manner in which they are needed to improve public health outcomes.

The extension of democratic institutions also had implications for public health services. This is because electorates tend to be in favor of using public resources to provide private goods (like medical care) rather than public goods (like measures to safeguard the health of the people as a whole). 111 To sell a public health achievement in an election context requires ingenuity because the achievements are essentially bad. Big news: Advances in surgical procedures. Not news: "No cases of typhoid last year." When this occurs in the rich world it means that public health authorities have to struggle to keep up adequate funding,12 but when it occurs in the undeveloped world it can lead to a serious neglect of public health services. Significantly, East Asia's non-democratic governments were the most successful in the developing world in improving health outcomes. They did this by employing their limited resources for public health and not for high tech medical care.

Another factor is the capture of elites. It is more common in India than in most other developing countries where public funding for health and education have gone to the higher levels rather than the elementary levels. Much of the health expenditures have been spent on expanding subsidized medical training, generating jobs for medical graduates in the public sector and providing high-end tertiary medical services. All these activities are basically for the benefit of the middle classes and are detrimental to the delivery of public health services.

Moreover, some legislative actions undertaken by the newly independent India hampered the provision of public health services. First, the main policy aim was to build up heavy industry, not to promote health and education. In the 1950s, medical services and public health services were integrated. The most competent people were drawn to qualifications in specialty curative abilities, which were far more valued than qualifications in public health. Thus, the senior jobs were gradually taken up by persons having little knowledge or competence regarding public health, who were not well equipped and not motivated to monitor the activities relating to public health. There was also a decline in the demand for and supply of public health training. This atrophy was also driven by the fact that it is politically far easier to respond to budget constraints by cutting (the largely invisible) public health positions and activities, while expanding curative therapies for which there is tremendous electoral demand. This was a factor in the atrophy.

In addition, the demands of the Constitution left public health services stripped of the funding they required to operate. It was declared that the provision of public health services shall be the responsibility of the State Governments, except in the case of quarantine of ports and rules relating to the transmission of disease from one State to another or between States. In addition, the constitutional rules that govern fiscal concerns require that the bulk of the tax revenues earned by the states be remitted to the central government. This enables the central health authority to optimize their funds by compelling states to co-finance a large percentage of their initiatives. This leaves states with limited budget flexibility to run programs that are only partially funded by the national government. Examples of such programs are the provision of environmental sanitation and other basic functions of a public health system.

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The collapse of public health care was a reflection of these global trends as well as the acts of the newly independent government in a number of distinct ways.:

Objective of The Study

1. To research how public health emergency regulations handle medical emergencies and how they affect India's economic expansion.
2. To research the impact of public health emergency measures on employment, corporate operations, and government spending in India.

Review Literature

Upreti and Alam (2024), in a research project titled "Analyzing India's Central Public Health Emergency Laws and Its Impact on India's Economy," analyzed the public health emergency laws of India with particular attention on the Epidemic Diseases Act of 1897. The study looked at the usefulness of legislative measures in health emergencies such as COVID-19 and highlighted the need to strengthen India's emergency response mechanism.

Gowd, Veerababu, and Reddy (2021) studied the use of the Epidemic Diseases Act of 1897 and Disaster Management Act of 2005 during the COVID-19 pandemic in their study titled "COVID-19 and the Legislative Response in India: The Need for a Comprehensive Health Care Law." From their findings, they concluded that India requires a comprehensive public health law to better emergency management and clarify the obligations of the government.

Deb and Xu (2021) studied the "State-Level Health and Economic Impact of COVID-19 in India", where they explored the impacts of containment measures on the health and economics of many states of India. Their results indicate that limits were efficient in reducing the incidence of diseases, but they also involved considerable financial costs. The study concludes that improving the availability of social safety nets and health care infrastructure is crucial for minimizing economic losses.

Jha & Jha (2020): In their study project "India's Response to COVID-19 Crisis" the writers examined the challenges that India confronted in both public health and its economy during the epidemic. They discussed government policy, the impact of lockdowns and strategies for economic recovery. The researchers noted the difficulty in balancing public health protection and economic stability.

The Public Health Provisions and Failure to Perform

Since colonial times, the statutory basis for the provision of public health services, the Public Health Acts, has not been amended or rationalized. For example, fifty years ago, when the state of Karnataka was founded out of many contiguous kingdoms and provinces, it has not evolved a unified and updated Public Health Act. The laws that were in place for each constituent area throughout the time of colonial control are still in existence after all these years. The Public Health Act of 1939 was passed by the Madras Presidency and was still in force in the state of Tamil Nadu in 1999.13 The national government produced a Model Public Health Act in 1950, which was revised in 1987.

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However, the federal government did not influence the states to enact the Act. The big cities still have their privileges dating back to colonial times. That is because they still have public health regulations on the books and some staff and infrastructure to implement those regulations. These are far less common in small towns and in rural places and even less so in rural areas.

Regarding public health law, the Prevention of Food Adulteration Act is one of the few legislations that is still publicly known to be in force. The Act however suffers from a number of serious problems that prevent it from being able to adequately ensure food safety. First of all, the Act deals almost exclusively with the issue of food adulteration. In the midst of a vast body of exhaustive laws just a comparatively few paragraphs are devoted to the subject of food hygiene. To make matters worse, the Act is largely designed to penalize individuals who break its rules, rather than to help businesses understand and comply with its requirements. The slow manner in which the courts dispose of cases, and the very limited funding available to inspectors to take food samples for testing, have made it obvious to those who sell food that the law does not have any weight. Food inspectors are another shrinking group of professionals as they are not a top priority for governments that are struggling financially.

Funds that were Meant for Public Health Services were Diverted

Specifically, the family planning program is used as an illustration of the distortionary implications linked with the fiscal and planning system. In the mid-1960s, after a period of several years of food shortages and the results of the Census showing that population growth rates had accelerated fast, the government of India embarked on a deliberate attempt to reduce the rate of population growth in the country. The network of public clinics was rapidly expanded to provide services such as sterilization and other contraception choices. The central government provides financial support to the family planning program to show its benevolence. For example, it pays the salary of female outreach staff. The share of the central government's health budget for this program has risen dramatically, at the expense of other health programs. States have to pay for the upkeep of the clinics and the salaries of the medical experts and other staff members.

The revenue available for what are supposed to be routine public health services has been slowly but surely declining, thanks to the great financial strain on the governments. Therefore, these services are usually unimportant, at best. For example, a large number of vacancies for Sanitary Inspectors are still unfilled in the state of West Bengal. With the salaries of male health workers to be paid by the state governments, there is an increasing trend all over the country for the post of male health workers to remain vacant also.

The difficulties are compounded by untargeted labor regulations that place a greater focus on safeguarding workers than ensuring that staff are appropriately qualified. For example, in West Bengal, malaria workers were provided job security by bringing them into the cadre of male health workers. Therefore, a large percentage of the critical remaining posts in this crucial but underfunded and shrinking cadre of public health workers are occupied by unqualified people. Moreover, the staff is also going through a reduction in their public health training. An example of this was the area Sanitary Inspector of a large area who said that in his 33 years of service he had been given virtually no training in public health."14" It is very important to improve the training and career opportunities available to public health personnel.

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Detrimental Organizational Changes to The Health of The General Population

Other problems arise from the fact that health care has been made principally the responsibility of the state and that a 'command and control' structure of centralized planning relies on the states' dependence on the center for their financial resources. The federal government is the main actor in the formulation of health policy and programs. Partly because of it, state budgets are very tight, as we talked about earlier. In contrast, the central government is mainly interested in the development of certain programs, e.g. the eradication of malaria or family planning. This means that the bulk of the funds that the national Health Ministry gives to the states are earmarked for particular programs and types of expenditure under the programs. Moreover, states cannot simply redirect the money to things that might be of greater local interest.

A related challenge is the very limited scope of full reviews of public health policies, fine-tuning their implementation and rationalizing the use of resources. All of these were actions that were done during the colonial period, through such forums as the Sanitary Conferences. Failure of a public health system also suggests that there is lack of adequate coordination across the sectors to reduce wastage of resources. For example, if the irrigation department creates malaria by leaving a canal half-built and inundated, the health department has little choice. But, if an epidemic emerges, they will be asked to expand the number of clinical treatments they offer to correct the condition. There are many agencies that might function in parallel or even against each other through their operations. Such inclinations are further reinforced by funders, as it was already stated in this paragraph.

The design and implementation of public health projects have increasingly become ad hoc in ways that are severely damaging to efficient functioning. For example, the practice of implementing health initiatives on a "campaign" basis soon became the conventional method of operation. The practical result of this is that if a particular problem is accorded high priority, then large resources are diverted to deal with it, and vise versa. Public health, however, cannot be sustained by constant 'campaign' activities. A campaign can do a lot; but the benefits may be short-lived if there are no continuing processes to identify and address any hazards that remain or are imported. For example, the United States of America has a few cases of different communicable diseases each year, but these cases are controlled and eliminated due to constant observation.

A historical perspective on public health in India since 1950 indicates that the service structure lends itself to successful campaigns which are subsequently followed by unsuccessful "maintenance" phases of disease control projects. Other health care personnel are initially classified as "multipurpose" except for female health workers who are designated to offer family-planning-related services. This is a nice idea in theory, but in fact they're allocated to whatever is considered a priority at the moment, and they're discouraged from doing other things like maintaining the gains that were earned via earlier efforts.

India is a good example. India came very near to eliminating malaria with a very effective campaign in the 1950s, but the program was put into a "maintenance phase" and malaria returned. This is a remarkable illustration of how near India was to wiping them out. While the revival has been widely attributed to the emergence of DDT resistant mosquito populations, there is no question that the

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government does not really buy this, given they still use DDT as their main weapon against malaria. The program design issues have not received the attention they need. The malaria control effort was well organized in the 1950s but later the emphasis on organization of the program declined. For instance, the present policy stipulates that the central government is responsible for providing the DDT, medications and other supplies while the state government is principally liable for all the costs associated with the labor. It is not unusual that states cannot afford the people necessary to thoroughly supervise the spraying activities and to prepare communities ahead of time so that they can plaster their homes before the spraying rather than plastering over the DDT. That's the sort of thing that occurs. There is also diversion of manpower.

There has been a rapid transition away from public health in independent India, and the Five-Year Plans record this change. Little was done to enhance sanitation in the 1950s, yet the Plans recognized the importance of cleanliness in the prevention of the spread of communicable diseases. In the chapter on health planning, water and sanitation were seen as a fundamental component and sanitary inspectors as a fundamental group of front-line worker staff. Water and sanitation had by the 1960s been delimited as outside the health sector, and no further mention was made of sanitary inspectors in the Plans. This is when the Plans were made.

Reduced emphasis on the outcomes of public health efforts was echoed in a number of other parts of the Plans. For instance, there is a huge difference between the discourses of the health programs and those of the high priority family planning program. The health components included in successive plans address inputs and the present thrusts of priority areas including the development of universal immunization drives. The remainder of the text provides a generally depressing review of policies and programs. In the case of the 9th Plan on malaria, the analysis of shortcomings often does not contain suggestions for possible solutions. For example, the new malaria policy do not mention environmental management at all. Essential concerns are not even being paid lip regard. This is one example.

Conversely, the family planning sections begin with a detailed examination of the performance of the program, the reasons for the flaws and the solutions to the problems. The paper not only emphasizes the need for operational research but also provides new suggestions to stimulate the demand for family planning services. In fact, the program developed a very effective IEC campaign which was aimed at changing the desired family size of the people and thereby improving the overall success of the programs. Such activities have seldom been undertaken in the health sector and when they have, they have usually been in support of campaign type efforts, e. g. immunization. These attempts are not to radically change the health practices of people to reduce their contact with communicable diseases.

Conclusion

There is plenty to be optimistic about the chances that public health will get more attention in the not too distant future. Some of the financing sources available are large scale programs like Rural Health Mission, National Sanitation Mission and enhanced support to the Employment Guaranty Scheme. Well-implemented programs of this sort have the potential to improve the outcomes of public health.

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As one example, food-for-work programs helped rid most of the South of malaria during the Great Depression. This undertaking was made successful via the labors of teams of sanitary engineers, entomologists and administrators. This was accomplished via careful planning and management of the job. At the same time, institutions are being built at national and institutional levels that have potential for major contributions to public health. The Panchayati Raj Act has laid stress on the need for setting up local governments and devolution of health related tasks to them. This makes possible the formation of institutions for the management of public health activities in the field, with the necessary intersectoral coordination. Some states like West Bengal and Kerala are experimenting with the feasibility of these options which can serve as examples for other states. The fact that elections and censuses have been conducted smoothly across a vast population which includes people living on the streets and those living in remote areas is proof of India's exceptional capabilities to deliver services. Its neglect of public health is having a huge impact not only on the economics of the country but also on the lives of its citizens. It is time for the administration to understand that public health is a critical part of the infrastructure needed to build the country.

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